College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

# Midwifery Scope of Practice

## June 2021

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# 1 INTRODUCTION

The role of the College of Midwives of Ontario (College) is to ensure that midwifery services provided to the public are delivered in a safe and ethical manner by midwives. Part of this involves ensuring that midwives understand their scope of practice and practise within it.

The purpose of this document is to describe the midwifery scope of practice set out in the *Midwifery Act, 1991*[1], its regulations and other legislation that govern the midwifery profession in Ontario. In addition to providing information about scope, this document also provides regulatory guidance to midwives about working within the midwifery scope of practice and what to do when a client's clinical condition or the care they required is no longer in the midwifery scope of practice.

This document is designed to assist midwives to ensure their practice complies with legislation. It does not replace professional and clinical judgment, and midwives remain accountable for their practice. The interpretations in the document reflect the context at the time of the document's implementation, and interpretations may change as midwifery practice develops. To reflect possible changes, the College will update the document from time to time. Please note that the document does not replace the authority of the *Midwifery Act, 1991*, and other legislation governing midwifery. If, after reviewing this document, you have questions involving scope of practice and need clarification you should contact the College for professional practice advice or seek the advice of a lawyer.

This document intended for use by midwives and their interprofessional colleagues including physicians, nurses, respiratory therapists, and pharmacists as well as by health care organizations that oversee institutions where midwives practise. The document is also intended to help clients understand the spectrum of care midwives are permitted to provide.

Throughout the document the terms "must" and "should" are used. The use of "must" indicates a requirement (e.g., a legislative requirement or a standard of practice) while the use of "should" indicates a recommendation.

1 *Midwifery Act, 1991*, S.O. 1991, c. 31 [*Midwifery Act*].

# 2 LEGISLATIVE CONTEXT IN ONTARIO: SCOPE OF PRACTICE SCHEME

A health care professional's scope of practice is the range of activities, including decisions and procedures, that they are authorized to perform by the laws that govern their profession. In Ontario, the scope of practice scheme is set out in the *Regulated Health Professions Act, 1991* (RHPA)[2] and consists of two main elements: a **scope of practice statement** and the **controlled acts** authorized to each profession.

## 2.1 Scope of Practice Statement

The **scope of practice statement** is found in each profession-specific Act, and it defines, in broad terms, the outer parameters of what that particular profession can do. For example, the midwifery scope of practice is set out in the *Midwifery Act, 1991*, which is the profession-specific Act for midwives. Profession-specific Acts of other health care professionals include the *Medicine Act, 1991* for physicians, the *Nursing Act, 1991* for nurses, and the *Pharmacy Act, 1991* for pharmacists.

The midwifery scope of practice is set out in the *Midwifery Act, 1991*, which is the profession-specific Act for midwives.

## 2.2 Controlled Acts

**Controlled acts** are set out in the RHPA and are procedures, tests, and treatments that are considered to pose a risk of harm when performed by someone who is not qualified to perform them. Because there is implicit risk of harm in the performance of controlled acts, they can be performed only by the regulated health professionals who are authorized by their profession-specific Acts (e.g. the *Midwifery Act, 1991*) to perform them. There are 14 controlled acts listed in the RHPA[3]. Some professions do not have any controlled acts. Other professions, like midwifery, are authorized to perform many controlled acts. No profession is authorized to perform all controlled acts.

Controlled acts can be authorized to professions either in their entirety or only partially depending on what is considered appropriate for that profession's scope of practice. For example, the controlled act of *managing labour or conducting the*

2 *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 [RHPA].

3 RHPA at s. 27(2)12.

*delivery of a baby*[4] is authorized to physicians in its entirety but is authorized to midwives only partially. This means that physicians can perform all of the controlled act of *managing labour or conducting the delivery of a baby* without limitations; whereas for midwives this controlled act is limited, and they can only *manage labour and conduct spontaneous normal vaginal deliveries*[5].

### 2.2.1 Delegation of Controlled Acts

Delegation is a formal process by which a regulated health professional, who is authorized to perform a controlled act, delegates the performance of that controlled act to another person who is otherwise not authorized to perform it. This other person may be a member of another profession regulated under the RHPA, a member of an unregulated profession, or a member of the public.

