College of Midwives of Ontario
Ordre des Sages-femmes de l'Ontario

The Midwifery Scope of Practice

The College of Midwives of Ontario
Submission to the
Health Professions Regulatory Advisory Council

May 30, 2008

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"We have suggested some important directions for evolution and change. Change is never a smooth process and we anticipate that there will be concern and some resistance among providers, but we are confident there is strong general support for our recommendations among all provider groups. In his article for the Journal of Obstetrics and Gynaecology of Canada, Sept 2005 SOGC president Michael Hellewa notes: 'But the biggest barrier, in my judgment, lies within: we are afraid of change. We must have the courage and confidence to go beyond traditional habits and practices.'"

Ontario Maternity Care Expert Panel report
Maternity Care in Ontario 2006: Emerging Crisis, Emerging Solutions.

Introduction

The College of Midwives of Ontario (CMO), in collaboration with the Association of Ontario Midwives (AOM), is pleased to respond to the Health Professions Regulatory Advisory Council's (HPRAC's) *Applicant Questionnaire* for review of the scope of practice of registered midwives. The CMO is particularly interested in assisting HPRAC in ensuring "that there are no legislative, regulatory, structural or process barriers to members of the profession working to the maximum of their scope of practice or to working in interprofessional settings or teams" (HPRAC letter to the CMO, April 12th 2008).

The CMO believes that this review of the scope of practice of midwives is both timely and crucial to the sustainability of primary maternity care for Ontario's women and families. Ontario is facing a maternity care crisis.[1] The number of family physicians providing maternity care services is dropping steadily, while the number of babies being born is increasing. Obstetricians are attending more births as their practice volumes increase, resulting in less time spent with each woman. There are far too many pregnant women in our province who receive no prenatal maternity care – not a family physician, not an obstetrician and not a midwife. Last year, midwives provided care to more than 10,000 women and reports indicate that in just five years the same number of women in Ontario may not be able to access any type of dedicated maternity care provider. Midwives are *primary maternity care providers* and should be relied upon as a significant part of the interprofessional solution to Ontario's maternity care crisis.

However, having stated that we are willing to be part of the solution, the current state of midwifery in Ontario is not adequate to meet the growing needs of Ontario's women and families. While the profession has been growing rapidly (since 1994, when only 75 midwives were regulated; there are now more than 400 midwives registered with the CMO) there continues to be a gap in terms of meeting demands. Our research shows that more than 40% of women who wanted midwifery care last year were unable to receive it.[2] And while those numbers are positive indicators that midwifery care is increasingly becoming a preferred mode of care for many women, the current supply of midwives cannot

meet the demand, despite the increasing number of new midwives graduating from the Ontario midwifery education programs every year; 346 midwives graduated from the baccalaureate Midwifery Education Program (MEP) between 1996 and 2007, and there continues to be 50 – 60 graduating annually.[3] Further, the International Midwifery Pre-Registration Program (IMPP) has accredited 76 foreign trained midwifery graduates to date, and continues to train approximately fifteen midwives every year.[4] While the Ministry of Health and Long-Term Care has committed to increasing the number of midwives being trained, the needs of Ontario's women and infants will still not be met.

The adjustments and amendments proposed in this paper are informed by evidence-based best practices and the current national standards of midwifery scope, as well as the considerable body of knowledge and experience registered midwives in Ontario have amassed since regulation. In particular, the recommendations the CMO is making are supported by the findings of the Ontario Maternity Care Expert Panel report (OMCEP). This panel, funded through the Ministry of Health and Long-Term Care's support for the Ontario Women's Health Council, was appointed in October 2004 to examine and make recommendations on an improved maternity care system in Ontario. The panel included experienced members of the main professional groups involved in maternity care: family physicians, midwives, nurses, and obstetricians, as well as consumer/client representation.

A portion of the material presented in this response is anecdotal. We believe that the direct and recent feedback received from practicing midwives regarding their scope of practice is extremely valuable and provides first-hand insight into the rationale behind the proposed amendments.

This submission proposes a number of considerations for HPRAC in the development of their scope of practice recommendations. These can be separated into two distinct, but interconnected, categories:

- *Existing barriers* to midwives practicing to their current legislated full scope of practice;
- *Proposed expansions* to midwives' current legislated scope of practice.

The proposed expansions to midwives' current scope of practice can themselves be separated into two areas: those changes that will be *mandatory* for all midwives to adopt as part of the scope of practice (***routine scope***), and those that will be *optional* additions to a midwife's scope (***extended scope***). The difference between these two types of expansion, the rationale for each, as well as the plans for integrating them into the profession, will be clearly delineated in the responses below.

In addition to the changes proposed in this submission, the CMO is developing a strategy to ensure that the scope-related issues that do not require legislative

amendments, and are therefore in our control, are revised to support the proposed changes to midwives' scope of practice.

"The limitations of the midwifery scope and model prevent me from effectively working collaboratively – this needs to be assessed and fixed if we are… part of the solution to the maternity care crisis."

Member comment, SPS survey
Oct 2007

MIDWIFERY IN ONTARIO – CONTEXT, PHILOSOPHY & DEFINITIONS

Ontario was the first Canadian jurisdiction to regulate the profession of midwifery. The CMO was established with the proclamation of the *Midwifery Act* on December 31, 1993 to govern midwifery in the interest of public safety.

Midwifery is a unique profession. It differs on a fundamental level from the traditional medical paradigm of Ontario's health care system. Midwifery care isn't the treatment of illness; rather it is the protection and promotion of health and wellness, and the prevention of unnecessary medical interventions in childbearing. It views pregnancy and childbirth as normal physiological experiences, and is a largely community-based profession, as midwives support women to give birth in their homes, as well as in the hospital. In Ontario, midwifery has benefitted from the opportunity to create a modern profession that incorporates the knowledge and experience of midwifery in other countries, as well as in other disciplines (for example, social justice, feminism, and consumerism).

Ontario's model of midwifery embodies the principle of informed choice and recognizes the client as the primary decision-maker. In that regard, midwifery is incongruent with the dominant medical model that has a well-established hierarchy between patient and caregiver. While this model is gradually changing to better reflect the ideals of informed choice and patient-control, there remains a philosophical difference between midwifery and other forms of maternity care. This difference has caused friction, confusion, and resistance among many of those stakeholders involved in the integration of midwifery into Ontario's health care system. Midwives have a different philosophy of care, a different funding model, a different organizational style (e.g. practice groups), etc. This friction continues to influence the accessibility of primary maternity care for Ontario's women and requires serious attention as we work together to mitigate the maternity care crisis.

"Whenever the midwifery view or management of an issue differs from the obstetrical model we are expected (in our community) to change. There is…no respect for a different approach…"

Member comment, regarding interprofessional care, SPS survey Oct 2007

Midwives and physicians, along with dentists, are the primary health care professionals required to apply for privileges at a hospital, but all authority for granting midwives admitting privileges within the hospital setting are given to the Medical Advisory Committee, through a credentialing committee. This places health human resources planning at the hospital level squarely in the hands of an exclusively physician-based governance structure, with interests that can lead to physician-centred, rather than woman/family-centred decisions about who will deliver services in local institutions.

"As long as midwives do not have the same voting rights as physicians within their department, there still is a hierarchy."

Member comment, regarding interprofessional care, SPS survey Oct 2007

The mandate of the College of Midwives of Ontario is to regulate the profession of midwifery in accordance with the *Regulated Health Professions Act* ("RHPA") and the *Midwifery Act, 1991*. The primary responsibility of the CMO is the protection of the public, specifically the childbearing women and their infants to whom its members provide care. The CMO ensures its members provide competent and ethical care to the clients they serve and establishes standards that make certain its members are responsive to both individual and community needs. The CMO promotes a model of care for the profession that encourages the participation of women through the provision of professional standards and guidelines that ensure quality of care. The CMO accomplishes these goals in an atmosphere that is responsive to both the public and its members.

The International Confederation of Midwives (ICM) defines a midwife as:

> *A person who, having been regularly admitted to a midwifery educational programme, duly recognised 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.*

> *The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.*
>
> *The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health, and childcare.*
>
> *A midwife may practise in any setting including the home, community, hospitals, clinics or health units* (adopted July 19 2005).

The proposed scope of practice changes should be viewed in relation to this ICM definition and Health Canada's *Family-Centred Maternity and Newborn Care: National Guidelines* (2000), which state:

> *Family-centred maternity and newborn care is a complex, multidimensional, dynamic process of providing safe, skilled, and individualized care. It responds to the physical, emotional, and psychosocial needs of the woman and her family. In family-centred maternity and newborn care, pregnancy and birth are considered normal, healthy life events. As well, such care recognizes the significance of family support, participation, and choice. In effect, family-centred maternity and newborn care reflects an attitude rather than a protocol.*

As evidenced by the Philosophy of Midwifery Care in Ontario (appendix A), preventative care is central to midwifery practice. This results in lower rates of clinical and technological interventions during childbirth. The Canadian Institute for Health Information (CIHI) released a report in 2004 entitled *Giving Birth in Canada: A Regional Profile,* which provides statistics regarding medical interventions that occur during labour and delivery per province/territory. In Ontario, the report cites an overall epidural rate of 45%, whereas the clients of Ontario midwives have a 21.5% epidural rate. [5]

Similarly, Ontario has a 24% episiotomy rate overall,[6] while the rate for midwifery clients is 6.5%. Cesarean sections are at an all-time high of 28% across the province;[7] while only 15.3% of midwifery clients require this surgical intervention (the World Health Organization states that no region in the world is justified in having a cesarean rate greater than 10 to 15 percent). It has been argued that

midwives have low intervention rates because they provide care to low-risk women who are less likely to encounter complications throughout pregnancy and birth; however, there is strong evidence to support the case that the midwifery model of care results in fewer interventions when compared to low-risk women whose maternity care is provided by a physician.[8]

And while the World Health Organization (WHO) states that between 70 and 80% of all pregnancies begin as low-risk,[9] the rates of clinical interventions in pregnancy and childbirth continue to rise in Ontario. Midwives, in that regard, are often referred to as the "guardians of normal birth."[10]

The CMO is aware that "the Health Professions Regulatory Advisory Council has been asked to provide advice to the Minister with respect to regulatory features that may enhance interprofessional collaboration between health professions in Ontario" (HPRAC letter to CMO, April 12th 2008). The CMO council passed a statement on Interprofessional Care in November of 2007 (appendix B), which states:

> *The College of Midwives of Ontario supports interprofessional care for its potential contribution to improved delivery and quality of care. The CMO will undertake activities to facilitate midwives' participation in interprofessional care.*

Further, it promotes the definition of the multidisciplinary care model outlined in the *Multidisciplinary Collaborative Primary Maternity Care Project* (2006), which states that:

> *"The model is designed to promote the active participation of each discipline in providing quality care. It is woman-centred, respects the goals and values of women and their families, provides mechanisms for continuous communication among caregivers, optimizes caregiver participation in clinical decision-making (within and across disciplines), and fosters respect for the contribution of all disciplines."*

The principles of the Multidisciplinary Collaborative Primary Maternity Care Model reflect and embody the foundational principles of the midwifery profession in Ontario.

