Government of British Columbia

HEALTH PROFESSIONS COUNCIL

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RECOMMENDATIONS ON THE DESIGNATION OF MIDWIFERY

Application by the
Midwives Association of British Columbia

April 1993

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The Health Professions Council is a three person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions under the
Health Professions Act (S.B.C. 1990, c.50).

A.STATEMENT OF ISSUES

The Health Professions Council has considered the application from the Midwives Association of British Columbia (MABC) for the designation of midwifery under the Health Professions Act.

There are four basic issues in connection with this application:

(a)is it in the public interest for autonomous midwifery to be designated under the Health Professions Act?

(b)if designated, what scope of practice is appropriate for midwives in British Columbia?

(c)should there be limitations on the scope of practice, requiring physician involvement in all midwife assisted births?

(d)should there be limitations on the scope of practice, prohibiting participation by midwives in planned home births?

At the present time, non-physician midwives are not permitted to practise in British Columbia because midwifery is included in the definition of the "practice of medicine" at section 72(2)(d) of the Medical Practitioners Act. It is a licensed activity which is reserved to members of the College of Physicians and Surgeons of British Columbia.

The applicant is seeking to have autonomous midwifery regulated under the Health Professions Act. In that event, a regulatory body would be established to regulate the practice of autonomous midwifery in the public interest, and the registrants of a College of Midwives would fall within an exempted class of persons pursuant to section 73(n) of the Medical Practitioners Act.

Although autonomous midwifery is an accepted practice in most parts of the world, it is not a part of the health care system in British Columbia. Only 9 of 210 members of the World Health Organization do not provide autonomous midwifery services - Canada is the only developed country of these 9.

There has been a growing consumer demand for midwifery services in this Province for some time. This is reflected in part by the organized consumer advocacy for midwifery conducted by the Midwifery Task Force since 1981. The need for those services to be regulated has also been recognized in other forums (see, for example, the recommendations of two 1988 Coroner's Reports regarding home births and the practice of midwifery). In 1991, the Royal Commission on Health Care and Costs recommended that midwifery be introduced in order to reduce costs of health care services.

The use of midwives as preventive primary care workers is recommended by WHO as the chief means of reducing costs associated with unnecessary medical interventions in childbirth. Money is saved through decreased reliance on medical interventions, shorter hospital stays, and reduced morbidity.

(**Closer to Home,** Vol.2, page D - 21)

The Governments of Ontario and Alberta have recently reconsidered the status of autonomous midwifery and are taking steps to regulate the profession and to integrate it into their health care systems. Other provinces are also considering autonomous midwifery services - pilot projects are being undertaken by the Government of Quebec, and the Manitoba Working Group on Midwifery is studying the feasibility of implementation.

The mandate of the Health Professions Council is restricted to issues related to professional regulation. While the Council may touch upon some issues related to the implementation of midwifery services in British Columbia, strictly speaking, it is outside the mandate of the Council to consider such issues as costs, payment options for midwifery services, hospital privileges, and liability insurance. Hence, the primary responsibility of the Council is to determine whether it would be in the public interest to designate midwifery under the Health Professions Act. Implementation/integration issues arising from designation will presumably be dealt with by the Ministry of Health, hospitals and other stakeholders, perhaps with the assistance of an interdisciplinary advisory committee.

The Council made an attempt to address issues regarding the practice of native midwifery but unfortunately did not have the resources to consult effectively with native groups. The question of whether native midwifery should be regulated is thus not dealt with in this report.

B.EXECUTIVE SUMMARY

The Health Professions Council has determined that it is in the public interest for midwifery to be a designated profession under the Health Professions Act and recommends that a College of Midwives be established.

Furthermore, the Council recommends a scope of practice which includes all services related to the care of the healthy mother and her baby during a normal pregnancy, labour and delivery. It is recommended that six specific midwifery services involving a serious risk of harm be considered controlled acts within an exclusive scope of practice. Those acts include managing spontaneous normal vaginal deliveries and performing episiotomies and amniotomies, among others.

The Council also recommends certain limitations on practice regarding physician consultation and practice setting. The Council is of the view that midwives should require their clients to consult a physician for a medical examination during the first trimester of pregnancy. With respect to home births, the Council is not prepared to recommend that they be sanctioned by Government at this time because of the lack of data upon which to base a decision in the public interest. The Council does, however, strongly endorse the idea of a demonstration project on planned home births.

Other ancillary recommendations relate to the systemic changes necessary to facilitate the implementation and integration of autonomous midwifery into the British Columbia health care system. The Council recommends the organization of birthing centres, the establishment of an inter-disciplinary advisory committee, and the review of all pertinent legislation, policies, procedures and protocols, in order to support the successful introduction of midwifery services into the health care system.

C.RECOMMENDATIONS

Pursuant to section 10 of the Health Professions Act, the Health Professions Council recommends to the Minister of Health and Minister Responsible for Seniors that:

1.the health profession of midwifery be designated under the Health Professions Act,

2.the college established under section 15(1) for the health profession be named the College of Midwives,

3.the title "Midwife" be reserved for the exclusive use of the registrants of the College of Midwives,

4.the services which may be performed by midwives are the assessment, monitoring, care and counselling of women during normal pregnancy, labour and the post-partum period; the management of spontaneous normal vaginal deliveries; care, assessment and monitoring of the healthy newborn; and advice and support regarding infant care,

5.the following limitations be placed on the performance of services by registrants, namely

(i)every client should be advised to consult a physician for a medical examination during the first trimester of pregnancy,

(ii)all deviations from normal require consultation with the client's physician and transfer of responsibility if necessary,

(iii)midwives shall not diagnose or treat pathological conditions, and

(iv)midwives shall not manage a delivery outside of a hospital or birthing centre,

6.the following services are "controlled acts" which comprise an exclusive scope of practice for midwifery:

(i) conducting internal examinations,

(ii) managing spontaneous normal vaginal deliveries,

(iii) performing episiotomies and amniotomies and repairing episiotomies and lacerations,

(iv) prescribing and administering certain drugs and substances designated in the bylaws of the College of Midwives,

(v) taking blood samples from women and newborns, and

(vi) inserting urinary catheters.

