College of Midwives of Ontario

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THE MIDWIFERY MODEL OF PRACTICE IN ONTARIO

WHAT IS A MIDWIFE?

On December 31, 1993 the *Regulated Health Professions Act,1991 (RHPA)* was proclaimed into law. According to this 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."

This is consistent with the International Definition of a Midwife as:

> "...a person whom having been regularly admitted to a midwifery education program, duly recognized in a country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period, to conduct deliveries on her own responsibility and to care for the newborn infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients, but also within the family and community. The work should involve antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions, or in any other service." (see reference 1)

THE MIDWIFERY MODEL OF PRACTICE IN ONTARIO

The midwifery practice model in Ontario reflects the tenets of continuity of care, informed choice and choice of birth place. Each of these concepts has been identified by The Interim Regulatory Council on Midwifery (IRCM) and its successor the Transitional Council of the College of Midwives, the College of Midwives of Ontario (CMO), the Association of Ontario Midwives (AOM) and the consumer group, the Ontario Midwifery Consumer Network (OMCN, formerly known as the Midwifery Task Force of Ontario (MFT-O)) as fundamental to midwifery care. (see references 2,3,4,5,6,7,8,9)

Within the midwife's scope of practice and according to the standards of practice set by the College of Midwives, the midwife follows the woman throughout a full course of care from pregnancy to post-partum and attends the birth in the setting chosen by the woman. Midwives are primary caregivers, responsible for their own clients.

This model is consistent with the following policies of the College of Midwives of Ontario: *Philosophy of Midwifery Care in Ontario*, *Code of Ethics*, *Statement on Home Birth*, and *Indications for Planned Place of Birth*, as well as the AOM's *Guidelines to the Scope of Practice*, the MTF-O's *Critical Principles of Midwifery Care* and the International Definition of a Midwife above.

CONTINUITY OF CARE

Continuity of care is essential to the model of practice. According to the College of Midwives of Ontario's *Regulation Made Under the Midwifery Act, 1991, Registration, (January 1994)*, "continuity of care" means midwifery care provided in accordance with the standards of practice of the College and available during all trimesters of pregnancy on a twenty-four hour on-call basis from a group of no more than four primary caregivers. All registered midwives are expected to provide continuity of care according to the College of Midwives standard on *Continuity of Care (January 1994)* which states:

> "Continuity of midwifery care is achieved when a relationship develops over time between a woman and a small group of no more than four midwives.[1] Midwifery services must be made available to a woman by

1 The standard for continuity of care does not restrict the number of midwives who may work together in a practice.

the same small group of caregivers from the onset of care (ideally, at the onset of pregnancy), during all trimesters, and throughout labour, birth and the first six weeks post-partum. The midwifery practice must ensure there is 24-hour on call availability of one of the group of midwives known to the woman.[2]

A consistent philosophy of care, and coordinated approach to clinical practice should be maintained by caregivers working together, facilitated by regular meetings and peer review.

One of the group of midwives will be identified as the health professional responsible for coordinating the care and identifying who is responsible if she is not on call.[3] A second midwife should be identified as the midwife who would normally take over this role if the first midwife is unavailable. The practice should allow for opportunities for the woman to meet other midwives as appropriate to accommodate circumstances when they may be involved in her care. The midwife coordinating the woman's care and the second midwife must make the time commitment necessary to develop a relationship of trust with the woman during pregnancy, to be able to provide safe, individualized care, fully support the woman during labour and birth and to provide comprehensive care to mother and newborn throughout the postpartum period.

The midwives identified as first and second midwife would normally be responsible for providing the majority of prenatal and postnatal care, and for attending the birth, assisted if necessary by other midwives in the group.