The AOM has further refined the concept of interprofessional care by clarifying the definitions of *collaborative* and *interprofessional* care in their paper entitled *Interprofessional Maternity Care: Getting There & Getting it Right* (draft February 6, 2008):

Collaborative care: *a cooperative and mutually supportive relationship characterized by respect for the contributions of all health professionals, trust, mutual support, excellent communication, and coordination among providers, and absence of hierarchy. The contribution of each participant is based on knowledge or expertise brought to the practice rather than a traditional employer-employee relationship. The goal of collaboration is enhanced patient care. In maternity care collaboration can include collaboration among the same professionals, between different professionals within the same stage of care (i.e. antepartum, intrapartum or postpartum), collaboration with women and their families, collaboration with other providers outside the model, and collaboration with support staff.*

Interprofessional care: *Interprofessional care is used to describe a specific type of collaborative care which is team based and where providers from different professions share responsibility for care for the same group of women and babies and may share on-call coverage as well. Individuals from the different professions work together, either in sequence or concurrently, to provide care to the same person or population. Usually these teams work in the same location, have a shared philosophy of care and/or protocols. There are many models of interprofessional collaboration that can enable physicians, midwives, nurses and other health care providers to work together as part of a maternity care team. Successful models provide mechanisms for ongoing communication among caregivers, optimize participation in clinical decision-making within and across disciplines, and foster respect for the contribution of all professionals within a group.*

Midwifery, as it is currently regulated and practiced, is an inherently collaborative profession. In the provision of continuous maternity care midwives work in both intra and interprofessional teams, in small midwifery groups, as well as alongside physicians, nurses and other health care professionals. Midwives are mandated to collaborate and consult through the CMO's *Indications for Mandatory Discussion, Consultation and Transfer of Care* (IMDCTC) guideline (appendix C), which sets out the clinical situations wherein midwives are required to consult with a physician. This document has been used since the regulation of midwifery as an effective tool to support and guide collaborative care between midwives and physicians. In its report, OMCEP recommended that hospitals use this standard as the basis for local consultation and transfer of care protocols. To that end, the CMO is well situated to provide evidence and experience-based recommendations to HPRAC regarding regulatory features that may enhance interprofessional collaboration between health professions in Ontario.

PROFESSION INFORMATION

All applicants should answer the following question:

1. Does your current scope of practice accurately reflect your profession's current activities, functions, roles and responsibilities?

No. The current scope of practice for midwives is outdated and does not accurately reflect the day-to-day activities, functions, roles and responsibilities of midwifery practice, nor does it allow for the flexibility required for sustainability and growth within the profession. This paper addresses two related issues:

A. External barriers to midwives practicing to the current legislated full scope, as well as proposed solutions.
B. Expansion of current legislated scope of practice to enable timely, efficient, seamless, and cost-effective provision of maternity care.

There are two types of changes to the current legislated midwifery scope of practice included in the proposed expansions. ***Routine*** refers to those areas of practice in which it will be mandatory for all midwives to participate, as they are a normal part of 'everyday' primary maternity care. ***Extended*** scope of practice areas will be accessible to midwives through a specialized certification process, which will be developed by the CMO in collaboration with the AOM and the education programs. All of the proposed changes are in line with current national midwifery standards.

External Barriers to current Scope of Practice

It is our experience that many of the changes we have identified that would support and allow midwives to enhance their services, currently cannot be made by the CMO alone. The surrounding health system, funding mechanisms for both midwives and physicians, the hospital credentialing process and restrictive local protocols, and the provincial process for amending regulations all have been identified as barriers to midwives' full integration and participation in the delivery of care.

<u>Hospitals</u>

An agenda from a recent meeting with the AOM to address hospital barriers to midwifery practice listed the following issues:

- scope restrictions in excess of CMO requirements (CMO required consultations resulting in transfer of care to an obstetrician);

- transfer of care to an obstetrician for women having an induction or epidural;
- inappropriate roles and tasks for midwives (i.e. nursing functions);
- limiting the number of midwives granted privileges;
- limiting of the number of births attended by midwives;
- restricting midwives' community practice (home birth attendance);
- restricting midwives' care for non- OHIP clients in hospital;
- inconsistent hospital midwifery policies across the province.

The integration of midwifery into hospitals has been inconsistent; there is significant variation across the province reflecting the issues listed above. Considerable time and energy has been put into attempted resolution of these barriers by midwives, other hospital staff, the CMO and the AOM; however not always with positive results.

Some of these barriers are due to a basic resistance to the philosophy of midwifery, especially informed choice and choice of birthplace. Others are due to very real human resource and financial resource shortages in hospitals. Some of the limitations on midwives' scope and activities, number of births and number of midwives are due to incongruence in the system.

Limitation of Midwifery Scope of Practice

Despite a 2003 Coroner's inquest recommendation that hospitals use the CMO's IMDCTC as the basis for midwifery rules, many hospitals restrict midwives' practices. Most often, this is through requiring a transfer of care for indications that the CMO requires a consultation.

The requirement for greater physician involvement ignores the CMO's role as the appropriate regulator. The provincial health regulatory system entrusts each profession with the privilege and duty of self-regulation, recognizing that members of the profession are best suited to set standards and rules for its members.

This also restricts the public's access to the scope of midwifery care that is funded by the OMP (Ontario Midwifery Program); resulting in unnecessary payments through OHIP for care that midwives have the skills and competence to provide, are legally able to carry out and are provincially funded to deliver.

Hospital Restriction of Community Practice

Similar to the previous issue, the scope of midwifery practice was established through multi-year, multi-stakeholder consultations resulting in a decision to establish a self-regulating profession. The CMO's predecessors undertook further consultation in the development of the specific model and standards for

Ontario midwifery. The CMO requires midwives to provide informed choice and choice of birthplace to their clients. The provision of informed choice involves providing women with information and allowing them to make the choice. It is inappropriate for hospitals to restrict midwives' practices for clients planning out of hospital births.

The CMO has established programs for ensuring members' accountability, continuing competence, quality assurance and complaints from the public; these mechanisms were established to ensure midwives' safe practice in any setting.

Regulatory Amendment Process

New medications and procedures are a constant in the delivery of health care in today's environment. It is in the best interests of the health care consumers of Ontario to have a regulatory system that ensures a timely response to emerging best practices and changes in the health care delivery system. Therefore, we recommend that an alternate mechanism be established for the processing of regulations that address clinical practice.

"…It is quite simply unacceptable that this regulation is so restrictive of midwives' ability to provide proper care to their clients and that it is so unresponsive and unable to change…"

Member comment regarding the drug regulation, SPS survey Oct 2007

Expansion of current Scope of Practice

The proposed expansion to midwives' scope of practice includes:

- Revisions to the scope of practice statement in the *Midwifery Act*
- Revisions to the authorized acts in the *Midwifery Act*
- Revisions to the Designated Drug regulation under the *Midwifery Act*
- Revisions to other legislation: *Public Hospitals Act, Ambulance Act, Laboratory and Specimen Collection Centre Licensing Act*, and the *Regulated Health Professions Act*

If the answer to question #1 is no, then please answer the remaining questions (only those that apply) as thoroughly as possible:

2. Name the profession for which a change in scope of practice is being sought, and the professional Act that would require amendment

Profession: Midwifery
Professional Act: *Midwifery Act 1991*, and regulations under the *Midwifery Act 1991*

3. Describe the change in scope of practice being sought

Please see question 12 for further details.

The proposed legislative changes to the Ontario midwifery scope of practice are the result of a number of influences, including:

- The findings of the Ontario Midwifery Care Expert Panel report, which was funded through the Ministry of Health and Long-Term Care's support for the Ontario Women's Health Council;
- Formal consultations with members over the last several years of regulated midwifery;
- Informal information gathered through members on issues related to scope of practice, hospital privileges, interprofessional collaboration, and the midwifery model;
- Periodic surveys of midwifery consumers;
- Midwives' reports of client evaluation questionnaire results;
- Current and emerging clinical best practices;
- The regulation of midwifery in other Canadian and international jurisdictions;
- Requests to the CMO from other regulated professionals (e.g. physicians, nurses, pharmacists), institutions (e.g. hospitals, Children's Aid Society), and individuals (clients, the public, ambulance personnel) for clarification regarding midwives' scope of practice

They include:

- Amending the Scope of Practice statement in the Midwifery Act
- Amending the *Designated Drugs Regulation* under the Midwifery Act
- Clarifying/Extending the authorized acts:
    a. Managing labour and conducting spontaneous normal vaginal deliveries

    b. Putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the post-partum period

    c. Performing a procedure on tissue below the dermis - Taking blood samples from newborns by skin pricking or from women from veins or by skin pricking

d. Performing a procedure on tissue below the dermis - Performing episiotomies and amniotomies and repairing episiotomies and lacerations, not involving the anus, anal sphincter, rectum, urethra and periurethral area

- Adding the controlled acts:
    a. Putting an instrument, hand or finger beyond the larynx
    b. Putting an instrument, hand or finger beyond the anal verge
    c. Communicating a diagnosis within the scope of midwifery

Proposed amendments to other legislation:

- *Ambulance Act*
- *Regulated Health Professions Act* O. Reg 107/96
- *Public Hospitals Act*
- *Laboratory and Specimen Collection Centre Licensing Act*

4. Name of the College/association/group making the request, if applicable

College of Midwives of Ontario

5. Address/website/e-mail

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7. Contact person (including day telephone numbers)

Deborah Adams
Registrar, College of Midwives of Ontario
Daytime phone: 416-327-3901

8. List other professions, organizations or individuals who could provide relevant information with respect to the requested change in scope of practice of your profession

There are a number of professions, organizations and individuals who could provide relevant information applicable to the proposed changes, including midwifery and maternity stakeholders, regulatory bodies, professional associations, academic institutions, hospitals and government.

While the CMO appreciates the tight deadlines in place regarding this submission, our consultation process was necessarily limited. However, we did distribute a survey (appendix D) regarding the proposed changes to midwives' scope of practice to the maternity and midwifery stakeholders listed below. The same survey was distributed to all 416 CMO members; a summary of member responses can be found in appendix E.

Midwifery Stakeholders

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Hospitals

Alexandra Hospital
29 Noxon St
Ingersol, ON N5C 3V6

Brant Community Healthcare System
200 Terrace Hill St
Brantford, ON N3R 1G9

Cambridge Memorial Hospital
700 Coronation Blvd
Cambridge, ON N1R 3G2

Chatham - Kent Health Alliance
80 Grand Avenue West
Chatham, ON N7M 5L9

Collingwood General and Marine Hospital
459 Hume St
Collingwood, ON L9Y 1W9

Grand River Hospital
Kitchener Waterloo Health Centre
Kitchener, ON N2G 1G3

Groves Memorial Community Hospital
235 Union St E
Fergus, ON N1M 1W3

Halton Healthcare Services Corporation
327 Renolds St
Oakville, ON L6J 3L7

Humber River Regional Hospital
Church St. Site, 200 Church St
Weston, ON M9N 1N8

Joseph Brant Memorial Hospital
1230 North Shore Blvd
Burlington, ON L7R 4C4

Lake of the Woods District Hospital
21 Sylvan St W
Kenora, ON P9N 3W7

Leamington District Memorial Hospital
194 Tabot St W
Leamington, ON N8H 1N9

Louise Marshall Hospital
630 Dublin St
Mount Forest, ON N0G 2L3

Markham-Stouffville Hospital
381 Church St
Markham, ON L3P 7P3

Mount Sinai Hospital
1465 - 600 University Ave
Toronto, ON M5G 1X5

Norfolk General Hospital
365 West St
Simcoe, ON N3Y 1T7

North York General Hospital - General Division
4001 Leslie St
Toronto, ON M2K 1E1

Notre Dame Hospital
1405 Edward St
Hearst, ON P0L 1N0

Ottawa Hospital
501 Smythe Rd
Ottawa, ON K1H 7W9

Peterborough Regional Health Centre
1 Hospital Dr
Peterborough, ON K9J 7C6

uinte Health Care Belleville General
265 Dundas St E
Belleville, ON K8N 5A9
Rouge Valley Health Systems
2867 Ellesmere Rd
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Sault Area Hospitals
969 Queen St E
Sault Ste. Marie, ON P6A 2C4

South Bruce Grey Health Centre
21 McGivern St, Box 1300
Walkerton, ON N0G 2V0

St. Joseph's Health Centre, Toronto
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Toronto, ON M5B 1W8

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Alliston, ON L9R 1W7

Sunnybrook Health Sciences Centre
2075 Bayview Avenue
Toronto, ON M4N 3M5

Timmins and District Hospital
700 Ross Ave E
Timmins, ON P4N 8P2

Trillium Health Centre - Mississauga
100 Queensway W
Mississauga, ON L5B 1B8

William Osler Health Centre
20 Lynch St
Brampton, ON L6W 2Z8

Windsor Regional Hospital
1995 Lens Ave
Windsor, ON N8W 1L9

Woodstock General Hospital
270 Riddell St
Woodstock, ON N4S 6N4

Transfer Payment Agencies

Carla Palmer, Executive Director
Barrie Community Health Centre
56 Bayfield Street
Barrie, ON L4M 3A5
705-734-9690