These services obviously overlap with the current scopes of practice of both medicine and nursing and it is not intended that there be any limitation on the services now being appropriately delivered by physicians and nurses.

ANCILLARY RECOMMENDATIONS

The Health Professions Council also makes the following ancillary recommendations.

7.A demonstration project on planned home births be initiated.

8.The Ministry of Health encourage the organization of birthing centres in order to support the practice of midwifery, decrease costs, provide families with greater choice in health care services, and promote less interventionist health care.

9.An inter-disciplinary advisory committee be established to provide advice to the Board of the College of Midwives, related health professions, hospitals, regional boards, community councils, and the Ministry of Health regarding the implementation/integration of midwifery services into the health care system of British Columbia.

10.Relevant legislation, policies, procedures and protocols be amended to allow midwives to become a recognized, integrated and functional member of the health care team.

D.RATIONALE FOR THE RECOMMENDATIONS

Recommendation 1

the health profession of midwifery be designated under the Health Professions Act

On balance, the Council considers that it would be in the public interest for midwifery to be designated under the Act. Clearly, the practice of midwifery satisfies the major criteria for designation in that it involves a risk of harm. The applicant identified the following aspects of practice as involving a risk of harm to the health, safety or well being of the public.

-assessing and diagnosing pathological conditions and consulting with/referring to physicians,

-managing of labour, delivery and post-partum,

-providing care in emergency situations,

-administering medications,

-counselling and education for preventive care, and

-discussing personal and confidential information.

(MABC Application, page 10)

In its submission, the British Columbia Health Association (BCHA) reiterated these same aspects of practice and noted that the risks are increased by the absence of legal regulations. Both the BCHA and the Registered Nurses Association of British Columbia (RNABC) stated that the practice of midwifery should be regulated because it poses a risk to the public. The Ontario and Alberta Reports on Midwifery both noted the need for regulation because of the inherent risks in the practice of midwifery.

PUBLIC INTEREST CRITERIA

Health Professions Regulation, s. 5(1)

Pursuant to section 5(1) of the Health Professions Regulation, the Council is required to have regard to four specific aspects of practice in assessing the risk of physical, mental or emotional harm to the health, safety or well being of the public. Each of these is discussed below.

(a)the services performed by practitioners of the health profession

The following definition of a midwife was first developed by the International Confederation of Midwives in 1972. It has since been endorsed by the World Health Organization, the International Federation of Obstetricians and Gynaecologists, the U.K. Central Council for Nursing, Midwifery and Health Visiting, the Interim Regulatory Council for Midwifery in Ontario, and the Alberta Midwifery Services Review Committee (with modifications). It was put forward during this investigation by the Midwifery Task Force, RNABC, Grace Hospital and the applicant.

> A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognized in the 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 practice midwifery.
>
> She [the midwife] must be able to give the necessary supervision, care and advice to women during [normal] pregnancy, labour and the post-partum period, to conduct deliveries on her [/his] own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in the mother and child, the procurement of medical assistance [when abnormalities are detected] and the execution of emergency measures in the absence of medical help.
>
> She [the midwife] has an important task in health counselling and education, not only for patients but also within the family and the

> community. The work should involve ante-natal education and preparation for parenthood and extend to certain areas of gynaecology, family planning and child care. She [the midwife] may practise in hospitals, clinics, health units, [community health centres,] domiciliary conditions or in any other service.

(N.B. The modifications made by the Alberta Midwifery Services Review Committee are added in brackets.)

Another description of the services performed by midwives is contained in a 1989 Resolution of the International Childbirth Education Association.

> Midwifery services include adolescent and well-woman gynecological and maternal health care, including prenatal education and counselling; prenatal intrapartum and postpartum care; continuous labour support, supervision and assistance during childbirth, breastfeeding counselling, preparation for parenthood; newborn care; and family planning.
>
> (ICEA Resolution, February 26, 1989)

Comment:

It should be noted that the Council's recommendation regarding scope of practice does not incorporate these international definitions in their entirety. This is dealt with further in Recommendation 4, page 23.

(b)the technology, including instruments and materials, used by

practitioners

The applicant identified four types of equipment used in the practice of midwifery - equipment to monitor maternal, fetal and neonatal well-being (eg. stethoscope and thermometer); equipment to maintain clean or aseptic technique (eg. gloves and scrub brushes); equipment relating to the birthing process (eg. scissors, cord clamps, IV equipment); and emergency resuscitation equipment (eg. masks).

(c)the invasiveness of the procedure or mode of treatment used by practitioners

Generally speaking, midwifery is characterized by a low technology, non-interventionist approach to childbirth. As "guardian of the normal", the role of the midwife is to support a natural healthy process.

(d) the degree to which the health profession is

(i)practised under the supervision of another person who is qualified to practise as a member of a different health profession, or

(ii)practised in a currently regulated environment

Since midwifery is defined as part of the practice of medicine, the practice of midwifery by a non-physician is a regulatory offence.

Midwives currently practising in B.C. do so without supervision, except for those working in the Grace Hospital Midwifery Program. Those midwives are employed by the Hospital and are registered nurses with recognized midwifery certification from other countries.

Health Professions Regulation, s. 5(2)

Section 5(2) of the Health Professions Regulation sets out a number of

facultative criteria which the Council may apply to determine whether designation of a health profession is in the public interest.

(a)the extent to which the health profession has demonstrated that there is a public interest in ensuring the availability of regulated services provided by the health profession

The Council received extensive correspondence from individuals expressing support for the regulation of midwifery. We also heard from two consumer organizations speaking specifically to the public demand for midwifery services. The Midwifery Task Force submitted the following assessment.

There is a consumer driven trend across the country toward the implementation of midwifery services similar to what is being proposed in B.C. As a consumer group (of approximately 650 members and 1200 supporters) our members have repeatedly expressed their desire for quality midwifery care. They are looking for a more humane approach to birth; for professional assistance in realizing a safe, natural and empowering experience.