For example, a midwife may be delegated the controlled act of *placing an instrument, hand or finger into an artificial opening into the body*[6] by a physician allowing the midwife to assist during a caesarean birth. Similarly, a midwife might delegate the act of *managing labour and conducting spontaneous normal vaginal deliveries*[7] to a registered nurse.

The delegation must be in accordance with any regulations or standards of practice. For example, it is a College standard that midwives are prohibited from delegating the controlled act of prescribing[8]. It is also a standard of practice that midwives must only accept delegated acts that they are competent to perform[9].

### 2.2.2 Exceptions to Controlled Acts under the RHPA

Section 29 of the RHPA permits the performance of controlled acts by people who do not have the authority to perform a controlled act. This person may be a member of another profession regulated under the RHPA, a member of an unregulated profession, or a member of the public. These exceptions differ from delegation because no handover of responsibility is required; however, the person must possess the knowledge, skills, and judgment required to perform the controlled act.

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4 *Medicine Act*, S.O. 1991, c. 30 at s. 4.11.

5 *Midwifery Act* at s. 4.2.

6 RHPA at s. 27(2)6vii.

7 *Supra* note 5.

8 College of Midwives of Ontario, *Standard on Prescribing and Administrating Drugs* (January 2014).

9 College of Midwives of Ontario, *Professional Standards for Midwives* (June 2018).

One of the exceptions is rendering first aid or temporary assistance in an emergency[10]. Whether or not a situation constitutes an "emergency" will depend on a number of factors, including the immediate harm to the client and the availability of other resources. What may be an emergency in a remote location may not be an emergency in an urban setting where other care providers, more experienced in managing such an emergency, may be readily available. This exception permits midwives to perform the controlled act of *putting an instrument, hand, or finger beyond the point in the nasal passages where they normally narrow* during the performance of neonatal resuscitation.

Another exception is granted to students or trainees who are authorized to perform controlled acts within the scope of their future profession if those acts are done under the direction and supervision of a member of the profession[11]. This exception permits midwifery students to insert a urinary catheter into a pregnant client under the supervision of a midwife registered with the College[12].

## 2.3 *Laboratory and Specimen Collection Centre Licensing Act*

The *Laboratory and Specimen Collection Centre Licensing Act, 1990* regulates Ontario's hospitals and private medical laboratories, including these laboratories' specimen-collection centres. General Regulation 45/22 of the *Laboratory and Specimen Collection Centre Licensing Act, 1990* authorizes midwives to collect specimens and order laboratory tests in accordance with a specific list outlined in Schedule 2. This means that while midwives are authorized to order laboratory tests and collect specimens, this authority extends only to those tests and specimens that are listed in Schedule 2[13].

## 2.4 The Public Domain

While the RHPA limits the performance of controlled acts to health professionals who are authorized by their profession-specific Act to perform them, many components of health care are not controlled acts because they do not pose risk of harm. This means that these components of care are not prohibited by the controlled acts in the RHPA and can be done by anyone, not only by regulated health professionals. This care is sometimes referred to as being in the **public domain**. For example, taking a blood pressure is in the public domain (i.e., is not a controlled act), which means that unregulated professionals and members

10 RHPA at s. 29(1)(a).

11 *Ibid* at s. 29(1)(b).

12 For a complete list of exceptions to controlled acts, see s. 29(1) of the RHPA.

13 *Laboratory and Specimen Collection Centre Licensing Act, 1990,* S.O. 1990.

of the public can do it. But diagnosing someone with a disease or disorder based on the reading of that blood pressure (e.g., diagnosing a pregnant client with gestational hypertension based on their blood pressure) is a controlled act. This is because there is not a great risk of harm in taking the blood pressure, but there may be a risk of harm when making a diagnosis based on that blood pressure.

# 3 LEGISLATIVE SCOPE OF MIDWIFERY PRACTICE

The legislative scope of midwifery practice consists of the scope of practice statement, the controlled acts authorized to midwives, laboratory tests midwives can order, and all other activities that are in the public domain. This is commonly referred to as the **midwifery scope of practice**. In essence, the midwifery scope of practice is the activities, decisions, and tasks that a midwife is permitted to do by law. The midwifery scope is a legal boundary; it is not flexible and cannot be expanded by practitioners, regulators, or institutions. Scope changes can only be achieved through a legislative change.