Konnie Peet, Executive Director
Guelph Community Health Centre
176 Wyndham Street North
Guelph, ON N1H 8N9
519-821-5363

Mary Wilson Trider, VP Information & Systems
Halton Healthcare Services Corporation
327 Reynolds Street
Oakville, ON L6J 3L7
905-815-5102

Bill Davidson, Executive Director
Langs Farm Village Association
887 Langs Drive
Cambridge, ON N3H 5K4
519-653-1470

Barbara Lillico, Executive Director
Ontario Early Years Centre - Peterborough, Peterborough Family Resource Centre
201 Antrim Street
Peterborough, ON K9H 3G5
705-748-9144

Johanne Messier-Mann, Director, Maternal Child Program & Decision Support
Sault Area Hospitals
969 Queen Street
Sault Ste. Marie, ON P6A 2C4
705-759-3434

Ken Haworth, Vice President Operations
Stratford General Hospital
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Stratford, ON N5A 2Y2
519-272-8210

Denise Squire, Executive Director
Woolwich Community Health Centre
10 Parkside Drive
St. Jacobs, ON N0B 2N0
519-664-3794

Other

Coalition of Ontario Regulated Health Professions' Associations (CORHPA)
Dr. Robin Hesler, President
Canadian Association of Medical Radiation Technologists
1000 - 85 Albert Street,
Ottawa, Ontario K1P 6A4
613- 234-0012

Dr. Andre Lalonde, Executive Vice President
The Society of Obstetricians and Gynaecologists of Canada (SOGC)
774 Echo Drive
Ottawa, ON K1S 5N8
613-730-4192

Jan Kasperski, Executive Director and CEO
Ontario College of Family Physicians (OCFP)
357 Bay Street, Mezzanine Level
Toronto, ON M5H 2T7
416-867-9646

FOR ASSOCIATIONS

9. Names and positions of the directors and officers

Kelly Stadelbauer
Executive Director, Association of Ontario Midwives
Phone: (416) 425-9974, Ext. 230
Email: executivedirector@aom.on.ca

President: Katrina Kilroy, RM

Vice-President: Lisa Weston, RM

Secretary: Mary Ann Leslie, RM

Treasurer: Jane Erdman, RM

Member at Large: Elissa Press, RM

East Regional Coordinator: Jane Somerville, RM

South Central Regional Coordinator: Tracey Franklin, RM

South East Regional Coordinator: Sara Stainton, RM

South West Regional Coordinator: Kelly Gascoigne, RM

West Regional Coordinator: Madeleine Clin, RM

10. Length of time the association has existed as a representative organization for the profession

The AOM was incorporated November 2, 1989.

11. List name(s) of any provincial, national or international association(s) for this profession with which your association is affiliated or who have an interest in this application.

Canadian Association of Midwives

Tonia Occhionero, Executive Coordinator
#442-6555 chemin de la Côte-des-Neiges
Montréal, Québec
H3S 2A6

Phone: 514-807-3668
Fax: 514-738-0370
Email: admin@canadianmidwives.org

Canadian Midwifery Regulators Consortium

Secretariat:
College of Midwives of Manitoba
235 - 500 Portage Ave
Winnipeg, Manitoba
R3C 3X1
Phone: 204.783.4520
Fax: 204.779.1490
Chairperson: Kris Robinson

DETAILS OF THE PROPOSAL

Legislative Changes

12. What are the exact changes that you propose to the profession's scope of practice (scope of practice statement, controlled acts, title protection, harm clause, regulations, exemptions or exceptions that may apply to the profession, standards of practice, guidelines, policies and by-laws developed by the College, other legislation that may apply to the profession, and other relevant matters)? How are these proposed changes related to the profession and its current scope of practice?

The proposed legislative changes to the Ontario midwifery scope of practice are proposed with the intention to:

a. reflect current and emerging maternity care best practices;
b. provide more flexibility for members;
c. allow responsiveness to community needs (i.e. the needs of women and care providers);
d. support members' participation in interprofessional care;
e. enable midwives to contribute to solving the maternity care crisis;
f. support efficient use of the health care system; and
g. allow timely, seamless, efficient, and cost effective access to primary maternity care.

As previously mentioned, there are two types of changes to the current legislated midwifery scope of practice identified in the tables below. ***Routine*** refers to those areas of practice in which it will be mandatory for all midwives to participate, as they are a normal part of 'everyday' primary maternity care. ***Extended*** scope of practice areas will be accessible to midwives through a specialized certification process, which will be developed by the CMO in collaboration with the AOM and the education programs. All of the proposed changes are in line with current national midwifery standards, and the appropriate educational components are being developed. They are proposed with the recognition that maternity care needs are diverse across the province and resources are varied, and therefore flexibility is required within the scope of practice to meet community needs.

The tables below show the proposed amendments to current legislation that will enable an extended scope of practice for midwives. However, there are also non-legislative changes required at a system level to allow midwives the ability to work to their *current* legislated full scope of practice. These issues are addressed in question 13.

These amendments are proposed with the intention to "remove barriers to care and create structures that support the effective use of all care providers to their full scopes of practice." [11]

<table>
<tr><th colspan="4">Midwifery Act</th></tr>
<tr><th>Current Legislation</th><th>Proposed Changes to Legislation</th><th>Type of Scope</th><th>Rationale for Proposed Changes</th></tr>
<tr><td rowspan="3">Scope of practice statement:

Scope of practice statement:
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.</td><td>Revise to allow well-woman/well-baby* (>6 weeks) care</td><td>Extended practice</td><td rowspan="3">The current legislation limits midwives involvement in:
primary maternity care
• interprofessional collaboration
• care in underserviced areas

The proposed amendments would bring Ontario's midwives in line with the national standards of midwifery care.</td></tr>
<tr><td>Revise to allow pre-conception counseling</td><td>Routine practice</td></tr>
<tr><td>Remove "spontaneous" to increase flexibility of scope – e.g. for conducting artificial rupture of membranes for induction</td><td>Routine practice</td></tr>
</table>

** "Well-woman care" is routine reproductive health care that goes beyond pregnancy, childbirth and postpartum. "Well-baby care" is the routine care of infants that goes beyond the current legislated limit of six weeks.*

<table>
<tr><td colspan="4">Clarification of Current Authorized Acts:</td></tr>
<tr><th>Current Legislation</th><th>Proposed Changes to Legislation</th><th>Type of Scope</th><th>Rationale for Proposed Changes</th></tr>
<tr><td rowspan="2">Putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the post-partum period.</td><td>Clarify to allow emergency manual removal of placenta</td><td>Routine practice - emergency</td><td rowspan="3">Recommendation from OMCEP report
In line with national midwifery standard
Support midwives' involvement in:
• primary maternity care
• interprofessional collaboration
• care in underserviced areas</td></tr>
<tr><td>Clarify to allow vacuum extraction</td><td>Extended practice</td></tr>
<tr><td>Performing episiotomies and amniotomies and repairing episiotomies and lacerations, not involving the anus, anal sphincter, rectum, urethra and periurethral area.</td><td>Clarify to allow 3rd and 4th degree tear repair</td><td>Extended Practice</td></tr>
<tr><td colspan="4">Extension of Current Authorized Acts</td></tr>
<tr><th>Current Legislation</th><th>Proposed Changes to Legislation</th><th>Type of Scope</th><th>Rationale for Proposed Changes</th></tr>
</table>

"Performing a procedure on tissue below the dermis" Taking blood samples from newborns by skin pricking or from women from veins or by skin pricking.	Revise to allow midwives to apply a fetal scalp heart monitor	Routine practice	Recommendation from OMCEP report In line with national midwifery standard Support midwives' involvement in: • primary maternity care • interprofessional collaboration • care in underserviced areas
	Revise to allow midwives to perform fetal scalp Ph	Extended Practice	
	Revise to allow midwives to take blood samples from fathers/donors	Routine practice	
	Revise to allow umbilical vein catheterization on newborns	Routine practice	

Extension of Current Authorized Acts cont'd.			
Current Legislation	**Proposed Changes to Legislation**	**Type of Scope**	**Rationale for Proposed Changes**
Managing labour and conducting spontaneous normal vaginal deliveries.	Remove "spontaneous" to increase flexibility of scope (for example, conducting artificial rupture of membranes for induction)	Routine practice	Support midwives' involvement in: • primary maternity care • interprofessional collaboration • care in underserviced areas
	Revise to allow c-section assist	Extended practice	
Addition of Controlled Acts from RHPA			
Current Legislation	**Proposed Changes to Legislation**	**Type of Scope**	**Rationale for Proposed Changes**
Putting an instrument, hand or finger beyond the larynx.	For intubation of newborn	Routine practice	Neonatal Resuscitation Program Standard In line with national midwifery standards Recommendation from OMCEP report Support midwives' involvement in: • primary maternity care • interprofessional collaboration • care in underserviced areas

Addition of Controlled Acts from RHPA cont'd.			
Current Legislation	**Proposed Changes to Legislation**	**Type of Scope**	**Rationale for Proposed Changes**
Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.	Communicating to a patient or to his or her representative a diagnosis made by the member identifying, as the cause of the patient's symptoms, a disease or disorder that can be identified from the results of any laboratory tests or other tests and investigations that the member is authorized to order or perform.	Routine practice	In line with national midwifery standards Allow discussion of results of tests – increases efficiency and effectiveness of the maternity care system Reduces unnecessary utilisation of physician services, allowing physicians to use skills appropriately
Putting an instrument, hand	To conduct routine perineal repair procedure	Routine practice	Support midwives' involvement in:

or finger beyond the anal verge	For the administration of suppository medications	Routine practice	primary maternity care • interprofessional collaboration • care in underserviced areas

Regulations under Midwifery Act			
Current Regulation	**Proposed Changes**	**Type of Scope**	**Rationale for Proposed Changes**
Designated Drugs Regulation O. Reg. 884/93 The current amendment request before the Ministry includes, but is not limited to, the following drugs (the complete submission is attached as appendix F)	Add antibiotics for the treatment of GBS	Routine practice	In line with national midwifery standards Support midwives in providing timely access to primary maternity care, according to evidence-based best practices The current standard of care recommended by the Society of Obstetricians and Gynecologists of Canada (SOGC) and the Canadian Task Force on Preventative Health Care and the Center for Disease Control (USA) is I.V. antibiotic prophylaxis in labour. Treatment with I.V. antibiotics in labour is thought to prevent early neonatal onset group B strep disease. • 21.8 % of Ontario women screen positive for GBS (Provincial Dataset, Ontario Perinatal Surveillance System) • 20.8% of midwifery clients in Ontario screen positive for GBS (Ontario Midwifery Program Reporting System, MOHLTC)

Regulations under Midwifery Act cont'd.			
Current Regulation	**Proposed Changes**	**Type of Scope**	**Rationale for Proposed Changes**
Designated Drugs Regulation O. Reg. 884/93 The current amendment request before the Ministry includes, but is not limited to, the following drugs (the complete submission is attached as appendix F)	Add antibiotics for the treatment of mastitis	Routine practice	In line with national midwifery standards Support midwives in providing timely access to primary maternity care, according to evidence-based best practices. Between 10-20% of breastfeeding women develop symptoms associated with a breast infection (mastitis). Presently midwives are required to consult for treatment of clients with symptoms of a breast infection. Because of the sudden symptomatic nature of this condition, this leads to women having to attempt to obtain treatment through their family doctors, emergency departments and walk-in clinics at a time when they should be resting, and continuing non-pharmacological management of the infection. In cases where there lacks prompt treatment with antibiotics and continued attempts to drain the breast, breast abscess may result.