The feedback we get from mothers includes:

-they do not want to be rushed through their birth experience

-they want a more personalized and non-authoritarian model of care

-they are frustrated being attended by a physician not of their choice

-they want to make informed choices and have their wishes respected

-they want knowledgeable support during labour and continuity of care

-they need more support, education and counselling during the days and weeks following birth

-they want fewer medical interventions

-they want to give birth safely, with power and dignity

(Midwifery Task Force Brief, page 2)

The Council is convinced there is a significant public demand for midwifery services. This was acknowledged by all stakeholder groups who participated in the investigation. In this regard,
Grace Hospital noted the preliminary results of a recent survey of 900 women in the Lower Mainland which showed 67% agree/strongly agree midwifery should be legalized. The popularity of the Grace Midwifery Program itself demonstrates the demand for midwifery care. The Program has the capacity to accept ten new clients per month and often turns away an equal number of women, plus receives many phone calls from interested consumers.

In its submission, the British Columbia Medical Association (BCMA) not only recognized consumer support for midwifery, but also noted "the significant number of B.C. physicians who have worked with midwives during their training or practice careers in other countries or with the midwifery pilot project in
British Columbia" (BCMA Background Paper, page 1).

(b)the extent to which the services of the health profession provide a recognized and demonstrated benefit to the health, safety or well being of the public

The BCHA gave the following endorsement of the services provided by midwives.

BCHA is convinced, based on the literature and evidence from other

> jurisdictions, that midwifery attended births have an excellent and in some ways a superior record to physician assisted births in terms of reduced perinatal mortality and morbidity as well as higher client satisfaction. Numerous women feel the continuity of care provides a more life-enhancing start to their family life laying the groundwork for caring and confident parenthood.
>
> (BCHA Submission, page 19)

Many of the letters the Council received from individuals attested to the benefits they received from midwifery services. The following extracts from two of these letters seem to typify consumer feedback regarding midwifery care.

> I delivered both my children through the Nurse Midwifery Clinic at Grace Hospital and found the experience extremely fulfilling. The midwives' positive, holistic philosophy was consistent with my own beliefs about pregnancy and childbearing. I especially appreciated the continuity of care in having the midwife follow my pregnancy and then having the same person support me through both labour and delivery.

> As a mother and grandmother, I have personal experience of many different birthing methods and am firmly convinced of the superiority of the natural, caring and non-intervention approach that midwifery offers.

A submission received from Birthing Options for Nanaimo and District (BOND) expressed the benefits of midwifery care particularly well.

> The legalization of midwifery will benefit the consumers in Nanaimo and across B.C. in a number of ways. First and foremost, health care for the childbearing woman will be improved. Around the world and throughout time women have shown that they prefer to give birth in the company of other women who have had the

> same experience and who they feel safe with. This is how the trade of midwifery arose. When a midwife is free to practise to her fullest potential, she can offer true family centred care. She can get to know the entire family and can offer the woman highly skilled, consistent and safe care throughout her pregnancy, labour and post-partum period. By applying this holistic approach to child bearing the midwife will attend to her physical, psychological and emotional well being; as these are very real parts of the child birth process and parenting. A midwife is trained to deal specifically with this period of a woman's life.
>
> (BOND Submission, page 2)

The BCMA and the B.C. Reproductive Care Program also recognized the advantages of the midwives' approach to maternity care.

> ... the B.C.M.A. recognizes that many consumers, and a significant number of physicians, would like to explore alternate models of care, one of these being a midwifery model.
>
> This model would be characterized by greater emphasis on patient empowerment, patient education, greater time spent with the patient, decreased levels of medical intervention, and greater sharing of responsibilities among the health care team. "Catching the baby" is but a small part of the birth process.
>
> (BCMA Background Paper, page 1)

> ... appropriately educated and dedicated professionals would help us achieve our objectives by assuring safe, happy, family centred maternity care.
>
> (B.C. Reproductive Care Program Hearing Transcript, page 97)

The Council shares the view that midwifery services would provide a recognized and demonstrated benefit to the health, safety or well being of the public.

(c)the extent to which there exists a body of knowledge that forms the

basis of the standards of practice of the health profession

As the College of Physicians and Surgeons of British Columbia stated so succinctly in its brief, "there is no doubt that a body of knowledge exists on midwifery and could (and should) form the basis of standards of practice". (Brief, page 3)
This opinion was shared by the BCHA.

BCHA is convinced that a unique body of knowledge forms the basis of standards of practice for midwifery as outlined both in the application by the Midwives Association of B.C. and by the Curriculum Design Committee established by the Interim Regulatory Council for Midwifery in Ontario. Midwifery is, after all, the oldest health profession.

(BCHA Submission, page 3)

The Council concurs.

(d)whether members of the profession are awarded a certificate or degree from a recognized post-secondary educational institution

Because midwifery is not legally recognized as a separate and distinct profession from medicine anywhere in Canada, there are currently no recognized training programs in existence for the profession of midwifery.

The Ontario Interim Regulatory Council on Midwifery has established a one-year pre-registration program for midwives at the Michener Institute in Toronto. The Michener Institute is a post-secondary educational institution funded by the
Ministry of Health with a mandate to provide educational health science courses and programs that meet the needs of the health care field.

The Ontario Ministry of Colleges and Universities sent a "Request for Proposals" to ten degree-granting institutions to take the lead, or be a partner, in developing a multiple-route entry, bachelor's midwifery

program in that province. In December 1992, it was announced that McMaster University in Hamilton, Laurentian University in Sudbury and Ryerson Polytechnical Institute in Toronto will jointly offer a baccalaureate level midwifery program. There are 26 seats allocated for the first year working up to a maximum of 40 (6 at McMaster, 6 at Ryerson, 6 anglophone and 6 francophone at Laurentian). Five of the total number of seats are reserved for aboriginals.

With respect to midwifery education programs outside Canada, the Council relied on the extensive study of this subject conducted by the Task Force on the Implementation of Midwifery in Ontario. The Task Force came to the following conclusion.