Normally, care is shared by a small group of midwives and two of these midwives are present at each birth. The College of Midwives recognizes that an alternate practice arrangement may be needed in some circumstances where this is not possible. Midwives in these

2 Midwives from different practices may occasionally share the care of a client (to help cover holidays, for example.)

3 This is consistent with *Indications for Mandatory Discussion, Consultation and Transfer of Care*.

> circumstances need to apply to the College of Midwives for approval of alternate practice arrangements.[4]"

According to the College of Midwives standard *Indications for Mandatory Discussion, Consultation and Transfer of Care*:

> "When primary care is transferred, permanently or temporarily, from the midwife to a physician, the physician, together with the client, assumes full responsibility for the subsequent decision-making. When primary care is transferred to a physician, the midwife may provide supportive care within her scope of practice, in collaboration with the physician and the client."

In situations where transfer of care to a physician is required, the midwife is expected to continue providing supportive care after transfer and may resume primary care if appropriate.

Supportive care involves education, counselling and advocacy throughout the course of care. It also includes labour support (emotional and physical comfort measures and advice about coping with labour) and assistance with infant feeding. In order to ensure coordination of care, the midwife and the physician need to maintain appropriate communication during the course of care.

INFORMED CHOICE

In the midwifery model, the pregnant woman is recognized and supported as the ultimate decision maker. The *Philosophy of Midwifery Care in Ontario* states:

> "Midwives encourage the woman to actively participate in her care throughout pregnancy, birth and post-partum period and make choices about the manner in which her care is provided."

and,

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4 *Temporary Alternate Practice Arrangements Within Model of Midwifery Practice*

> "midwives promote decision-making as a shared responsibility, between the woman, her family (as defined by the woman) and her caregivers. The mother is recognized as the primary decision maker."

This does not mean that a primary care midwife is less responsible, but that part of her responsibility is to facilitate the process of informed choice. The College of Midwives further requires that midwives be responsible for informing clients about what to expect from midwifery care.

Informed choice is a decision-making process which relies on a full exchange of information in a non-urgent, non-authoritarian, co-operative setting. Time is a necessary component to the successful facilitation of informed choice. The model of midwifery care as developed in Ontario incorporates time into the care provided. Normally, pre and post-partum visits last 45 minutes to one hour. Further, midwives known to the woman are on 24-hour call during the entire course of care, including both the pre and post-natal periods as well as for labour and birth.

PRACTICE SITES AND CHOICE OF BIRTH PLACE

Midwifery in Ontario developed in response to womens' expressed need for client responsive care. This demand reflects a desire for the appropriate use of technology, continuity of care, choice of birth place and informed choice. To date, community-based midwives in Ontario have incorporated these basic principles into the care they provide. Both midwives, and the women they care for, believe that a community setting, rather than an institutional one, is most appropriate for the provision of prenatal care, that post-partum care is best provided in the woman's home, and that care for labour and birth should be provided in the setting chosen by the woman.

The College of Midwives states that it is in the best interests of the public that all midwives practise in all settings in accordance with the model of practice. The midwife must be capable of and willing to provide care in all settings, for example, hospital, birth centre, and home. It is important that those working in such facilities understand that the College of Midwives will require that midwives work according to the model of midwifery practice.

The College has also identified the need to encourage out-of-hospital birth in order to promote normal childbirth. It is equally important, however, that midwives have access to providing primary care for women who choose to give birth in hospital.

Midwives must be able to function within their full scope of practice in the hospital setting. Establishing choice of birth place as a fundamental component of midwifery practice is essential to any attempt to create equitable access to those choices. It is hoped that a midwifery system in which some midwives specialize in out-of-hospital birth while others restrict their practice to a hospital setting can be avoided. This is particularly important in rural and remote communities where it is unlikely that women will have access to a choice of midwives.

To ensure that this model of midwifery care will flourish in all settings, midwives working in hospitals and birth centres must familiarize other health care providers in those systems with the midwifery model of care, particularly with birth outside hospital. In so doing, midwives will act to further connect these facilities and the community.

According to the College of Midwives of Ontario midwives registered in Ontario must be competent to provide care in a variety of birth settings. Further they must maintain this competence in order to have their registration renewed.