Regulations under Midwifery Act cont'd.			
Current Regulation	**Proposed Changes**	**Type of Scope**	**Rationale for Proposed Changes**
Designated Drugs Regulation O. Reg. 884/93 The current amendment request before the Ministry includes, but is not limited to, the following drugs (the complete submission is attached as appendix F)	Add antibiotics for the treatment of Bacterial Vaginosis	Routine practice	In line with national midwifery standards Support midwives in providing timely access to primary maternity care, according to evidence-based best practices. Women with a past history of premature labour and who have Bacterial Vaginosis, whether or not it is symptomatic, may benefit from treatment with antibiotics (Health Canada STI Guidelines)

Regulations under Midwifery Act cont'd.			
Current Regulation	**Proposed Changes**	**Type of Scope**	**Rationale for Proposed Changes**
Designated Drugs Regulation O. Reg. 884/93 The current amendment request before the Ministry includes, but is not limited to, the following drugs (the complete submission is attached as appendix F)	Add antibiotics for the treatment of Urinary Tract Infection	Routine practice	In line with national midwifery standards Support midwives in providing timely access to primary maternity care, according to evidence-based best practices. Urinary tract infection (UTI) is a common occurrence in the course of normal pregnancy (5-11%) which, if left untreated, leads to a high rate of pyelonephritis and concurrent risk for preterm labour. Research evidence indicates that prompt treatment of asymptomatic UTI will lead to a tenfold decrease in the rate of pyelonephritis. Midwives are presently able to order urine culture and sensitivities. Prompt treatment of UTIs, without adding the concurrent cost of women having to see another caregiver to seek treatment, is a good example of effective, preventative health care. Midwifery care of UTI would be limited to a non-systemic manifestation of illness. For example, a midwifery client

			with suspected significant illness (e.g. signs of pyelonephritis) would require consultation with a physician as per the standard on Indications for Mandatory Discussion, Consultation and Transfer of Care.

Regulations under Midwifery Act cont'd.			
Current Regulation	**Proposed Changes**	**Type of Scope**	**Rationale for Proposed Changes**

Designated Drugs Regulation O.Reg.884/93 The current amendment request before the Ministry includes, but is not limited to, The following drugs (the complete submission) is attached as appendix F)	Add Mumps/Measles/ Rubella vaccine	Routine practice	Caregivers in Ontario routinely screen for rubella immunity in pregnancy. It is recommended that women who are not immune to rubella receive a booster in the postpartum period to protect future pregnancies from the risk of congenital rubella syndrome. As primary caregivers, midwives should be able to provide a booster shot to women in the postpartum period.
	Add Varicella immunoglobulin	Routine practice	For women who are not immune to varicella (chicken pox), there is research evidence that receiving VZIG in pregnancy after known exposure to varicella decreases risk to the woman and baby.
Additional changes under consideration			
The following are proposed as additional amendments to the Designated Drugs Regulation	Add childhood vaccinations	Extended practice	Support midwives' involvement in: • primary maternity care • interprofessional collaboration • care in underserviced areas
	Add antibiotics for the treatment of Sexually Transmitted Infections	Routine practice	
	Add hormonal contraception	Extended practice	
	Change format to Classes and Categories	N/A	N/B: Timely changes to regulations will support midwives in meeting the current

			standard of care as recommended by OMCEP

Other Legislation			
Act	**Proposed Changes**	**Type of Scope**	**Rationale for Proposed Changes**
Laboratory and Specimen Collection Centre Licensing Act **The current amendment request before list is attached as appendix G**	Add cord blood gases test	Routine practice	Ensure proper treatment and Support midwives in providing: • Timely access to care • Interprofessional care • Care in underserviced areas
	Add drug screen	Routine practice	
	Add PIH	Routine practice	
	Add blood tests for father/donor	Routine practice	
Regulated Health Professions Act O. Reg 107/96	Revise section 4 to authorize midwives to order maternal postpartum ultrasounds & newborn follow-up ultrasounds	Routine practice	In line with the national standards of midwifery care Support midwives in providing: • Timely access to care • Interprofessional care • Care in underserviced areas
Ambulance Act	Amend/clarify to allow midwives the proper medical authority during ambulance transport	Routine practice	Support midwives in providing timely access to care.
Public Hospitals Act	Revise in order to allow midwives to participate in hospital Medical Advisory	Routine practice	Support midwives in providing: • Maternity care to the current full scope of midwifery • Timely access to care

	Committees and other decision-making committees, as well as to provide midwives' the same rights to due process in regard to the credentialing process that physicians receive		• Primary maternity care • Interprofessional care • Care in underserviced areas

There are also a number of scope-of-practice issues that can be dealt with at the CMO level, rather than through a regulatory amendment process. In our planning for expanding the scope of midwifery practice, building the capacity of the profession to respond to emerging health care needs, and the province's plans for the provision of maternity care, the CMO has identified standards and policies that will need to be reviewed, revised or rescinded. These policies will be examined within the framework of our guiding principles of informed choice, choice of birthplace, and continuity of care to continue to support the philosophy of birth as a normal physiologic process.

This review also considers the current context of health care (i.e. the appropriate and increasing emphasis on interprofessional collaboration, continued and growing economical constraints on the system, the shifting demographics of the province's population, etc.)

Specifically, the CMO will be reviewing:

• the requirement that there be 2 midwives at every birth;
• the current active practice requirements;
• the continuity of care requirements;
• the guidelines for certification to work outside the primary scope of practice;
• the CMO standard *Indications for Mandatory Discussion, Consultation, and Transfer of Care.*

The CMO currently has in place a mechanism to allow flexibility for our members within their practice. This mechanism, Temporary Alternate Practice Arrangements within the Model of Midwifery, permits midwives to apply for approval to work outside the established model. Typically this arrangement is used by practices to ensure adequate on-call coverage for primary midwifery care of clients. Practices with small numbers of midwives, large catchment areas, or unforeseen changes in midwives' availability (e.g. illness) can receive approval to work with second birth attendants other than midwives. Most often, this involves the support of labour floor nurses as second birth attendant in hospital and/or an identified second birth attendant to assist the midwife at a home birth. This mechanism was established to address the CMO's requirement for two midwives to be in attendance at every birth.

While this arrangement has provided the necessary flexibility to allow midwives to plan appropriately for on-call availability, the underlying standard needs to be reviewed, and rescinding considered. We have had discussions with the membership since 2000 about how to modify the model and retain its primary tenets. The requirement for two midwives at a birth has been raised as an impediment to the provision of more primary care by midwives and as a possible deterrent to the establishment of more positive relationships with hospital personnel, particularly nurses. Provinces that regulated midwifery after Ontario

have not put the requirement for two midwives at every birth in place. Further, it is not an international practice to require more than one midwife at a birth. Therefore the CMO is fully prepared to rescind this requirement following discussion and planning with the appropriate stakeholders and government representatives.

Rescinding this requirement will have an impact on the nursing support needed in hospital, the Ontario Midwifery Program budget (to pay for an increase in number of primary births by midwives), the need for member preparation regarding caseload planning for increased primary care, and ensuring the availability of the appropriate attendant for home births. It has been suggested that this is an opportunity for senior midwifery students to receive more home birth experience. The removal of this requirement will allow more midwives to be available for the provision of more primary care midwifery, thereby reducing the number of women who currently seek midwifery care but are unable to be accommodated. As stated above, it may also have the potential to foster more collegial relationships with nursing colleagues. Finally it is a more effective and efficient utilization of a primary care profession.

"The two midwives at every birth requirement segregates midwives in hospitals, impedes professional relationships, fosters suspicion and lack of trust and burns out midwives. As primary care providers our skills are much better used in providing primary care than second attendant services."

Member comment, SPS survey
Oct 2007

Active practice requirements were put in place to ensure that members attend a minimum number of births in both settings (home and hospital) where midwives provide primary care. Members must report these numbers after their first two years of practice and each subsequent five-year period, unless they did not meet their initial requirements; wherein a plan is put in place to ensure they maintain the requisite skills. The mechanism to allow for a plan to address shortfalls provides the Registration Committee panel with authority to be flexible while still providing for protection of the public. A review of the active practice requirements process will consider enabling options for a member to provide aspects of midwifery care or utilize skills that are a part of the midwifery scope while still maintaining her registration with the CMO. Policies and procedures can be developed to provide guidance to members and the Registration Committee for enabling a wider variety of practice within the scope.

"More flexibility in the kind of work midwives need to maintain active practice. This will help the profession be sustainable, responsive to health care needs of women, and encourage collaborative care."

Member comment, SPS survey
Oct 2007

The CMO standard on continuity of care restricts the number of midwives involved in a woman's care to no more than four. Continuity of care has been cited by many studies and reports as an important factor in safe care and care that is viewed positively by midwifery clients. The CMO will review this standard with the intent to revise the language to recognize that other professionals may be involved in a woman's care and to support more explicitly the concept of continuity of philosophy among and between the professionals providing care. The revision of this standard will continue to support this important component of care while reflecting the changing environment of practice.

The CMO also has two guidelines for certification processes for members wishing to be involved in care that is outside the primary scope of midwifery practice (e.g. maintenance of epidurals in labour and first assist at cesarean sections). The CMO will review to determine if there are other areas of practice where such guidance is appropriate or needed to support interprofessional care and primary maternity care delivery.

"…first assist at Cesarean section should be added to the list of expanded scope items as it is essential in rural communities for most effective use of human resources."

Member comment, SPS survey
Oct 2007

The CMO's Standard *Indications for Mandatory Discussion, Consultation, and Transfer of Care* sets out the clinical situations in which midwives are required to consult with a physician. This document has been used since the regulation of midwifery as an effective tool to support and guide collaborative care between midwives and physicians. As the scope of practice for midwives evolves, the standard will be closely evaluated for comprehensiveness and accuracy and changes will be made to ensure that it supports members as they participate in interprofessional collaboration. Changes will be based on research, experience and ongoing evaluation of midwifery practice to ensure the relevance of the standard to safe and effective midwifery care.

13. How does current legislation (profession-specific and/or other) prevent or limit members of the profession from performing to the full extent of the proposed scope of practice?

Within the current legislated scope we have previously made proposals to amend the CMO's drug regulation and to expand the list of laboratory tests authorized to midwives; we have assisted members, where there is cooperation from hospitals and physicians, to develop medical directives to ensure access to intrapartum antibiotics for GBS positive clients (as well as other tasks identified as clinical best-practice); and we have communicated with hospitals, individually and collectively, to provide education about the legislated scope of practice to ensure that midwifery privileges reflect this scope. Through these processes we have learned that these changes cannot be made without the cooperation of other parties, including government.

Midwifery Act

The current *Midwifery Act* limits midwives' ability to provide continuous care to their clients within the full scope of primary maternity care. It also limits midwives' participation in the larger healthcare system, specifically in areas of the province where health care providers are scarce. For instance, midwives currently have the competency to provide pre-conception counseling to women and care to well infants. In underserviced regions it would be beneficial for midwives to provide this service to women beyond their current legal scope of "within pregnancy, childbirth and postpartum". Similarly, midwives have the skills to provide well-woman reproductive health care services (for example, conducting pap tests), yet are currently not legally authorized to provide services to women outside of the scope of childbearing. There are communities in Ontario that are facing severe health human resource shortages, where an extended scope of practice for midwives would alleviate some of the existing gaps in service to women and infants, and relieve the pressure on strained local health service delivery systems.

Regulations under the *Midwifery Act*

<u>Designated Drugs Regulation - O. Reg. 884/93</u>

Regulating categories of drugs as opposed to individually listed pharmaceuticals will enable midwives to provide routine maternity care within their scope of practice without the unnecessary involvement of physicians. It will allow for the "right provider" at the "right time" by freeing up physicians to consult on cases where they are truly needed and enabling midwives to work to their full scope as primary care providers for low-risk women and their infants. Significant delays to treatment (and costs to the health care system) occur when a physician consult is required simply due to restrictions created by regulation and not clinically necessary.