Our investigation of midwifery education in other countries was not particularly helpful on the question of level of education. In European countries, the system of education for all health professions is quite different from that in North America. In Denmark, The Netherlands, and the U.K., Midwifery schools are either affiliated with hospitals or "free-standing" - that is, not affiliated with any post-secondary educational institution. While we did not hear of pressure to affiliate midwifery schools with universities there, we did hear about the scarcity of advanced education and research opportunities for midwives, the kinds of opportunities usually provided at universities. In the United States, all but one or two nurse-midwifery programs are university affiliated, at either the certificate or the Master's level.

(Ontario Report, page 125)

In the U.S., there are both certified nurse-midwives (CNMs) and midwives. The Ontario Task Force found that there are far fewer formal educational opportunities for non-CNMS in the U.S. than there are for nurse-midwives. The Seattle Midwifery School apparently offers the only comprehensive direct entry program. Unfortunately, the Seattle Midwifery School did not respond to the Council's request for information during this investigation.

To summarize, the current situation is that midwives are not awarded a certificate or degree from a recognized post-secondary Canadian educational institution. An educational program in midwifery will be offered at three post-secondary institutions in Ontario in September,

1993. The B.C. Ministry of Advanced Education, Training and Technology also informed the Council that several post-secondary institutions in this Province have expressed an interest in delivering the service.

(e)whether it is important that continuing competence of the practitioner be monitored

Because of the serious risk of harm to the health, safety and well being of the mother and baby should midwifery services be delivered by incompetent, impaired or unethical practitioners, it is extremely important that continuing competence of a practising midwife be monitored.

(f)the extent to which there exists within the health profession recognized leadership which has expressed a commitment to regulate the profession in the public interest

Within this health profession, there is an abundance of recognized leadership which has expressed a commitment to regulate the profession in the public interest. Unfortunately, this leadership is divided into three camps (RNABC, the College of Physicians and Surgeons, and the Midwives Association of B.C.) because midwifery services may be delivered by three different practitioners: nurse-midwives, physicians, and midwives.

The Royal Commission recommended that nurse-midwives be recognized first as they are already sanctioned by the BCMA, College of Physicians and Surgeons, and the RNABC. The BCMA and the B.C. Reproductive Care Program supported RNABC as the governing body for non-physician midwives as it views those practitioners as a nursing specialty profession.

The BCHA stated that it would prefer that regulation take place under an existing regulatory body, although did recognize the leadership shown by the Midwives Association of B.C.

RNABC itself advocated "dual registration" whereby a nurse-midwife would be regulated by RNABC but would have the option of also being a registrant of the College of Midwives.

RNABC strongly believes in the principles of self-regulation. We believe that the majority of midwifery practice falls within the scope of nursing practice. Therefore, nurse midwives should be exempted under the Medical Practitioners Act and allowed to practice midwifery under the Nurses (Registered) Act, regulated by RNABC. However, we do recognize that there are qualified midwives in B.C. who are not nurses. In addition, some nurse midwives wish to support midwifery through a separate college. Autonomous midwifery practice, regulated by a College of Midwives would address this need. Dual registration with the RNABC and the College of Midwives should be an option for nurse midwives.

(RNABC Presentation, page 4)

Comment:

The Council feels somewhat confined on this issue by the terms of its mandate under the Health Professions Act. Should nurses wish to expand their scope of practice to include all elements of midwifery practice, then the Council would want to conduct an investigation of nursing to determine whether that scope of practice is in the public interest. In the absence of an application by RNABC for the designation of nursing under the Act, or a reference from the Minister, the Council is unable to fully address this submission.

The Council is satisfied that the leadership of the applicant Association has expressed a commitment to regulate the profession in the public interest, despite some misgivings about statements made regarding the ethical responsibilities of midwives towards home births, discussed below.

(g)the likelihood that a college established under the Act would be capable of carrying out the duties imposed by the Act, having regard to factors which in the view of the council may affect the viable operation of the college

One of the most important factors affecting the viability of a college is that there is a sufficient number of registrants to support its activities.

In its application, the Midwives Association stated it had a membership of 44 midwives. At the hearing on January 25, the Council was informed that this number had since increased to 55.

Also at the hearing, the Midwifery Task Force submitted letters from both trained and aspiring midwives interested in practising midwifery in this Province. In addition, it was estimated that there are 250 nurse-midwives currently practising obstetrical nursing in British Columbia, some of whom may be interested in becoming registrants of a College of Midwives.

The BCHA made the following observation:

> BCHA believes that the Midwives Association of B.C. has demonstrated their ability to assume the responsibilities and the expense of administering their own College to carry out the duties imposed by the Act, although midwifery will, at least initially, be a very small profession.
>
> (BCHA Submission, page 20)

The applicant submitted a proposed budget for a college, an organization chart for an "Interim Regulatory Body", and a draft outline of an annual general report for a British Columbia College of Midwives.

The budget showed a deficit of $26,750 in the first year.

There is no provision for the creation of an "interim regulatory body" in the Health Professions Act. The Council presumes this is a structure the applicant has borrowed from Ontario where an Interim Regulatory Council on Midwifery was established pending proclamation of the legislation. In B.C., once a profession is designated under the Health Professions Act a College is established to regulate the practice of the profession. The members of the first Board are appointed by the Minister until an election of registrants can be held.

The draft outline for an annual report demonstrates a good understanding of the responsibilities of a College, although some particulars are omitted. The applicant clearly recognizes that the College must be a separate entity from the professional association of midwives.

The Midwifery Task Force gave the following assessment of the viability of a

College of Midwives.

Historically, the Midwives Association of B.C. has, in our estimation, demonstrated a commitment to:

-developing and adopting guidelines to practise

-setting registration requirements

-supporting the development of a school in British Columbia

-administering a professional body with a very small practitioner (and financial) base

-disciplining members through peer review

-developing strong links with other health care professions and government

We, many of us consumers of midwifery care, have been reassured and inspired by these efforts and are confident that the members of a College of Midwifery will be capable of carrying out the duties imposed by the Act.

(Midwifery Task Force Brief, page 4)

The applicant has shown an adequate understanding of the duties and organization of a College established under the Act. Some reservations remain, however, with respect to the potential number of registrants and the financial viability of the College.