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## 3.1 Scope of Practice Statement – Key Concepts and Definitions

The midwifery scope of practice statement is set out in the *Midwifery Act*:

> *The practice of midwifery is the assessment and monitoring of women during pregnancy, labour, and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour, and post-partum period and the conducting of spontaneous normal vaginal deliveries.*[14]

The scope of practice statement uses several terms including **postpartum**, **newborn**, **spontaneous**, and **normal** that have no universal definition. In order to understand the scope, these terms need to be defined. The following are definitions of these terms for the purpose of interpreting the scope of practice statement in the *Midwifery Act, 1991*.

14 *Midwifery Act* at s. 3.

- **Newborn** means a baby from the moment of birth up to eight weeks after birth. *Note: Midwives are authorized to perform the controlled act of communicating a diagnosis only up to six weeks after birth. More on the controlled act of communicating a diagnosis is described in Table 1.*
- **Normal** means a clinical picture that is considered healthy or uncomplicated. Normal applies to the overall health status of the individual and does not necessarily rule out the presence of a specific condition or indicate the complete absence of abnormal. Normal can include infections, conditions, or clinical presentations requiring monitoring or treatment when the overall health status of the client or newborn is considered healthy or uncomplicated. Determining if a clinical situation is normal requires clinical judgment and may also require diagnostic tests or consultations with other care providers.
- **Postpartum** means the period of time beginning with the birth of a baby and ending eight weeks after the birth when the effects of pregnancy on many systems have largely returned to the unpregnant state. *Note: Midwives are authorized to perform the controlled act of communicating a diagnosis only up to six weeks after birth. More on the controlled act of communicating a diagnosis is described in Table 1.*
- **Spontaneous** means a birth that occurs with maternal effort only and is not assisted by any means. A birth requiring forceps or vacuum is not spontaneous. Spontaneous refers only to the birth of the newborn and does not refer to the onset of labour and can therefore include induction and augmentation.
- **Woman** means an individual who is pregnant, labouring, giving birth, or postpartum. In this document, the terms "client" and "individual" will be used in place of woman unless woman exists in the language of the legislation.

Normal means an overall clinical picture that is considered low-risk or uncomplicated. Normal applies to the overall health status of the individual and determining if a clinical situation is normal requires clinical judgment.

Using the definitions provided above, the midwifery scope of practice involves providing care to individuals during normal pregnancy, labour, spontaneous vaginal birth, and for up to eight weeks postpartum for both clients and newborns. Any person who falls outside of this time frame is not considered in the scope of practice, and midwives cannot provide care to them on their own

authority. This means midwives are not permitted to provide midwifery care to anyone who is not pregnant or postpartum or who are not in labour or having a spontaneous vaginal birth. Midwives also cannot provide midwifery care to babies over eight weeks of age.

## 3.2 Controlled Acts Authorized to Midwives

Midwives are authorized to perform a number of controlled acts. Controlled acts are only authorized to midwives while engaging in the practice of midwifery. All of the controlled acts authorized to midwives are authorized only partially, which means midwives do not have the authority to perform any of the controlled acts in their entirety. The details of the controlled acts are described below in Table 1. Column 1 sets out the controlled acts authorized to midwives as set out in the *Midwifery Act* and the *Controlled Acts Regulation*. Column 2 interprets what midwives are permitted to do and not permitted to do, related to the authorized act.

TABLE 1 | Controlled acts authorized to midwives and their interpretation

| CONTROLLED ACT | INTERPRETATION |
|---|---|
| **Authorized to midwives under the *Midwifery Act, 1991*:** | |
| 1. Communicating a diagnosis identifying, as the cause of a woman's or newborn's symptoms, a disease or disorder that may be identified from the results of a laboratory or other test or investigation that a member is authorized to order or perform on a woman or a newborn during normal pregnancy, labour, and delivery and for up to six weeks postpartum. | **PERMITTED**<br>• May communicate a diagnosis to a client identifying diseases and disorders, based on tests or investigations that a midwife is authorized to perform, for clients and newborns up to six weeks postpartum. |
| | **NOT PERMITTED**<br>• Must not communicate a diagnosis identifying diseases and disorders for individuals after six weeks postpartum or for newborns who are older than six weeks.<br>• Must not communicate a diagnosis to a client identifying diseases and disorders, based on tests or investigations that a midwife is not authorized to order or perform. |