Currently, the *Designated Drugs Regulation* limits midwives to a specified list of drugs they are legally authorized to prescribe and/or administer on their own authority, as well as under direction from a physician. Limiting midwives to a specified list of drugs leads to numerous problems and inefficiencies. For example, in 2003 one of the two medications listed in the CMO's designated drug regulation to treat postpartum hemorrhage, Ergonovine, became unavailable due to a raw material shortage. The CMO notified the Ministry of Health (DPRPU) that this posed a clinical risk for clients of midwives and inquired about the process for an urgent clinical amendment. We were informed that there was an expedited process that we could access, but that this process would still take months to finalize. In actual fact it took one year.

Because the CMO was concerned with the significant amount of time required for the expedited amendment process we looked for alternatives for our members to ensure they were able to continue providing safe care to their clients. We approached the CPSO to discuss the establishment of a medical directive process for our respective members to address this issue. Unfortunately, this process, too, would be months in the making. We learned about the Special Access Program of Health Canada and made this information available to all midwives. This situation caused considerable stress among our members and required considerable efforts on the part of the CMO. Any options for addressing this situation were not within our immediate responsibility. This situation clearly illustrated the need for a drug regulation that provides for classes or categories of drugs, and at the very least a more responsive and flexible regulatory amendment process for regulations affecting clinical practice.

Ontario does not meet the national standard in this area. Saskatchewan and Manitoba name categories of drugs that are required within the scope of providing maternity and newborn care. It is currently a proposed amendment in BC. There has been no evidence of abuse of this authority. In fact, the scope of practice for midwives naturally limits the usage and prescription of proposed categories of drugs. Midwives are committed to a non-interventionist approach to maternity care, and while they are eager to have the tools available to them to provide a broader scope of maternity care to their clients, midwifery philosophy dictates an appropriate use of technology. [12]

Authorising drug categories will enable midwives to practice fully within the current legislated scope, as well as in accordance with evidence-based best practices. It will enable the CMO, and by extension, practitioners, to respond to ongoing changes in the standard of care in obstetrics in a timely way. For example, in August 2006 an article in the Journal of Obstetrics and Gynaecology Canada demonstrated that maternal consumption of folic acid was associated with decreased risk for several congenital anomalies, including neural tube defects. Since then, Motherisk, (a program at the Hospital for Sick Children and a leading national authority on pregnancy information) has recommended a dosage

of 5 mg of folic acid/day for all pregnant women. However, midwives in Ontario are currently limited to prescribing no more than 1 mg of folic acid. Women under midwifery care need to go to their family doctor or a walk-in clinic to access a folic acid prescription. Again, this is a delay to the client receiving appropriate care and an added cost to the already overburdened provincial medical system.

Last year midwives cared for more than 10,000 women. If each one of these women saw a physician to receive her prescription for folic acid, as recommended by the Motherisk program, the system suffered unjustified costs. It costs approximately $30 for a physician to see a woman and write a prescription; if we assume that each of those women went to a physician for a prescription for folic acid, that would equal $300,000 spent on appointments that were not clinically necessary. Drug lists create these kinds of health system redundancies.

Ambulance Act

According to changes made to the *Ambulance Act*, midwives, as primary maternity care providers, currently do not have the authority to provide care to women and infants during an ambulance transport; to direct the ambulance to a particular facility where the midwife holds privileges; or be able to give orders to ambulance personnel regarding the care of a woman or infant. The CMO was neither consulted prior to these changes being made, nor notified of the changes once they took place. This did not provide an opportunity for education of our members and led to confusion in a number of situations.

As a result of these amendments to the *Ambulance Act*, clarification regarding decision-making with respect to hospital transfer is required. The College worked with Ministry representatives in 1994 to prepare a document entitled “Midwives at the Scene” that set out the roles and responsibilities of midwives and ambulance personnel.

This document states:

> *“A midwife, in relation to their patient, has the same status as a physician and will be afforded the same actions as for a physician. Where a midwife or physician remains in attendance with the patient throughout transport, the midwife or physician will have overall responsibility for the care of the patient.*
>
> *When arriving upon a scene with a midwife in attendance to a patient who is their client and for whom the midwife is acting as a midwife, the ambulance crew will accept the advice and direction of the midwife as it relates to the care of the patient(s).”*

The CMO recognizes that every ambulance transport is urgent, but not necessarily an emergency. It is our position that midwives, as highly skilled professionals in the provision of out of hospital birth care and who have hospital privileges, should have a role to play in the decisions respecting the most appropriate hospital for transport. In BC, for example, midwives have the same authority as physicians during an ambulance transport.

We believe that our College should be consulted on the impact of the current regulations and have an opportunity to provide knowledgeable input into the planned changes. In the unfortunate event that changes are made without our consultation, we require the time to provide our members with guidance, in order to give them the opportunity to incorporate any changes into practice protocols.

Laboratory Specimen and Collection Centre Licensing Act

Currently, the *Laboratory Specimen and Collection Centre Licensing Act* limits midwives to a specified list of laboratory tests they are legally authorized to conduct and/or order on their own authority. The proposed amendments are currently before the Ministry of Health. Limiting midwives to a specified list of lab tests leads to numerous problems and inefficiencies. For example, midwives are currently not authorized to order the tests for pregnancy-induced hypertension (PIH), which is a standard in the provision of routine maternity care. Midwifery clients must see a physician for the order of the test, which results in an unnecessary delay in care and additional cost and stress on the health care system. Giving midwives the authority to order PIH tests (as well as other tests that are a routine part of primary maternity care) will enhance client safety and the timely provision of care.

Please refer to the full *Laboratory Specimen and Collection Centre Licensing Act* submission (appendix G) for more information.

Public Hospitals Act

It is widely agreed that the *Public Hospitals Act* has needed amendments since the Ontario Hospital Association's *The Integration of Midwifery Services into Hospitals* manual was developed in 1994, just after midwifery was regulated:

> *"In order for midwives to fully function as independent professionals in a hospital, there is a general agreement that the Public Hospitals Act needs to be amended. Because there have been other major proposals for the amendment of the Act, and because the government is not yet prepared to undertake this legislative initiative, a process of regulatory amendment will be used, on an interim basis."* [13]

The manual was developed fourteen years ago, and no amendments to the *Act* have since been made. The process is currently dependant on individuals and their relationships rather than on legislation or regulations. The proposed changes require enhanced understanding of midwives' role, as well as supportive leadership within hospitals.

Collaboration

14. Do members of your profession practice in a collaborative or team environment where the recognition of competencies will contribute to multidisciplinary health care delivery? Please describe any consultation process that has occurred with other professions.

The amendments proposed in this submission are a response to needs identified at the community level, and are intended to enhance midwives' participation in interprofessional care. Currently, unnecessary consultations comprise a large portion of those interactions between midwives and physicians, which has resulted in frustration on both sides.

Collaborative Environment

Collaboration is entrenched in the philosophy of midwifery care. For example, the following College documents contain collaboration as a key element:

- Core Competencies, which includes a section entitled "Collaboration with other Caregivers"
- *Indications for Mandatory Discussion, Consult and Transfer of Care*
- Standard on Shared Primary Care
- Guideline: Shared Care with a Consulting Health Provider
- Guideline for Antepartum Consultation to Anesthesia
- Ambulance Registration for Home Births
- AOM/CMO Consensus Statement on the Model of Midwifery

Collaborative relationships have been developing among midwives and other health professionals since the beginning of regulation. For example, in 1994 (just after regulation) the CMO worked in collaboration with the College of Physicians and Surgeons of Ontario (CPSO) and the College of Nurses of Ontario (CNO) on the development of joint standards of care for birth centres (see appendix I). Similarly, the CMO worked with the College of Dental Hygienists of Ontario (CDHO) on a project regarding dental care during pregnancy and infant dental care. The pamphlet developed from this collaborative process was distributed to clients by the members of both colleges. More recently, the CMO consulted with the CPSO, the CNO, and the Ontario College of Pharmacists (OCP) regarding the proposed amendments to midwives' drug regulation.

The AOM, through the AOM-OMA Liaison Committee, meets regularly with the OMA Obstetrical Section to discuss issues of mutual concern. Recently, interprofessional care has been a major focus of discussion. Two policy statements have been developed as a result of this collaboration: *Guidelines for Maternal/Neonate Transfers from Home to Hospital* and *Joint Statement of Professional Relations Between Obstetricians and Registered Midwives in Ontario*.[14]

Midwives collaborate with a range of health care professionals (physicians, nurses, respiratory therapists, paramedics, etc.) on a daily basis, and are therefore familiar with the concept of providing collaborative care to women and infants. Midwives have been formally involved in the development of interprofessional maternity projects in several communities and the CMO continues to hear inquiries from members regarding the establishment of IPC teams in their regions. Midwives are taking the initiative to develop these projects in response to the "crisis" of maternity care in their communities.

We are aware that these projects face numerous obstacles, which are reflected in the IPC literature: concerns with professional liability, different funding models for the professions involved, and lack of government will to support the types of changes necessary (e.g. regulatory changes for midwives).

Finally, it is important to note that midwives learn early the value and necessity of interprofessional collaboration. IPC is an established mandatory component of the Midwifery Education Program curriculum. Currently midwifery students are required to participate in one interprofessional care placement in their third year; by 2009 there will be two mandatory IPC placements.

Consultation Process

As part of this review, the CMO has undertaken a wide consultation process through an online survey with other regulated professions (through both their regulatory colleges and associations), with hospital administrators, with midwifery transfer payment agencies, and with other midwifery and maternity system stakeholders. Through this survey, we have identified the need for concerted communications to inform other health care professionals of the proposed changes, in order to avoid confusion at the clinical practice level. To this end, we have begun the process of sharing information with relevant organizations regarding both the current and proposed scope of midwifery practice in an effort to enhance professional awareness of the role that midwives play in both the community, as well as in hospitals. For example, an article regarding midwives' prescribing authority has recently been developed in collaboration with the OCP, for publication in the CMO newsletter. We are in the process of sharing the information for publication in the OCP newsletter, as a reference for pharmacists working with midwives writing prescriptions.

Public Interest

15. Describe how the proposed changes to the scope of practice of the profession are in the public interest. Please consider and describe the influence of any of the following factors:

a. Gaps in professional services

If not addressed, the maternity care crisis in Ontario will worsen as the population increases and professionals and institutions become more stretched. The OMCEP report noted that a key to ensuring the sustainability of the maternity care system in Ontario is finding a good balance between primary maternity care provided by family physicians and midwives and specialist maternity care provided by obstetricians. Excellence in the system will come from ensuring there is effective collaboration when needed between these groups.

The proposed legislative and regulatory amendments will reduce the existing and growing gaps in professional services created by the health human resource shortage and the decreasing or changing services provided by hospitals.

Long-term statistics demonstrate that there has been a reduction of family physicians willing and able to provide intrapartum care. Responses to the 2007 Canadian Family Physician Survey[15] show that only 10.5% of family physicians/ general practitioners are doing obstetrical on-call and that 30% do not provide care at all to pregnant women. The province's obstetricians are not able to compensate for this loss. Figure 1 below illustrates ministry projections of capacity for intrapartum maternity care activity by physicians and midwives to 2012, based on projected increases to the number of family physician and obstetrician graduates and a stable number of midwifery graduates. Scenario 1 assumes an increased pool of family physicians and obstetricians with a declining proportion of both choosing intrapartum care. Scenario 2 is based on an increased pool of obstetricians and family physicians with a stable percentage choosing intrapartum care. In both scenarios, using average volumes for 2005, the Ministry projects excess capacity.[16]

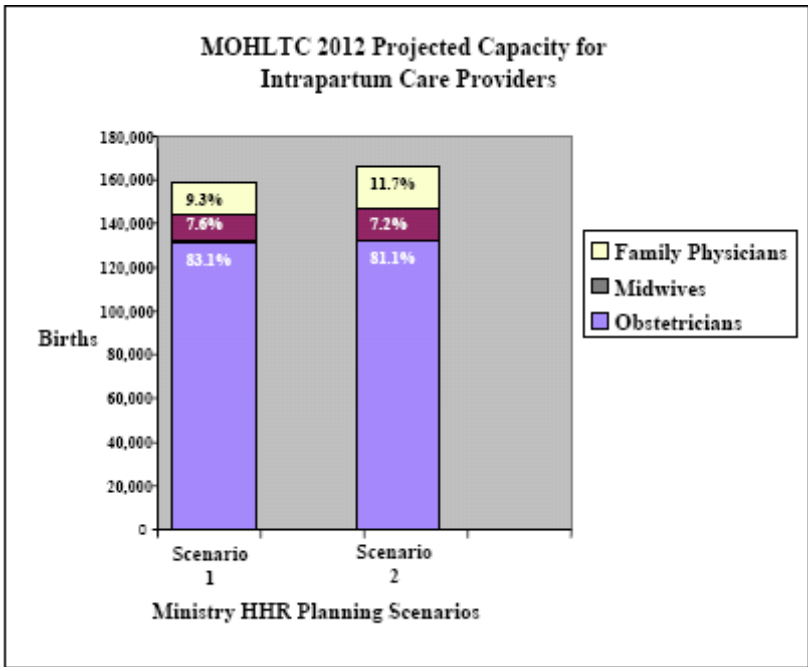

Figure 1

Further, the CFPC survey responses indicate that only 18.2% of family physicians rate the access that their patients have to obstetricians as fair and that 7.3% rate it as poor.