(h)whether designation of the health profession is likely to limit the availability of services contrary to the public interest

In the Council's view, designation is likely to have a positive impact on

access and availability of midwifery services to childbearing women. This view is reinforced by the comments of the BCHA and the College of Physicians and Surgeons in this regard.

Based on the foregoing analysis, the Council is of the opinion that designation of the practice of midwifery is in the public interest.

Recommendation 2

the college established under section 15(1) for the health profession be named the College of Midwives

The applicant proposed the "B.C. College of Midwives" and the "College of Midwives (B.C.)" as names for the regulatory body established upon designation.

Its Ontario counterpart is to be established under the name "College of Midwives of Ontario".

Consistent with the Council's previous reports and other professional colleges, the Council recommends the College use the name of the practitioners and not the profession.

Recommendation 3

the title "Midwife" be reserved for the exclusive use of the registrants of the College of Midwives

In its application, the applicant proposed the reserved titles of "Licensed Midwives" and "Certified Midwives".

The Ontario legislation will reserve the title "midwife".

The Council also prefers that the generic title "midwife" be reserved for registrants of the College of Midwives.

Recommendation 4

the services which may be performed by midwives are the assessment, monitoring, care and counselling of women during normal pregnancy, labour and the post-partum period; the management of spontaneous normal vaginal deliveries; care, assessment and monitoring of the healthy newborn; and advice and support regarding infant care

The applicant proposed a scope of practice for midwifery which encompasses the international definition of a midwife (cited previously) and also includes the following activities:

•assessment of client status during pregnancy, including obtaining the woman's medical, family, obstetric, social, and emotional history, and performing the appropriate physical examinations

such as pelvic and breast examinations.

•securing basic laboratory assessments, including blood tests and urinalysis and examinations necessary for earliest possible diagnosis of risk factors.

•providing education and preparation for childbirth, including advice on exercise and nutrition;

•caring for and assisting the mother throughout labour, including: providing comfort measures, monitoring the condition of the fetus, abdominal and pelvic examinations, conducting spontaneous vaginal births and delivering the placenta, performing and repairing episiotomies, and repairing first and second degree lacerations.

•prescribing and administering specified medications on her own authority, including anti-haemorrhagic agents after birth for mother and newborn, local anaesthetics for use in repairing episiotomies and lacerations, analgesics and prophylactic eye medications for the newborn.

•after the birth, caring for and providing the initial examination of the newborn and providing comfort measures and performing postpartum physical examinations of the mother, and educating and counselling her on family planning and providing contraceptive care.

•recognizing warning signs of abnormality in the mother or infant, consulting with, providing collaborative care with or referring to a physician.

•taking necessary emergency measures in the absence of a physician, including administering cardio-pulmonary resuscitation, or providing initial treatment of prolapsed umbilical cord, hemorrhage, seizures or fetal distress.

•providing well-woman gynaecological care including performing screening and diagnostic tests, prescribing and fitting contraceptive

devices, and providing appropriate intervention or referral.

(MABC Application, page 25)

Section 3 of the Ontario Act defines a scope of practice for midwifery as follows:

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.

The Alberta Report of the Midwifery Services Review Committee (1992) recommended that the following scope of practice statement be adopted by the regulatory body governing midwifery in Alberta.

A registered midwife functioning as a primary caregiver may provide the following health services:

1)carry out examinations necessary to confirm and monitor normal pregnancies;

2)advise on and secure the examinations necessary for the earliest possible diagnosis of pregnancies at risk;

3)provide counselling and education in preparation for childbirth;

4)care for the woman and monitor the condition of the foetus during labour;

5)conduct spontaneous vaginal deliveries;

6)identify the warning signs of abnormality in the woman or foetus that necessitate referral to a physician;

7)take emergency measures when necessary;

8)examine and care for the newborn; and

9)care for the mother in the postpartum period and advise her on newborn and infant care and family planning.

In the course of practising midwifery, a registered midwife may:

1)perform episiotomies and amniotomies and repair episiotomies and lacerations not involving the anus, anal sphincter, rectum, urethra and periurethral area;

2)independently prescribe and administer the drugs listed in Appendix "B";

3)on the order of a physician, independently administer any drugs by the route and in the dosage specified by the physician;

4)order the screening and diagnostic tests listed in Appendix "C";

5)screen potential clients during the initial interview and either accept or decline to care for a client or make a referral at the midwife's discretion; and

6)transfer primary care of a client to a physician if conditions arise requiring management outside of the scope of practice for midwives, and continue to provide collaborative care to the extent determined jointly by the client, physician and midwife.

(Alberta Report, pages 16 & 17)

The Council has recommended a scope of practice for midwifery which includes all of the tasks and services related to a normal pregnancy and the care of the healthy mother and her baby. The Council has not included such activities as advice on family planning, well-woman gynaecology or

diagnosis and treatment of medical conditions. It is anticipated that a College of Midwives will develop a detailed list of activities within these parameters.

Recommendation 5

the following limitations be placed on the performance of services by registrants, namely

(i)every client should be advised to consult a physician for a medical examination during the first trimester of pregnancy,

(ii)all deviations from normal require consultation with the client's physician and transfer of responsibility if necessary,

(iii)midwives shall not diagnose or treat pathological conditions, and,

(iv)midwives shall not manage a delivery outside a hospital or birthing centre

The Council focused on two types of practice limitations in the practice of midwifery:

•physician consultation, and

•practice setting.

Physician Consultation

The applicant made the following comments in its application with respect to proposed practice limits.

> The Midwife is an autonomous primary health care practitioner, exercising independent clinical judgement, and within her scope of practice does not require supervision. However, circumstances may occur during labour, delivery or immediate postpartum where there is a deviation from the normal which requires consultation and transfer of primary responsibility to a physician. The midwife may continue, in collaboration with the physician, to perform services as a delegated function. .... In emergency situations where there is an absence of medical help, the midwife may be called upon to perform certain acts that would normally be transferred to physician care, eg. manual removal of placenta.

(MABC Application, page 26)

With respect to this issue, the Council noted the recommendation of the Ontario Task Force that the standards of practice for midwives incorporate a minimum of two mandatory medical visits during pregnancy. It was recommended that the first mandated visit be as early in the pregnancy as possible, and that the second be at 32 to 34 weeks.