| CONTROLLED ACT | INTERPRETATION |
|---|---|
| *Note: Not every interaction with a client, in relation to their health or condition, constitutes communicating a diagnosis. It is generally accepted that communicating a diagnosis includes the following three components:*<br>1. *It must identify the existence of a disease or disorder based on tests and investigations*<br>2. *It must include direct communication with a client or their representative regarding the identified disease or disorder based on tests or investigations*<br>3. *It must be reasonably foreseeable that a client or their representative will rely on this diagnosis to make choices about treatment*[15]*.* | |
| *This means that communicating a diagnosis to another healthcare provider, communicating the results of an assessment to a client or forming a hypothesis of what could be causing the symptoms do not fall within the controlled act of communicating a diagnosis and so can be performed for individuals up to eight weeks postpartum or for newborns who are up to eight weeks old.* | |
| 2. Managing labour and conducting spontaneous normal vaginal deliveries. | **PERMITTED**<br>• May manage labours and only conduct deliveries that are spontaneous, normal and vaginal. |
| | **NOT PERMITTED**<br>• Must not conduct deliveries that are not spontaneous, normal and vaginal. |
| 3. Inserting urinary catheters into women. | **PERMITTED**<br>• May go beyond the opening of the urethra only for inserting catheters into clients. |
| | **NOT PERMITTED**<br>• Must not insert urinary catheters into newborns. |
| 4. Performing episiotomies and amniotomies and repairing episiotomies and lacerations, not involving the anus, anal sphincter, rectum, urethra and periurethral area. | **PERMITTED**<br>• May perform episiotomies and amniotomies. May repair lacerations and episiotomies that involve the skin and muscle of the perineum and labia. |
| | **NOT PERMITTED**<br>• Must not perform any other procedures below the dermis as they fall under the broader controlled act not authorized to midwives. This includes repairing tissues of the anus, anal sphincter, rectum, urethral or periurethral area and performing procedures such as acupuncture or newborn frenectomies. |

15 Richard Steinecke, *Complete Guide to the Regulated Health Professions Act*, (Aurora, Ont: Canada Law Book, 1995).

| CONTROLLED ACT | INTERPRETATION |
|---|---|
| 5. Administering, by injection or inhalation, a substance designated in the regulations. | **PERMITTED**<br>• May administer, by injection or inhalation, any substance that is included in the Designated Drugs regulation under the *Midwifery Act, 1991* such as nitrous oxide for inhalation, Hepatitis B vaccine by injection, or fluids through intravenous catheters. |
| | **NOT PERMITTED**<br>• Must not administer by injection or inhalation a substance that is not designated in the Designated Drugs regulation. |
| 6. Prescribing drugs designated in the regulations. | **PERMITTED**<br>• May prescribe drugs included in the Designated Drugs regulation and drugs that can be lawfully purchased or acquired without a prescription. |
| | **NOT PERMITTED**<br>• Must not dispense, sell, or compound a drug.<br>• Must not prescribe a drug that is not included in the regulation. |
| 7. Putting an instrument, hand or finger beyond the labia majora or anal verge during pregnancy, labour and the postpartum period. | **PERMITTED**<br>• May perform procedures that involve hands, fingers or instruments placed beyond the labia majora or anal verge. This means midwives may perform numerous procedures on clients including inserting a speculum into the vagina, inserting fingers, catheters or intrauterine devices into the vagina and cervix, inserting a finger into the rectum, and inserting a fetal scalp electrode. |
| | **NOT PERMITTED**<br>• Must not perform a procedure on a newborn that goes beyond their labia majora or the anal verge. |
| 8. Administering suppository drugs designated in the regulations beyond the anal verge during pregnancy, labour and the postpartum period. | **PERMITTED**<br>• May go beyond the anal verge for the purpose of administering medications that are included in the Designated Drugs regulation under the *Midwifery Act, 1991*. |
| | **NOT PERMITTED**<br>• Must not administer any medication beyond the anal verge that are not included in the Designated Drugs regulation.<br>• Must not administer suppository drugs to newborns. |