Even if available, obstetrical care is not necessarily the right care for the 70 to 80% of women whose pregnancies are low-risk or normal and that do not require medical intervention for a safe outcome. As the only practitioners whose sole responsibility is primary maternity care, midwives, particularly with access to full current or expanded scope, are a consistent and predictable resource that should be better utilised in health human resource planning to meet the gaps in services for women and families in Ontario. Figure 2 below demonstrates the increasing number of Ontario women receiving care from a midwife. [17] Following that is a map outlining the areas of the province where midwives are practicing. Despite the comparatively small number of midwives providing services to Ontario's women, they reach a large portion of the rural, northern and underserviced regions.

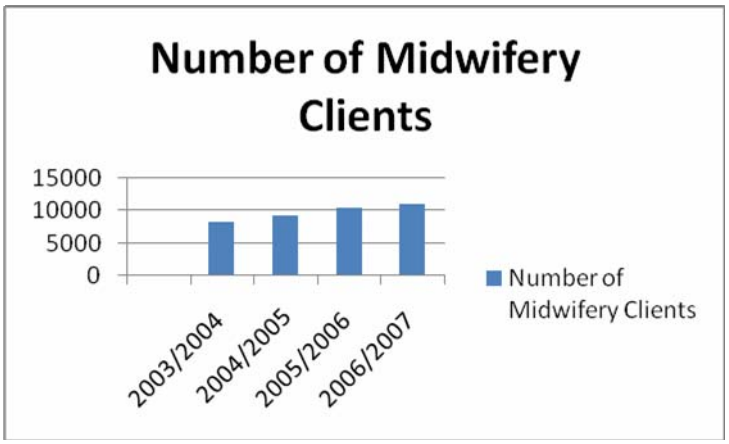

Figure 2

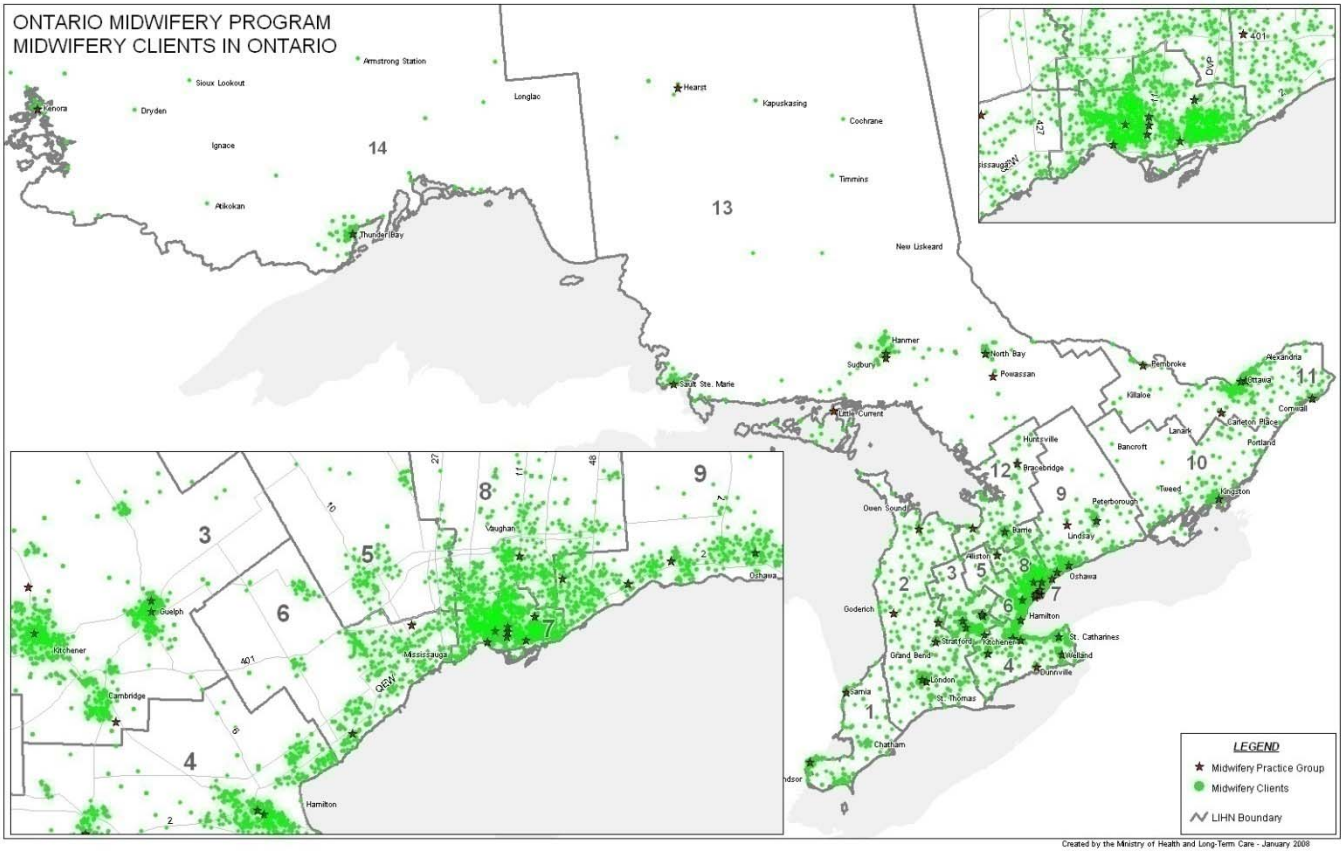

Figure 3

As hospitals continue to consolidate services because of economic and health human resource issues, there are fewer birthing hospitals and fewer newborn support services available in Ontario (93 of Ontario's 211 hospitals currently offer maternity care services).[18] In some hospitals where the choice has been made to preserve birthing services, they have been maintained at the cost of other elements of maternity care such as dedicated maternity nursing, lactation support, prenatal education, social work and mental health services.[19]

The removal of barriers to current full scope of practice, and the expansion of practice, will allow midwives to fill many of the gaps created by the reduction in hospital-based maternity services. Midwives currently provide dedicated maternity care, prenatal education and lactation support, and – by virtue of their intimate relationship with the women they serve – can effectively monitor the need for, and make referrals to, social work or mental health support.

In short, the ability of midwives to work to the optimal extent of their scope and skills is not only in the public interest but the most efficient, safe and productive method of reducing the "gap" in service and will "ensure the system's capacity to meet local patient and population health needs." [20]

b. Epidemiological trends in illness and disease

As caregivers for healthy pregnant women, trends in illness and disease are less relevant than trends in the rates of intervention and the accompanying increased incidence of resulting complications. The proposed scope of practice changes for midwives can be viewed in the context of changing trends in the care provided to women during pregnancy, labour and the postpartum period.

- Increasing intervention rates
    - In Canada, the rate of caesarean births was 25.6% in 2003. [21] Currently, the rate in Ontario is 28%.[22]
    - The Maternity Experience Survey found that 1 in 5 childbearing women in Ontario were induced at labour. The same survey indicates that 44.8% of women across the country are induced; 48.8% of women receiving care from an obstetrician, and 31.5% receiving care from a midwife.

As the Ministry works with providers toward the goal of decreased intervention and an improved infant mortality rate, midwives – with their low rates of intervention and consistently high rates of client satisfaction - clearly have a significant role to play. The removal of barriers to midwifery involvement through the proposed expansions to scope will further enable midwives to contribute to bringing Ontario's maternity care system to a standard of excellence in accessibility and quality.

c. Changing public need for services and increased public awareness of available services

Currently the demand for midwifery care far outstrips the supply; the number of clients who receive services increases every year, but so does the number who are turned away. The following chart (figure 4) demonstrates this pattern between 1999 and 2006. Further, anecdotal evidence from practising midwives tells us that the number of clients who can't access midwifery care is increasing.

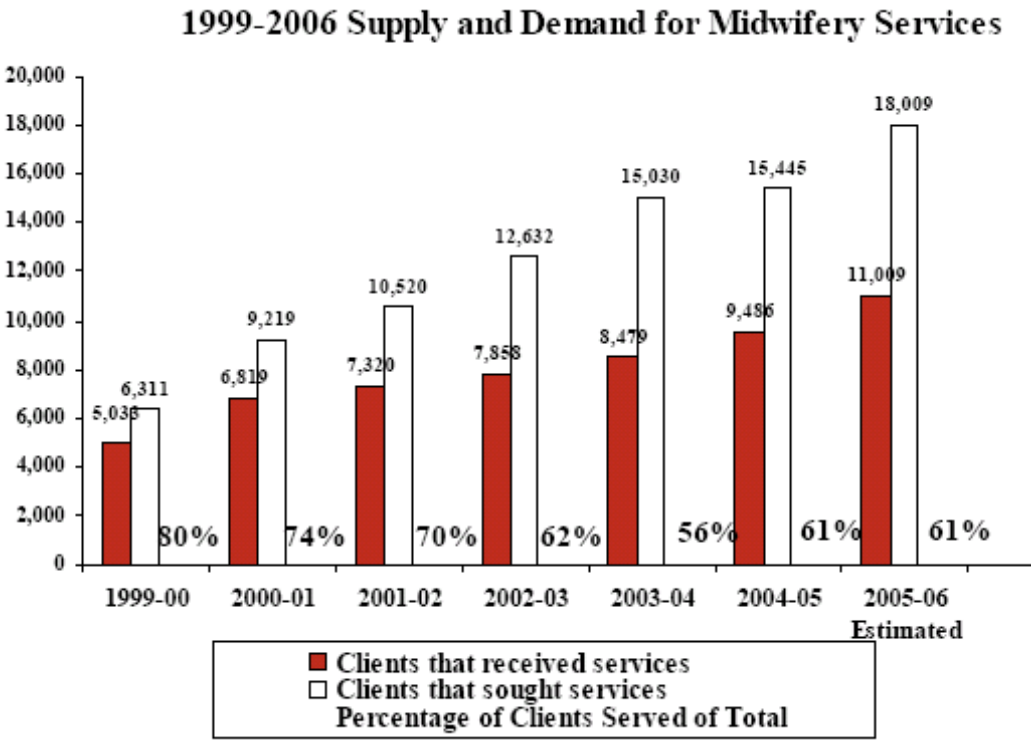

Figure 4

The Maternity Experiences Survey showed that clients are extremely satisfied with midwifery care. Women whose primary caregiver at birth was a midwife rated their labour and birth experiences as "very positive" more often (71%) than those cared for by obstetricians, gynecologists, family doctors or nurses and nurse practitioners (who received a 53% incidence of this rating).

d. Waiting times for health care services

In its June 2007 report “A National Birthing Strategy for Canada” the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) points out that “providers of intrapartum maternity care are in a unique situation in that a woman in labour requires immediate attention and the timing of the delivery is not usually a procedure that can be scheduled according to the availability of maternity care providers. A ‘wait-time’ approach to this sector of health care will not work. Therefore, as part of primary health care strategies women must have access to maternity care services 24-hours a day, 365 days a year.” [23]

Clearly, any wait time for maternity care is unreasonable. The SOGC March 2008 policy statement on wait times is clear on this issue, stating: “Timely access to consultation, antenatal testing, and delivery of health services is essential to

ensure a safe pregnancy and delivery for the woman and her baby." [24] There has long been clear evidence that early and continuous prenatal care increases the chances of a healthy baby and mother. Babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die, than those whose mothers received prenatal care. [25]

The Wait Times Expert Panel commissioned by the Ministry of Health and Long-Term Care in 2006 concluded in their January 2007 report that a "critical success factor in increasing access . . . is the role of primary care and family practice professionals in early detection and management of disease, appropriately referring their patients for specialised assessments." While the panel was dealing specifically with the Ministry's identified wait time target areas, their research and conclusions can also be applied to maternity care access. Early access to primary care with a midwife will ensure that low-risk women receive the needed care and that women who have or are at significant risk for complications receive an early referral to the appropriate specialist.