REGULATIONS, STANDARDS OF PRACTICE, POLICIES AND GUIDELINES

The IRCM's Standards and Qualifications Committee created a number of documents, many of which have evolved out of AOM policies and practices, to guide the practice of midwifery in Ontario. Broad consultation among health professions and regulators has taken place and will continue as the College of Midwives of Ontario further develops its regulations, standards of practice, policies and guidelines. These documents include the *Philosophy of Midwifery Care in Ontario*, the *Statement on Home Birth* and the *Code of Ethics*, as well as very detailed and practical protocols. The research-based standard of practice, *Indications for Mandatory Discussion, Consultation and Transfer of Care,* clearly defines the midwife's scope of practice in practical terms. The regulation *Designated Drugs/Notation* outlines the drugs and other controlled substances within the midwife's scope. The list of *Essential Equipment, Supplies and Medications* identifies what is necessary to attend a birth in any setting. The College of Midwives of Ontario guidelines on *Laboratory Testing* and *Diagnostic Imaging* lists the tests that midwives will be able to independently order for their clients.

TWO MIDWIVES AT EACH BIRTH

The Canadian standard of care is to have two skilled attendants at every birth. Community midwives in Ontario have attended home births in teams of two midwives for over a decade. They agree that the safest care can be provided at births when there are two fully qualified midwives present, each skilled in neonatal resuscitation, cardiopulmonary resuscitation and the control of maternal haemorrhage.

In order to provide a high standard of safe care and protect the model of midwifery practice, the College of Midwives of Ontario standard, *Number of Midwife Attendants at Birth,* states:

> "Two midwives will attend each birth regardless of setting except in those circumstances as permitted by the College of Midwives under the *Alternate Practice Arrangements within the Model of Midwifery Practice*."

In these situations, it is likely that the second attendant would be a registered nurse or a physician. The AOM supports the College of Midwives of Ontario's standard with the understanding that alternatives to the two-midwife model, especially in hospital practice may be **widespread in the first years of recognized midwifery because of the demand for midwifery services.**

MIDWIFERY PRACTICE IN HOSPITAL

The RHPA has been proclaimed and the Public Hospitals Act has been amended to allow midwives to admit, discharge and write orders in hospital for women and newborns. Many midwives now have admitting and discharge privileges to hospitals.

Eventually, it is expected that a new Public Hospitals Act will see a process in place for peer credentialling and peer supervision of midwives in hospital. In the interim, midwives have been applying for privileges to hospital Boards via the existing Medical Advisory Committee structure, and supervision takes place through departments of Obstetrics and Paediatrics and sometimes via a Department of Family Medicine.

Hospitals have been developing their own policies to integrate midwifery into hospital practice. The Ontario Hospital Association has published a discussion paper *The Integration of Midwifery Services into Hospitals (1994)* as a guide for hospitals in

considering issues associated with the introduction of midwifery into hospital practice. In addition, legislation, regulation and documents like the College of Midwives' *Indications for Mandatory Discussion, Consultation and Transfer of Care* can provide a framework for developing hospital policies that support the midwifery model of practice in Ontario. This should ensure some consistency across the province as midwives enter hospitals as primary caregivers. The AOM has a strong commitment to supporting midwives in developing good working relationships with both physicians and nurses.

COMMUNITY INPUT

The College of Midwives supports the concept of ongoing community input into midwifery practices in all practice sites, including hospitals, and recommends that:

- Community participation be structured into the midwifery system during the development and ongoing planning of midwifery services and midwifery education.
- Each and every user be able to give input at some level.
- There be ongoing community input into midwifery practices in all sites.
- Each midwife be responsible for soliciting client and community input.
- Education about the role of community input at all levels be provided to all student midwives.

LIABILITY INSURANCE

The IRCM recommended that all midwives be covered by liability insurance for all settings and the midwife be named as the insured. Currently, practising midwives have access to professional liability insurance which covers practice in all settings through the AOM. The College of Midwives requires that every registered midwife carry professional liability insurance.