| CONTROLLED ACT | INTERPRETATION |
|---|---|
| 9. Taking blood samples from newborns by skin pricking or from persons from veins or by skin pricking. | **PERMITTED**<br>• May take blood samples from newborns by skin pricking only.<br>• May take blood samples from a client's veins by venipuncture or by skin pricking.<br>• May take blood samples from a non-client if the test is related to the delivery of midwifery care to the client. |
| | **NOT PERMITTED**<br>• Must not perform venipuncture on newborns.<br>• Must not take blood samples from a non-client if the test is unrelated to the delivery of care to the client. |
| 10. Intubation beyond the larynx of a newborn[16]. | **PERMITTED**<br>• May insert an instrument beyond the larynx of a newborn for the purpose of intubation only. |
| | **NOT PERMITTED**<br>• Must not insert an instrument beyond the larynx of a newborn for anything other than intubation.<br>• Must not insert anything beyond the larynx of an adult. |
| 11. Administering a substance by injection or inhalation if the procedure is ordered by a member of the College of Physicians and Surgeons of Ontario. | **PERMITTED**<br>• May administer by injection or inhalation any substance that has been ordered by a physician. |
| | **NOT PERMITTED**<br>• Must not administer by injection or inhalation a substance that is not designated in the Designated Drugs regulation or is not ordered by a physician. |
| **Authorized to midwives under the *Controlled Acts Regulation*:** | |

16 Under the Midwifery Act, a midwife is only authorized to perform this procedure when performed in accordance with the Intubation of a Newborn requirements set out in the General Regulation O. Reg. 335/12, 1991 c. 31. S. 15.1.

| CONTROLLED ACT | INTERPRETATION |
|---|---|
| 12. Applying and ordering the application of soundwaves for pregnancy diagnostic ultrasound or pelvic diagnostic ultrasound[17]. | **PERMITTED**<br>• May order and perform pregnancy diagnostic ultrasounds and pelvic diagnostic ultrasounds during the postpartum period. Examples include routine fetal assessment, confirmation of placental location and retained products of conception. |
| | **NOT PERMITTED**<br>• Must not order or perform diagnostic ultrasounds for conditions that are not related to pregnancy, birth or postpartum, or on parts of the body that do not include the fetus or pelvic organs.<br>• Must not order or perform ultrasounds on newborns. |

## 3.3 Practising to the Full Legislative Scope

Practising to the full legislative scope, also known as full scope midwifery, means providing all aspects of midwifery care scope including labour, birth, postpartum

and newborn care, including all of the authorized acts.

The ability to work to the full midwifery scope is influenced by intrinsic and extrinsic factors. Intrinsic factors are personal factors, such as being a new midwife who has not been exposed to all of the procedures required to work to full scope or a midwife who has an injury that limits their ability to provide all aspects of midwifery care. Midwives cannot, however, limit their scope of practice in contravention of provincial or national laws. For example, a midwife cannot use discretion over their own scope of practice to exclude individuals from care based on one of the protected grounds in the *Ontario Human Rights Code*.

Extrinsic factors are those such as practice setting

As primary care providers and regulated healthcare providers, midwives are responsible for determining the limits of their own competence.

17 This controlled act is authorized to midwives by way of an exemption under s. 4 of the Controlled Acts Regulation under the RHPA. The exemption means midwives are permitted to apply and perform pregnancy and pelvic diagnostic ultrasounds but the authorization to do so is not found in the *Midwifery Act, 1991* with the other authorized acts.

or client needs. For example, a midwife may be practising in a hospital that does not provide epidural analgaesia so would not have access to this part of the scope. While extrinsic factors should be based on resources and the best interest of clients, there are situations where this is not the case. This occurs when midwifery practices choose not to work to the full scope even when their privileging hospital supports it. This also occurs when institutions, such as hospitals, limit midwives from providing full scope midwifery care despite evidence showing that optimizing the midwifery scope of practice is in the best interest of the public. The scope of practice of every health professional should enable them to contribute optimally to providing high quality patient-centred care without compromising patient safety and that … the health care system should enable them to practise to the fullest extent of this scope[18]. When client care is not central to the decision-making about scope limitations then midwives, midwifery practices, and advocacy organizations should work with these institutions to develop policies and protocols that reflect the legislative scope of midwifery practice.

A transfer of care is the transfer of primary clinical responsibility to another care provider and is required when a client's condition is outside the legislative scope of practice.