The Alberta Midwifery Services Review Committee recommended that there should be an initial medical consultation to establish a link with a physician during pregnancy, and to confirm that there is no medical condition present which would preclude a midwife from acting as the primary caregiver. This medical consultation should occur as early in the pregnancy as possible. The Committee recommended that the regulation developed to regulate midwifery practice provide that midwives be responsible for advising their clients to consult with a physician.

It is apparent that the key to the safe delivery of midwifery services is in the determination that the pregnancy is normal and that there are no contra-indications suggesting that it is high risk. It is therefore desirable that a physician participate in this risk assessment and early screening in order to minimize the risk of harm to the health and safety of the mother and baby. Ideally, the midwife and physician should be in accord about the normalcy of

the pregnancy and whether the client is a candidate for midwifery care. It is anticipated that the new College would establish standards of practice along the lines of Appendix D of the Report of the Midwifery Services Review Committee in Alberta ("Criteria for Medical Consultation and Transfer of Primary Responsibility").

The Council is aware of some concern regarding the role of the physician as "gatekeeper" to midwifery services. In every field of health care, it is essential that the regulations governing the practice of a profession strengthen the development of the health care team. The public interest is best served when all related health professions work together in a spirit of mutual respect and cooperation to maximize the quality and choice of services for the consumer in any field of health care.

For this reason, the Council recommends that the onus be on the client and the midwife to ensure that a medical examination is conducted during the early stages of pregnancy. The Council is of the view that this recommendation will enhance consumer choice and professional collaboration in perinatal care. The Council is also confident that a College of Midwives would be vigilant in demanding its registrants adhere to such standards of practice and presumably the bylaws of the College would reflect and reinforce this requirement.

The College of Physicians and Surgeons suggested additional physician involvement in the provision of midwifery care.

-A designated physician should remain involved in the antenatal care.

-At the time of delivery a physician should be readily available should assistance be needed.

-The patient should be assessed by a physician in the postnatal period.

-All investigations, including laboratory work and ultrasound investigations, should be ordered by a physician, and the results should be

reviewed by a physician.

(President's Letter to members re: Introduction of Midwifery to B.C., February 17, 1993)

The Council is not convinced that this degree of supervision is warranted given the training and qualifications of midwives. Obviously, a client may require care by a physician should complications develop either during the pregnancy or during labour and delivery. As the BCMA noted in its submission, "Medical disorders require physician care". (BCMA Background Paper, page 2) In that case, responsibility would be transferred from a midwife to a physician in accordance with pre-established criteria for transfer. Outside of this scenario, it is not necessary for physicians to supervise the delivery of midwifery services.

In conclusion, the Council is of the view that physician consultation early on in the pregnancy is in the public interest for three reasons. This consultation is necessary for a risk assessment of the pregnancy; it will establish a link should transfer of responsibility be necessary; and it will enhance continuity of care subsequent to the perinatal period when the mother and newborn may require the services of a physician at some point.

Practice Setting

The controversy surrounding the safety of planned home births must be addressed in this investigation as it presents itself as a possible limitation on the practice of midwifery. Pursuant to section 10(3)(b)(iv) of the Health Professions Act, the Council may recommend limitations on the performance of services by registrants.

The College of Physicians and Surgeons of British Columbia prohibits its members from attending planned home births because it believes there is a significant risk incurred in delivering a baby outside the hospital setting. During this investigation, the College, BCMA, RNABC, BCHA and the B.C. Reproductive Care Program all opposed midwives being involved in planned home delivery. RNABC explained its position as follows.

Domiciliary births are a component of midwifery practice in many countries.

> Although the Association recognizes some women and families in British Columbia may wish to give birth at home, and supports the consumer's right to choose a provider and location of care, RNABC does not support home births or domiciliary midwifery practice at this time. Although recent research suggests that home births for the low-risk woman attended by a well prepared health care professional are as safe as hospital births, it is also known that five to 15 per cent of women who have been assessed as low-risk during their pregnancy will experience unforeseen complications requiring sophisticated intervention during the intra-partum phase. In these cases, access to the necessary equipment and personnel must be immediately available to prevent poor outcomes for the mother and infant.

(RNABC Brief, page 7)

The applicant maintains there is no statistical evidence to show that a prohibition on home births is necessary. "Research into this issue has consistently demonstrated that for a population of well screened, low risk women, giving birth at home is as safe as giving birth in the hospital." Moreover, the applicant and the Midwifery Task Force characterize home birth as a civil rights issue which does not fall under the jurisdiction of physicians or midwives. At the hearing, the applicant stated "Choice of birth place belongs to parents and our ethical responsibility is to provide them with the most recent information, based on research findings, to enable them to make informed choices."(Hearing Transcript, page 204)

This position is of some concern to the Council. The issue is not parents' freedom to choose but rather the desirability of a midwife attending a home birth should parents choose that setting. That individual freedom must be viewed in the context of society's collective interest in the health and safety of the mother and baby. Society as a whole bears the consequences of any maternal or infant morbidity which may result from that choice. Society also has a collective responsibility towards the baby, who cannot exercise a choice and, generally, in the health and well being of its citizens.

Should Government decide that home birth is not a safe option for parents in British Columbia, it cannot be condoned by Government. Since a self-governing College acts on behalf of Government with respect to the practice of a profession, it must enforce limitations on practice which have been determined by Government to be in the public interest. If the Council's

recommendations on home births are implemented by Government, it is expected that registrants would adhere to any conditions which are imposed with respect to home births and that the College discipline those registrants who do not. The statement with respect to the ethical responsibility of midwives as expressed by the President of the Midwives Association of British Columbia is somewhat alarming.

The Council is aware that both the Alberta Health Disciplines Board and the Task Force on the Implementation of Midwifery in Ontario found no substantial evidence that giving birth at home is significantly less safe than giving birth in hospital for appropriately selected and properly attended women. On the other hand, the recent report of the Royal Commission on Health Care and Costs (**Closer to Home**), recommended that home births should be prohibited until Canadian studies have been conducted.