MIDWIFERY EDUCATION AND CONTINUING EDUCATION

A four-year baccalaureate program in Midwifery began in September, 1993 at Laurentian, McMaster and Ryerson Polytechnical universities. The College of Midwives strongly recommends that the concepts of continuity of care, choice of birth place and community input be inherent parts of the theoretical education of midwives.

Clinical education takes place within the model of practice, with student midwives following the woman's care throughout the pregnancy, birth and the post-partum periods. During their education, students must attend birth in all settings.

The RHPA provides for the development of a continuing education program that promotes competence in all areas of skill for all settings. There may be circumstances where the midwife cannot practice in all settings, e.g., the midwife working in a community in which the clientele chooses only hospital births or the midwife who largely provides care for home births because she lives in a community where she does not have access to hospital facilities or a local birth centre.

According to the College of Midwives registration regulation on active practice, midwives must maintain competence and confidence in all settings. The College of Midwives will promote continuing education opportunities to assist midwives in maintaining this competence.

Midwifery practices will be reviewed on a yearly basis. Following a review, midwives will have access to appropriate updating of skills including experience in appropriate practice sites.

The College of Midwives requires that all midwives be current practitioners including midwives who teach or are on the faculty of the midwifery education program. This is in accord with the *Philosophy of Midwifery Care in Ontario* and in support of the *Report of the Curriculum Design Committee on the Development of Midwifery Education in Ontario*. This will avoid a hierarchy between those midwives who teach and administer only, and those who practise. It will also keep midwifery education relevant to practice and responsive to consumer needs.

CONCLUSION

The major function of the College of Midwives is to administer the Midwifery Act in the public interest. The College will develop regulations and/or standards of practice that protect the public by defining professional performance and College expectations regarding practice models and sites. The midwifery model of practice is based on the premise that the midwife follows the woman throughout the full course of care from pregnancy to post-partum and attends the birth in the setting chosen by the woman. In the initial years of integration all midwives may not have access to home, birth centre and hospital settings. As members of the public and other health care professionals become more aware of midwifery, this situation is expected to change. As integration proceeds, most midwives will have access to all settings. However, every midwife must be able and willing to practise in the setting chosen by the woman.

REFERENCES

1. International confederation of Midwives (ICM), International Federation of Gynacaecologists and Obstetricians (FIGO), World Health Organization (WHO)

2. The Interim Regulatory Council on Midwifery, *Core Competencies*, January 1991, adopted by the Transitional Council of Midwives, March 23, 1993, adopted by the College of Midwives of Ontario, January 1993, amended January 1994.

3. The Interim Regulatory Council on Midwifery, *Core Competencies*, January 1991, adopted by the Transitional Council of Midwives, March 23, 1993, adopted by the College of Midwives of Ontario, January 1993, amended January 1994.

4. The Interim Regulatory Council on Midwifery, *Code of Ethics*, April 1991, adopted by the Transitional Council of Midwives, March 23, 1993, adopted by the College of Midwives of Ontario, January 1993, amended January 1994.

5. The Interim Regulatory Council on Midwifery, *Indications for Mandatory Discussion, Consultation and Transfer of Care*, May 1991, adopted by the Transitional Council of Midwives, March 23, 1993, amended by the College of Midwives of Ontario, January 15, 1994.

6. The Interim Regulatory Council on Midwifery, *Statement on Home Birth*, June 1991, adopted by the Transitional Council of Midwives, March 23, 1993, adopted by the College of Midwives of Ontario, January 1994.

7. The Interim Regulatory Council on Midwifery, *Indication for Planned Place of Birth*, January 1992, adopted by the Transitional Council of Midwives, March 23, 1993, adopted by the College of Midwives of Ontario, January 1993, amended January 1994.

8. Association of Ontario Midwives, *Guidelines to the Scope of Practice*, 1989.

9. Midwifery Task Force of Ontario, *Critical Principles of Midwifery Care*, May 1992, adopted by the Ontario Midwifery Consumers Network, September 1994.