Practising to the full legislative scope requires that midwives have the necessary competencies to do so. As primary care providers and regulated healthcare providers, midwives are responsible for determining the limits of their own competence. A midwife's competence can change throughout their career. Midwives can gain new competencies by engaging in professional development activities, such as participating in trainings, taking courses, and providing elements of care they had not previously provided. At the same time, a midwife may lose competencies if they have not provided certain elements of care for an extended period of time. In allsituations midwives must be competent in all aspects of care they are providing or they must consult with, or transfer the care of the client to, another care provider.

18 Canadian Medical Association, "Best Practices and Federal Barriers: Practice and Training Health-care Professionals" (Submission to the House of Commons Standing Committee on Health: 2015) at 3.

# 4 WHEN A CLIENT'S CONDITION IS OUTSIDE THE LEGISLATIVE SCOPE OF PRACTICE

When a client's condition falls outside the legislative scope of practice, the midwife has two options: either they transfer responsibility and accountability (i.e., transfer care) for the client to another health care provider or provide care under delegation in accordance with College standards.

## 4.1 Transfer care to another care provider

A transfer of care is the transfer of primary clinical responsibility to another care provider and is required when a client's condition is outside the legislative scope of practice. For example, a pregnant client with a breech presentation choosing a caesarean section must be transferred to a physician for the birth because only births that are spontaneous and vaginal are in the midwifery scope of practice and a caesarean birth is not spontaneous and vaginal. If this same client were to choose a vaginal birth, then a transfer of care would not be required if the midwife is competent to provide this care because a spontaneous vaginal birth is not outside the legislative scope of practice.

Delegation allows midwives to provide care outside the scope of practice as long as a regulated health professional with the authority to perform the controlled act grants this authority to the midwife.

Transfers can be temporary, such as in this case of a planned caesarean section for a breech presentation, because only the intrapartum period is outside of the scope of practice. Transfers can also be permanent, for example, when a client gives birth at 24 weeks gestation, and the newborn requires months of hospitalization and treatments. When a transfer of care is required, clients should understand the need to transfer and that they will be under the care of a physician so their plan of care may change. After a transfer of care has taken place, a midwife should continue providing care in collaboration with the most responsible provider and in the best interest of the client and their newborn. In this situation, all controlled acts must be performed under delegation.

## 4.2 Working under delegation

Delegation allows midwives to provide care outside the scope of practice as long as a regulated health professional with the authority to perform the controlled

act grants this authority to the midwife. This provides midwives with the legal authority to perform a controlled act that is otherwise not authorized to the profession. For example, in the case of the 24-week preterm infant transferred to physician care, a midwife can participate in the care of this newborn as long as any controlled acts, such as inserting an intravenous catheter, are provided under delegation. Midwives must also work under delegation when performing controlled acts on individuals who are not pregnant, in labour, postpartum or newborn. A decision-making tool for working under delegation can be found in Appendix A.

## 5 WHEN ELEMENTS OF CARE ARE OUTSIDE THE LEGISLATIVE SCOPE OF PRACTICE

When a client's clinical condition is in the midwifery scope but they require tests, treatments, or procedures that are not authorized to midwives, the midwife must consult with another health care provider, such as a physician, to provide the required care. For example, midwives are able to determine that a perineal tear involving the anus, anal sphincter, rectum, urethra, and periurethral area is outside their scope of practice and requires a consultation with a physician to repair this tear. While a complete transfer of accountability is not required for the management of the client's course of care, a consultation is required to perform the controlled act that is not in the midwifery scope. Another example demonstrating the need to consult relates to ordering ultrasounds. It is in the scope of practice to order pregnancy and postpartum diagnostic ultrasounds but it is not in scope to order ultrasounds on newborns. This means that when a healthy newborn requires an ultrasound to follow up on findings from an ultrasound done in pregnancy, a midwife must consult with a physician to order it. A tool for supporting a midwife's decision-making regarding scope of practice is found in Appendix B.

# 6 CONCLUSION

Providing care on the midwife's own authority requires that all clients and all procedures, tests, and treatments are in the legislative scope of practice. Providing care on the midwife's own authority also requires that they have the necessary knowledge, skills, and judgment to perform each task competently. Determining what is within or outside the scope of practice is not always straightforward; it may involve a range of inter-related factors and may require a consultation with another care provider.