The Council considered one 1991 study of midwife-attended home births in Toronto from 1983 to 1988 and was surprised to see the high percentage of primiparous women who were transferred to the hospital during the first stage of labour (24.7%). Although the Council agrees with the author that "Since this study is descriptive, with no control group for comparison, conclusions about safety of home birth and generalizability of data cannot be made", it is still a useful snapshot of the home birth experience in a Canadian urban setting.

Because of the lack of statistical evidence regarding the safety of home births in Canada or in British Columbia, the Council is choosing to err on the side of caution and recommend that home births not be sanctioned by Government at this time. Should home births be regulated by Government (through a College of Midwives), consumer demand is likely to increase. (At the hearing, the applicant stated that the increase in Washington State was from 1% to 5%.) Therefore, it is not as simple as "giving seatbelts" to that segment of the population who will continue to choose home births.

Without further assurance that the margin of risk in a home birth setting as compared to a hospital/birthing centre setting is acceptable and in the public interest, the Council is reluctant to disregard the advice of the College of Physicians and Surgeons, the BCMA, the RNABC, the BCHA, the B.C. Reproductive Care Program, and the Royal Commission on Health Care and Costs on this issue.

Recommendation 6

the following services are "controlled acts" which comprise an exclusive scope of practice for midwifery:

(i)conducting internal examinations,

(ii)managing spontaneous normal vaginal deliveries,

(iii)performing episiotomies and amniotomies and repairing episiotomies and lacerations,

(iv)prescribing and administering certain drugs and substances designated in bylaws of the College of Midwives,

(v)taking blood samples from women and newborns, and

(vi)inserting urinary catheters

These services obviously overlap with the current scopes of practice of both medicine and nursing and it is not intended that there be any limitation on the services now being appropriately delivered by physicians and nurses.

The applicant cited an exclusive scope of practice consisting of the first four "controlled acts" contained in the Ontario Midwifery Act, 1991. Other controlled acts identified in the Ontario legislation were omitted by the applicant but the Council is of the opinion they are essential to the proposed scope of practice which had been previously outlined in the application.

The Council's recommendation with respect to an exclusive scope of practice for midwifery includes all those aspects of midwifery practice which should only be done by either a midwife, nurse or physician. The performance of these acts involves a significant risk of harm and it is in the public interest that only trained and qualified registrants of a regulated health profession be permitted to deliver these specific services.

ANCILLARY RECOMMENDATIONS

Recommendation 7

A demonstration project on planned home births be initiated.

The Council strongly endorses the idea of a demonstration project on home births here in British Columbia in order to base a decision regarding home births on clearly documented evidence. A spokesperson for the B.C. Reproductive Care Program also indicated support for such a study (Hearing Transcript, page 110). The Council would like to see midwifery services being delivered in domiciliary conditions on a pilot project basis in selected communities where consumer demand for home births is high and where there is easy access to a hospital equipped to deal with obstetrical emergencies.

The Council would also recommend that only specially qualified and experienced registrants be permitted to participate in such pilot projects, which have established clinical trial protocols in consultation with the inter-disciplinary advisory committee on midwifery services (see Ancillary Recommendation 9, page 5).

Recommendation 8

The Ministry of Health encourage the organization of birthing centres in order to support the practice of midwifery, decrease costs, provide families with

greater choice in health care services, and promote less interventionist health care.

The Obstetrics and Perinatal Services Subcommittee of the Greater Vancouver Regional Hospital District established a Birthing Centre Working Group to review the potential for organizing birth centres in the region. This Working Group commissioned a survey of 900 women of child-bearing age and found "more than three quarters" (77%) of all respondents said they probably or definitely would consider using a birthing centre if one was available in their community." It was concluded that "The likely user is a woman who is supportive of midwife participation, does not feel that the presence of a medical doctor is required for all births and finds a home-like, non-hospital setting for childbirth appealing." (Birthing Centre Survey, December 1992, page iv)

The results of this survey would suggest that the majority of women would choose a birthing centre as an alternative to a hospital based labour and delivery. As a spokesperson for Grace Hospital stated, "Women are not satisfied with the limited options available to them for maternity care today in B.C." (Hearing Transcript, page 16)

A birthing centre would seem to be well suited to midwifery practice and might serve as a point of access for all midwifery services. A new practice setting run by midwives would also serve to alleviate the inevitable resistance to change by existing institutions and the established professions who deliver midwifery services.

Comment:

The Ontario Government is also moving in this direction. The Ontario Minister of Health recently requested proposals for three out-of-hospital birthing centres which will be staffed by midwives.

Recommendation 9

An inter-disciplinary advisory committee be established to provide advice to the Board of the College of Midwives, related health professions, hospitals, regional boards, community councils, and the Ministry of Health regarding the implementation/integration of midwifery services into the health care system of British Columbia.

The Health Professions Council endorses the following statement by the Midwifery Task Force.

> An interdisciplinary approach should be supported from the outset, one in which physicians, nurses, and other health professionals are fully consulted, so that midwifery services can be integrated into our existing health care system. This can be facilitated by establishing an advisory board to the regulatory college that includes these professionals.
>
> (Midwifery Task Force Brief, page 5)

The Council believes that an inter-disciplinary advisory committee would not only provide advice and assistance to the College, but it would also be a valuable resource to the Ministry, hospitals, and local health boards during the implementation/integration phase for midwifery services. Ideally, this committee would be coordinated by the Ministry and be well "plugged-in" into the various layers of decision-making bodies which shape how health care services are actually delivered.

The committee should include at least one member drawn from each of the stakeholder groups, including the College of Physicians and Surgeons, the BCMA, RNABC, the B.C. Council of Licensed Practical Nurses, BCHA, the B.C. Reproductive Care Program, the Midwifery Task Force, and the Ministry of Health.

Recommendation 10

Relevant legislation, policies, procedures, and protocols be amended to allow midwives to become a recognized, integral and functional member of the health care team.