The Wait Times Expert Panel also noted "that family physicians and nurse practitioners are finding that working in collaborative relationships with one another, and with other health professionals, enables them to provide comprehensive and patient-centric health care. Interprofessional teams utilize the combined skills and expertise of different professionals recognizing that often no single provider or discipline is able to meet all the health care needs of many of the populations served in a sustainable fashion." If midwives are to equally contribute to the care of low-risk women they require the same authorized scope of practice that family physicians have in maternity care. Equipping midwives, through expanded scope of practice, to participate more fully in these interdisciplinary teams will contribute to the entrenchment of a system that is sustainable, that meets the needs of the population and reduces wait times for health services.

In addition to relieving pressure at the point of entry to care, the proposed expansion will also expedite care for women who are already midwifery clients. This will be accomplished by giving midwives, as primary caregivers, the authority to respond to the needs of their clients at point of care.

The Wait Times Expert Panel concluded that "when there is a delay in patients' ability to access their preferred primary provider, alternative routes to care are utilized such as emergency departments, walk-in clinics, and providers not registered within the primary care model. This can result in sub-optimal care given the lack of continuity of health information that often results." [26] An excellent example of this is that, currently, midwifery clients must visit a family physician for commonly occurring urinary tract infections. This necessitates the scheduling of a visit to their family physician, the wait time associated with this appointment, attending the visit to be assessed, receiving a prescription, and waiting to have it filled before commencing treatment. Further, if the family

physician does not participate in maternity care, they may be unfamiliar with the protocol around treating asymptomatic UTI in pregnancy and be reluctant or refuse to provide care. This process will be even further delayed for the woman who does not have a family doctor and so must visit a walk-in clinic and see a physician whom she does not know.

The same scenario plays out for midwifery clients who develop mastitis post partum (10-20% of all breastfeeding women develop mastitis)[27] and for the 21.8% of women who are GBS positive and require antibiotic prophylaxis before labour.

In addition to the obvious benefits to midwifery clients, this access will also contribute to reducing the burden on family physicians already stretched to meet the needs of their patients, and it will help to contain costs since the system will not have to pay for an unnecessary visit to a physician.

"…The current need for consultations can lead to unnecessary delays in women receiving intrapartum antibiotics (which can result in prolonged postpartum hospital stays) as well as effective pain management. Furthermore, these consultations are resulting in increased costs for the ministry of health. The change in scope of practice for registered midwives would increase their autonomy and improve working relationships between midwives and physicians."

Letter from 4 obstetricians at Sudbury Regional Hospital
Jan 18, 2006

e. Geographic variation in availability and diversity of health care providers across the province

Over the past 10 years an increasing number of hospitals have opted to consolidate services in order to increase efficiency and be more economical. In small and medium urban settings and rural communities in Ontario, there is increasing financial pressure to abandon maternity care entirely. This has resulted in a significant decrease in the availability of maternity care services. For many women, this means they must travel greater distances to receive maternity care. This raises safety concerns for the women and their infants and a myriad of other social concerns for families who must make arrangements for and assume the burden of the woman's absence.

Midwives have traditionally provided care in remote and isolated communities, and often have been the only source of maternity care (e.g. nursing stations in Canada). If geographic variation is viewed as a dimension of equity in health care for women, the absence of maternity care in many communities, particularly rural and remote communities, could and should be seen as an inequity in this

province's health system. Increased access to midwives who have the ability to provide a broader scope of services would serve to alleviate this inequity, particularly in diverse and vulnerable populations.

Access to full scope of practice for midwives, particularly those practicing in underserviced or remote communities, would have the effect of increasing availability and diversity of health care services. Midwives who are able to utilise their full skill set will be able contribute to the entire spectrum of care for pregnant women and women of childbearing age.

f. Changing technology

More relevant than changing technology to the review of the midwifery scope of practice is changing best practices in maternity care.

As the first province to regulate midwifery, Ontario was a national leader in developing the scope of practice needed to provide the best quality of primary maternity care for midwifery clients. However, many of the decisions regarding the profession were made 25 years ago as a part of the Health Professions Legislation Review. The provinces that have since regulated midwifery have gone further to allow midwives to provide primary care that ensures the best continuity of care possible to women choosing to have a midwife-assisted birth (see question 32 for further information). International best practices in regulation have also surpassed this province, as evidenced by the ICM essential competencies for midwifery practice (appendix H). As a result, Ontario is no longer at the leading edge in the country. The proposed legislative and regulatory amendments will bring Ontario's midwives into line with the other provincial standards and with the current best practices in maternity care.

g. Demographic trends

<u>Clients</u>

The Ontario Maternity Care Expert Panel (OMCEP) published a comprehensive report on the state of maternity care in Ontario. It states that:

> *Ontario is already facing problems of access to maternity care; without proactive changes to our system, we anticipate serious future challenges resulting from projected increases in our population, the projected number of annual births and their geographical distribution. According to the Ministry of Finance mid-range forecast, the population of Ontario will grow by 4 million (32.6%) to 16.43 million by July 2031. As our population grows, the number of births will also increase from the current level of about 130,000 per year to 157,000 in 2024-25. The increase in births is related to immigration projections, more women of childbearing age and slightly increasing fertility rates. The growth will take place against the*

background of health service provision that is already stretched and stressed. Population increase will also be uneven across Ontario, with dramatic increases in births in some areas and status quo levels in others. In some areas of the province, up to 30% more births are anticipated over a 25-year forecast. This will make planning for maternity care even more challenging in both urban and dispersed population areas.[28]

Further, the skills and philosophical approach midwives bring to their provision of care is ideally suited to supporting clients regardless of their demographic profile. For example, midwives in Manitoba are mandated to provide care to "priority populations"; immigrant, aboriginal, single, adolescent, poor and socially disadvantaged women. To date, 62% of midwifery clients are from these special populations. [29] In northern Quebec, three midwifery-led birth centres have been providing care to Aboriginal women in their home communities since 1986. The outcomes for these women are consistent with outcomes across Canada and studies of these birth centres have shown improvements in perinatal mortality, preterm labour, and breastfeeding rates. [30]

Midwives

The proposed expansions of scope (e.g. well-woman care) will contribute to the CMO's efforts to create the flexibility in the model to support sustainability by giving midwives the ability to apply their skills in the delivery of care related to their community's needs and enhance the opportunity for necessary off-call time. At the same time, when a midwife enters the system it can be counted on that she will be participating in the delivery of primary maternity care.

h. Promotion of collaborative scopes of practice

Midwives, who have always worked from a philosophical base that recognises and utilizes the benefits of collaborative care, are well poised to be active contributors to effective interprofessional care. The proposed legislative and regulatory changes will enable midwives to participate more completely in primary maternity care and to the full extent of their skills; something which both the OMCEP report and the MCP^2 report found to be critical to the success of interdisciplinary teams.

Both the CMO and our members have been taking the initiative and seeking solutions to the issue of interprofessional collaboration for some years. For example, a document was developed in 1995 by the CMO, CPSO and CNO to provide clinical practice parameters and facility standards for planned birthing centres (appendix I).

Since then, OMCEP and MCP^2 – both comprehensive studies and reports - have examined IPC specifically in regard to maternity care and concluded that midwives have a key role to play in the provision of quality interprofessional care. The proposed changes to midwifery scope will enhance midwives' capacity to provide care to low-risk women and their babies at a level that is similar to a family physician. This will support the recommendation that primary maternity care providers should have overlapping competencies, to better meet the needs of the community while working in interprofessional environments. As is noted in MCP^2:

> *It is important for team members to respect each other's scopes of practice and to maintain appropriate standards of care. At the same time, collaborative models offer opportunities to share care and build upon the expertise of others, thus building broader core competencies as a team. Scope of practice may be variable or change over time as providers in the core team acquire new or different skills. Although there are well known inherent contextual barriers to addressing scope of practice issues in the respective jurisdictions across the country, the ability for different professionals to overlap practice functions offer strong benefits to both the providers and recipients of care. There are two main benefits of a collaborative model with regard to the scopes of practice:*
>
> ***Benefits to Providers**: While there may be concerns expressed over potential loss of professional autonomy, a key benefit of overlapping scopes of practice is that team members may be better able to provide more timely care to women, and also learn more about and respect other professionals' activities.*
>
> ***Benefits to Women**: As the overall raison d'être of the collaborative model is to provide positive outcomes for women and their babies it should be expected that, to the greatest extent possible, the collaborative team will be able to respond to a woman's needs with a caregiver that will have the ongoing support, influence and interaction of other professionals on the collaborative team.*[31]

Midwives are required, through the CMO's *Indications for Mandatory Discussion, Consultations, and Transfer of Care* standard, to collaborate with physicians in a clearly articulated framework. Providing midwives with the scope needed to maintain responsibility for the care they are already providing (i.e. primary maternity care) would enable midwives' to better contribute to IPC.

The CMO sees evidence that liability issues are a barrier to IPC in the nature and frequency of both member and physician enquiries related to this concern. We do not believe, however, that there are insurmountable or perhaps even substantial legitimate liability issues. Unfortunately, the perceived issues amount to and/or are used as a barrier to IPC. A good example of this is epidural monitoring;

something that is currently in-scope for midwives and typically done by registered nurses not physicians, but often denied to midwives by physicians and/or hospital policies that - citing liability issues - dictate that once a physician has been consulted there must be a transfer of care. Clearly articulated and extended scope would serve to alleviate these barriers since the midwives' insurer, HIROC, has stated that they will insure midwives for the full scope of practice sanctioned by the CMO.

"Fear of litigation dominates the relationship."

Member comment, regarding interprofessional care, SPS survey Oct 2007

Interprofessional care is already built into the Midwifery Education Program curriculum and clinical placements have been developed and will be implemented by 2009 to ensure that all third year students will have two placements that are within an interprofessional team or setting (appendix J). The International Midwifery Preregistration program is working to have similarly comprehensive interprofessional care placements for its students.

i. Patient safety

Safety through better access to care

The OMCEP panel was clear in their vision that "every woman in Ontario has access to high quality, woman and family-centred maternity care as close to home as possible." [32]

Decisions to regionalize maternity care have forced rural and remote as well as some smaller urban hospitals to close obstetrical units, thus compounding the human resource problems. This has also had a serious impact on the viability of small communities and their ability to safely provide appropriate primary health care services, including maternity care. As a result, shortages are felt most acutely in rural and remote communities.[33]

Safety through changes to the system

The CMO is aware that HPRAC shares our concern regarding the government's regulation-making procedures and that HPRAC intends to address this issue in its Interprofessional Collaboration advice to the Minister. We strongly support the exploration of alternate mechanisms for regulation. Midwifery regulatory colleagues in other provinces report more flexibility in a framework that provides by-law making authority for the practice of the profession (e.g. drug lists, lab tests, entry to practice requirements). We also understand that in Ontario there are professions (lawyers, public accountants) that have been granted rule-

making authority, thereby setting a precedent and practice to guide the development of the use of this approach to the regulation of health professions.