No document can define every activity, such as a test or treatment, that a midwife is or is not authorized to perform because it is not possible to foresee and address all clinical situations that will arise throughout a midwife's professional career. The following decision-making tools (see Appendices A and B) were developed to assist midwives in determining which clients and what activities are in the midwifery scope of practice and when to accept a delegation.

## APPENDIX A

# DECISION-MAKING TOOL FOR A MIDWIFE ACCEPTING A DELEGATION

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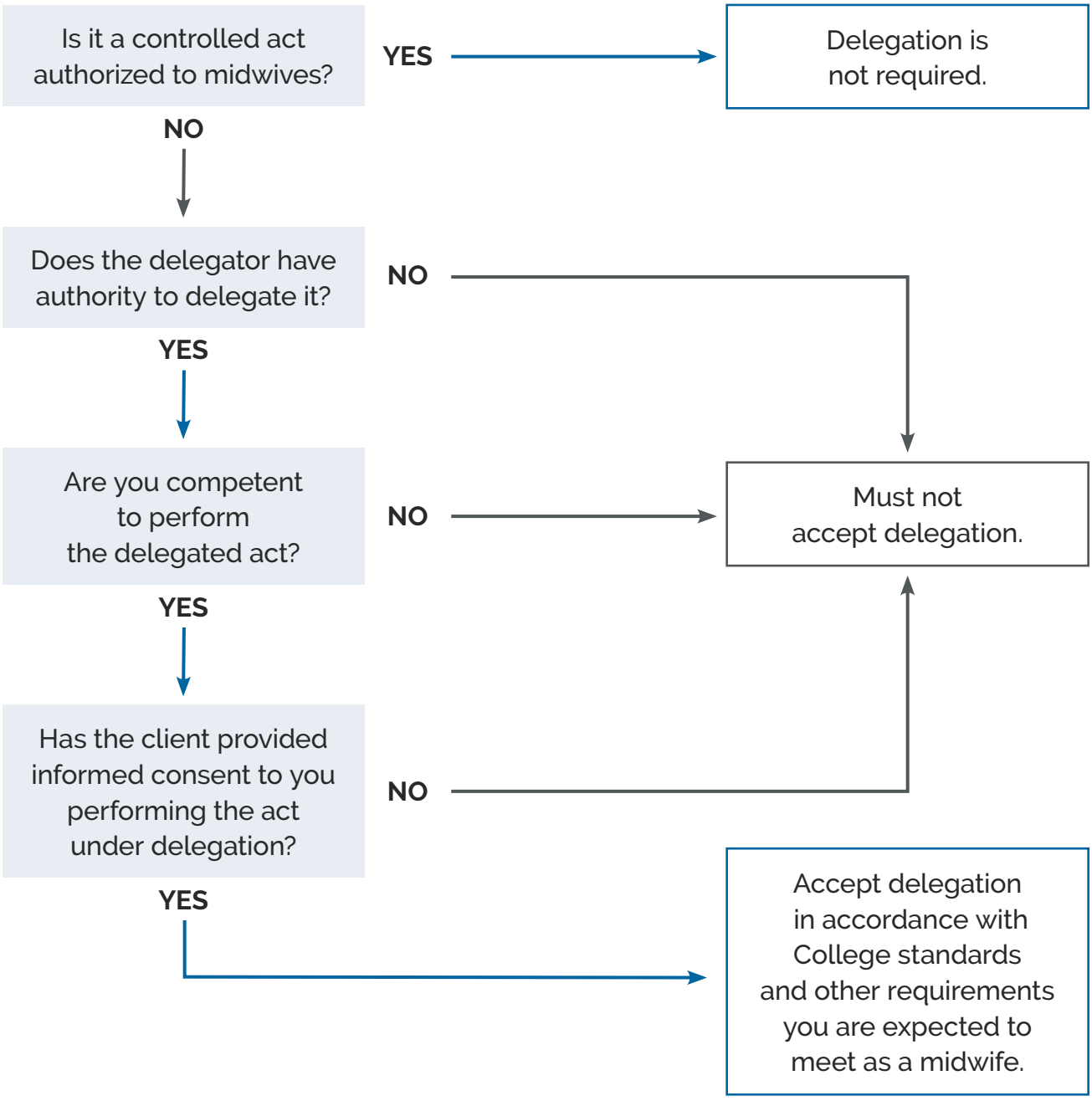