It is essential that midwives have working conditions which allow them to effectively deliver midwifery services to their clients. For example, midwives require admitting privileges to hospitals, access to diagnostic facilities and authority to give notices of birth. This will require consequential

amendments to many regulations, procedures and protocols. The input of the inter-disciplinary advisory committee would be invaluable in this task and it is hoped that the Ministry would oversee the implementation of that committee's recommendations at every level of decision-making to ensure access to midwifery services.

It is recommended that the inter-disciplinary advisory committee develop hospital and birthing centre protocols regarding the delivery of midwifery services.

E.APPLICATION AND PROCESS OF INVESTIGATION

The application by the Midwives Association of British Columbia for the designation of midwifery under the Health Professions Act was received by the Council on July 14, 1992. The application provided basic information about the applicant, the midwifery profession and what was being sought in terms of recommendations from the Health Professions Council. The applicant relied extensively on material from analogous processes in Ontario and Alberta.

On the basis of the information provided in the application, the Health Professions Council decided to conduct an investigation of midwifery. Public notice of the investigation was published in the Gazette as required by the Act.

The Council chose to engage in a consultation process involving related professions, consumer groups, educators, hospitals, and other jurisdictions. A list of the organizations contacted for information regarding the practice of midwifery is included at Appendix A. A synopsis of the positions expressed by the principal stakeholders is at Appendix B. The Council also received numerous letters from individuals (including some 90 form letters) and petitions from both the applicant and the Midwifery Task Force.

A public hearing into the application was held on January 25, 1993 in Vancouver. This provided the Council with an opportunity to ask questions

and discuss the written submissions which had been made. A transcript of the hearing was taken for the benefit of the Council.

With respect to the public hearing, the Council wishes to underline the fundamental importance of that forum to an investigation. First, it provides an unprecedented opportunity for the applicant and those affected by designation of a profession to explain publicly their specific interests and concerns about the profession and the issues raised by its designation under the Health Professions Act.

Second, it assists the Council in acquiring a better understanding of the practice of the profession, particularly the risk of harm which is involved in the services being provided. In order to learn, the Council must be able to conduct a dialogue with those who are familiar with the profession and the activities described in the proposed scope of practice. Obviously, the Council requires correct information and honest opinion from those having unique and important perspectives on the matters being considered. The Council is very dependent upon this respectful sharing of specialized knowledge and points of view by the participants to its investigations and remains indebted to all those who contribute so generously to the Council's learning process.

The recent work done by the Governments of Ontario and Alberta on midwifery was particularly useful to the Council's deliberations. The reports from Alberta by the Health Disciplines Board (1991) and the Midwifery Services Review Committee (1992) were extensively studied, as was the "Report of the Task Force on the Implementation of Midwifery in Ontario" (1987).

It is hoped that these recommendations may assist the Government, and others involved in the provision of midwifery services, to make informed decisions in the public interest about the regulation of midwifery in British Columbia.

Appendix A

Consultation Process

1. ASSOCIATIONS

Alberta Association of Midwives
Association of Ontario Midwives
Association des Sages-Femmes du Quebec
Birthing Options for Nanaimo and District
British Columbia Health Association
British Columbia Medical Association
British Columbia Reproductive Care Program
Canadian Confederation of Midwives
Greater Vancouver Regional District
Health Action Network Society
International Confederation of Midwives
Midwifery Task Force

2. HEALTH PROFESSIONS

British Columbia Council of Licensed Practical Nurses
College of Physicians and Surgeons
Registered Nurses Association of British Columbia
United Kingdom Central Council for Nursing, Midwifery and

Health Visiting

3. EDUCATIONAL PROGRAMS

Grace Hospital
Interim Regulatory Council for Midwifery (Ontario)
International Childbirth Education Association
Seattle Midwifery School

4. OTHER MINISTRIES

Aboriginal Affairs
Advanced Education, Training and Technology
Women's Equality

5. OTHER PROVINCES

Alberta Health
Alberta Professions and Occupations Bureau
Manitoba Health Services Commission
New Brunswick Department of Health and Community Services
Newfoundland Department of Health
Northwest Territories Department of Health
Nova Scotia Department of Health and Fitness
Ontario Ministry of Health
Prince Edward Island Department of Health and Social Services
Office des Professions du Quebec
Saskatchewan Department of Health
Yukon Department of Health and Human Resources

6. U.S. ORGANIZATIONS

American College of Nurse-Midwives
State of Washington Midwifery Advisory Committee

Appendix B

Synopsis of Submissions from Stakeholders

1.ASSOCIATIONS

British Columbia Health Association

Midwifery practice poses a risk to the public and should be designated under the Health Professions Act. Premature to extend admitting and discharging privileges to midwives; hospitals must retain autonomy to decide whether midwifery services will be provided and scope of practice for midwives within hospital. Does not support home births.

British Columbia Medical Association

Accepts implementation of midwifery in B.C., supports RNABC as governing body. Recommends scope of practice be limited to care of uncomplicated pregnancies and interim care of newborn. Home deliveries not acceptable. Economic and clinical outcome evaluation of midwifery services is required.

British Columbia Reproductive Care Program

Support introduction of midwifery under jurisdiction of a professional body and nursing education as basis for midwifery preparation. Midwives should be integral part of perinatal health care team.

Midwifery Task Force

Designation of midwifery is in the public interest; demand for quality midwifery care is increasing. Scope of practice should be consistent with international definition of midwife. Consumers should be strongly represented on board of college. Midwives should have hospital privileges.

2.HEALTH PROFESSIONS

B.C. Council of Licensed Practical Nurses

Four initial areas of concern: right of LPNs to practise within midwifery model; clinical competition for obstetrical placements; dual licensure; accessibility of obstetrical nursing care.

College of Physicians and Surgeons of B.C.

Midwives should be educated, licensed, accredited and demonstrate generally accepted standards of continued competence. No place for planned home delivery managed by licensed providers of obstetrical care. Midwifery should ideally be taught in a high volume hospital setting.

Registered Nurses Association of B.C.

Midwifery practice poses a risk to the public and should be regulated; offers

safe cost-effective health care alternative for childbearing families. Nurse midwives should be allowed to practise under Nurses (Registered) Act. Scope of practice should be consistent with nationally and internationally accepted definitions. Does not support home births.