## APPENDIX B

# DECISION-MAKING TOOL FOR A MIDWIFE DETERMINING SCOPE OF PRACTICE

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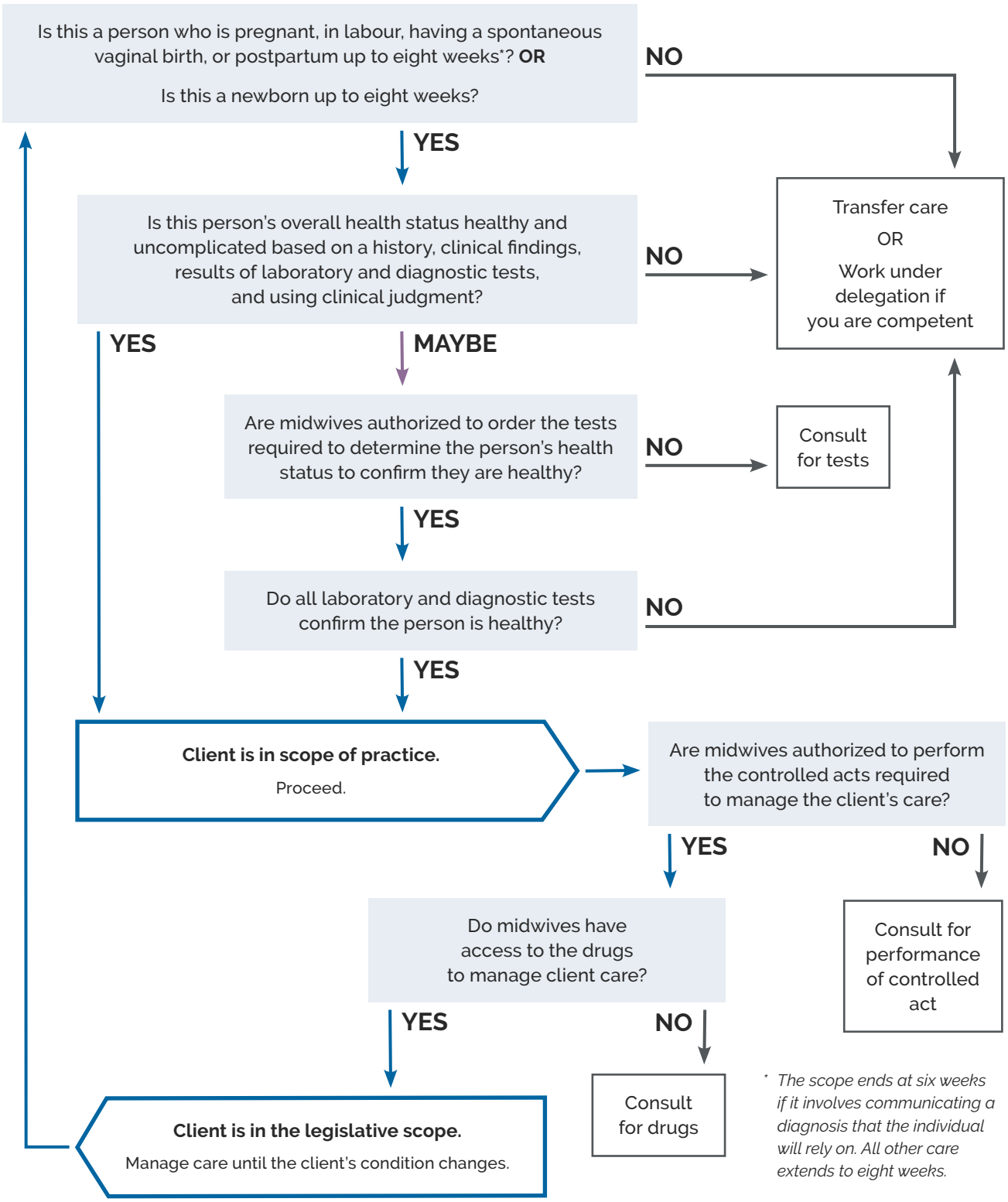


* *The scope ends at six weeks if it involves communicating a diagnosis that the individual will rely on. All other care extends to eight weeks.*

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