The CMO believes that risk to patient safety currently exists because of the regulatory amendment process, which restricts our ability to amend regulations in time to reflect current best practices and therefore restricts members in providing care. This is evidenced by the changes to scope that are needed simply to bring Ontario's midwives in line with midwives in other regulated jurisdictions in the country. In short, the current process, which prevents the CMO from readily updating lists of drugs and laboratory tests – areas of health care that necessarily evolve continuously – hinders the CMO in fulfilling its mandate of the protection of the public and contributes to the erosion of the province's health care system.

As previously noted, a stark example of this safety issue was the loss of one of the two anti-hemorrhagic drugs available to midwives in the drug regulation. In 2003 there was a supply issue with the anti-hemorrhagic drug Ergonovine. The drug was not available in hospitals and midwives were without other options to treat women experiencing postpartum bleeding. The expedited process undertaken to add a third anti-hemorrhagic drug to the drug regulation took in excess of 12 months. Clearly, this was an unacceptable situation as the safety of all women under the care of a midwife during this time was compromised due to a regulatory process outside their control.

Safety of Midwifery care

Through our Quality Assurance Program (appendix K), both the CMO and members have already demonstrated a long-standing commitment to patient safety; a commitment that will be renewed with the introduction of any extensions of midwifery scope. The QAP facilitates the implementation of practice modification tools, encourages learning from incidents, near misses, adverse events and fosters the use of principles of high reliability organizations (HROs).[34]

Specific examples of this commitment can be seen in involvement in initiatives like the MORE^{OB} program and the CMO's peer case review requirement. This requirement stipulates that members must participate in at least six sessions of peer case review in every twelve-month period, and that each session must include a minimum of four midwives, at least one of whom should be from another practice. One of the essential characteristics of the peer case review process is a commitment to quality improvement and continuing education: a philosophy well-aligned with a patient-safety centred approach. Similarly, the CMO's continuing competencies require midwives to re-certify for Emergency Skills (bi-annually), Cardiopulmonary Resuscitation (bi-annually), and Neonatal Resuscitation (annually).

j. Wellness and health promotion

Wellness and health promotion is a core element of midwifery care. The midwifery philosophy approaches birth as a normal physiological event and dictates an approach to care that places the woman and all of her needs as central.

The fact that midwife-attended births have such a low rate of intervention further supports the midwife's role as a guardian of health and wellness. Midwifery supports a non-interventionist approach to birth whenever possible, within strict safety guidelines (e.g. the *Indications for Mandatory Discussion, Consultation and Transfer of Care* and the *Indications for Planned Place of Birth* documents). Midwifery rates of intervention remain low despite the increasing rates overall in Ontario and Canada. To illustrate, the current provincial rates of intervention are compared with midwifery rates in the table below.

Type of Intervention	Provincial Client Average[35]	Midwifery Client Average[36]
Episiotomy	24%	6.5% (most recent data 04/05)
C-section	28%	15.4% (most recent data 06/07)
Induction	24.6%	15.9% (most recent data 06/07)

Data consideration: values in this chart are not adjusted for risk in the population or parity of the woman.

Similarly, midwives' outcomes on a national level indicate a much lower rate of intervention when compared to obstetricians, family doctors, and nurses. Some of the results of the recent Maternity Experiences Survey,[37] conducted by the Public Health Agency of Canada, are shown in the table below.

Source: Maternity Experience Survey, 2006
E: Use with caution.
F: Too unreliable to be published.
… Not applicable

Methods of delivery	Total	Midwife	OB	Family Physician	NP
Vaginal	73.7	98.0	66.5	92.9	99.4
Spontaneous vaginal	61.1	91.3	52.7	81.9	92.2
Caesarean section	26.3	F	33.5	7.1	F
Mothers having vaginal or attempting vaginal	83.7	98.9	78.6	97.0	99.9

births					
Labour					
Any EFM	90.8	42.7	94.9	90.3	92.3
EFM on admission only	5.2	F	4.5	7.7	F
Intermittent	21.1	15.2	19.0	30.0	24.5
Continuous	62.9	23.7	69.8	51.2	58.7
Unspecified method of EFM	1.6	F	1.6	F	F
Induction	44.8	31.5	48.8	37.5	34.0
Augmentation	37.3	22.6	40.9	29.3	27.6
Enema	5.4	F	6.3	3.5[E]	F
Pubic/perineal shaving	19.1	14.7	20.9	12.8	19.8
Pushing on abdomen	13.2	F	14.4	12.3	F
Epidural	57.3	15.1	64.9	43.5	49.8
Birth					
Instrumental delivery					
Forceps	3.6	F	4.5	F	F
Vacuum extraction	7.2	F	7.6	8.0	F
Forceps and Vacuum	1.2	F	1.3	F	F
Unspecified method of instrument delivery	0.7	F	F	F	F
Perineum					
Episiotomy	20.7	F	23.9	17.0	14.0
Sutures	64.1	56.8	64.9	65.2	64.3
Birth position					
Supine	47.9	31.4	51.4	42.4	43.1
Propped up or sitting	45.8	37.4	44.9	50.6	49.8
Side lying	3.3	14.6	2.4	4.2	F
Other	3.0	16.6	1.4[E]	2.8[E]	F
Legs in stirrups	57.0	23.4	62.4	52.2	46.9
Experienced any intervention	86.6	60.9	91.1	82.4	81.7

By simple virtue of the amount of time a midwife spends with each client over the course of her pregnancy, during labour and the post-partum period, midwives are in an excellent (and perhaps the best) position to promote health and wellness of both mother and infant. For instance, 84% of midwifery clients continue to breastfeed their babies at discharge (six weeks postpartum). Breastfeeding promotion and support is a well established part of Ontario's public health promotion strategy and midwives are clearly contributing to its advancement. This positive impact can only be increased and strengthened through enabling midwives to play a broader role in providing care to women and infants.

k. Health human resources issues

Health Force Ontario reports that "trend data indicates that Ontario faces a significant reduction in its health human resources workforce by 2010", and that "unless new ways of practising health care are introduced, Ontario will face a significant shortage of health care workers and Ontarians will risk receiving sub-optimal care." [38] This same crisis is threatening maternity care in the province

and will require considerable planning and resources to resolve. Health Force Ontario has indicated that there is a commitment to "developing new provider roles and new models of care that will make the best use of all our skills and resources" [39] as part of the effort to resolve sustainability issues across the health system. The proposed changes to the midwifery scope will support the development of new roles by allowing midwives to provide needed care in many of the province's underserviced communities. Moreover, it will support a better balance between primary and specialist care, ensuring that the province's other obstetrical resources are better used through the removal of the need for unnecessary consultation regarding issues or aspects of care that are well within the midwifery skill set. This conclusion is well supported by the Ontario Midwifery Care Expert panel's report, which states that:

> *With the significant withdrawal of family physicians from maternity care, and reduced access to other primary prenatal care providers in some communities (nurse practitioners, public health, community health clinics and other community programs), more and more women are receiving their prenatal and postnatal care from specialists, and a smaller but growing proportion, from midwives. OMCEP's assumption about future prenatal care is that every healthy (low-risk) woman should be able to access early (first trimester) prenatal care and have regular prenatal and postnatal visits with a primary maternity care provider(s) in her home community. This will require Ontario to develop and maintain targets for a wider, better distributed group of prenatal and postnatal providers than will be practical for intrapartum services. Secondary assumptions are: 1) that with better access to prenatal primary care an increased number of women will avoid pregnancy and postpartum complications by improved preventive care, 2) the subgroup of women and newborns with complications will also be better able to be prioritized for specialist care."*[40]

Adding to the difficulty of effective health human resource planning for midwifery care is the fact that there are limited ways of predicting the future distribution of caregivers.[41] Midwives, as the only providers who are dedicated to pregnancy care, are the exception to this situation. Midwives are a consistent and predictable resource and are poised to play an even more significant role in solving the maternity care crisis.

I. Professional competencies not currently recognized

As primary care providers, midwives must have the clinical decision-making skills to provide and oversee others in providing safe, effective care to their clients. The proposed changes to scope build on these skills and will support members in providing more continuity of care to women through the prenatal, intrapartum, and postpartum periods. This will reduce the number of transfers, and in doing so, reduce potential for compromise to patient safety. The American Joint Commission Annual 2006 Report on Quality and Safety[42] shows that

communication issues are the leading root cause of sentinel events, and that transfer of care situations are a key point at which these communications issues arise.

Greater clarity of scope of practice (e.g. that it is currently within scope for midwives to monitor epidurals, inductions and augmentations) will help to reduce the current barriers to midwives practice in hospital settings. Currently, a lack of understanding of the authority and accountability contributes to perceived liability issues and causes physicians and hospitals to restrict midwives in these areas. Removing this confusion will contribute to better care and consistency of care for women across the province. It will also support improved IPC by allowing teams to work within more clearly defined roles.

m. Access to services in remote, rural or under serviced areas

It is in the remote, rural and underserviced areas that access to an expanded scope of practice will have the most significant impact on the availability of maternity care. The Ministry has reported that more than one million Ontarians cannot find a family doctor close to home, and 142 communities are under-serviced for basic health care[43] and that these shortages are not only in the province's northern reaches but in cities as large as Windsor.[44] These shortages have been well-documented in maternity care over the past decade[45] and the causes largely attributed to a number of health factors including health human resource challenges such as insufficient off-call time for family physicians in small communities and limited support from colleagues for the provision of maternity care.[46]

The OMCEP report concluded that it is "time for the Ministry of Health and Long-Term Care and regulatory colleges to consider expanded roles for nurses and midwives working in 'special' environments to deliver care closest to home in a culturally sensitive manner. This might include first assist for Caesarean section in rural and underserviced areas, use of vacuum-assisted birth in urgent situations and repair of third and fourth degree perineal tears for midwives where specialist care is not available."[47] Supporting OMCEP's conclusions and the recommended changes to scope included in this submission is the strong evidence that suggests that maternity service provision in rural and remote communities improves obstetric and neonatal outcomes.[48] Midwives, particularly with an expanded scope of practice, have a significant contribution to make to preserving maternity care in the province's rural, remote and underserviced communities.

Services for vulnerable populations would also be affected positively by the proposed changes. During the last four decades, policies and practices based on modern obstetrical techniques and knowledge have replaced traditional practices in many rural and remote Aboriginal communities. As most of these communities do not have obstetrical facilities or staff, women often have to leave their homes

to give birth. Policies currently in place in many Aboriginal communities recommend evacuation of all pregnant women at 36 to 37 weeks' gestation to deliver in a Level 2 hospital.[49] This evacuation is known to cause considerable hardship for both the women who must leave and give birth without the benefits of family and community, and for the families who are left behind.[50] The Society of Obstetricians and Gynaecologists of Canada, in its policy statement "A Guide for Health Professionals Working with Aboriginal Peoples"[51] recommends that health services for Aboriginal peoples take place as close to home as possible. Registered midwives are already providing care in many northern communities and the availability of expanded midwifery services will allow them to make further contributions to supporting rural, remote, underserviced and vulnerable communities. This could be accomplished through such services as outreach prenatal care and midwifery involvement in sustainable interdisciplinary maternity care teams.

"Interprofessional models have many potential advantages – in my work in remote communities sharing care with RNs and MDs is vital…"

Member comment, regarding advantages or disadvantages to interprofessional care, SPS survey, Oct 2007

16. How would this proposed change in scope of practice affect the public's access to health professions of choice?

Fewer barriers to midwives working within expanded scope of practice will mean increased access to midwifery services across the province. Midwives in Ontario continue to turn away approximately 40% of potential clients due to full caseloads. The proposed expansion to scope of practice would directly address the shortage of midwives in Ontario through the removal of barriers in hospitals that place caps on the number of midwives with privileges, as well as the number of births midwives are allowed to attend. An AOM survey of members indicated that 90% of midwifery practice groups face hospital-imposed barriers: 19% cited restrictions on the number of midwives able to obtain privileges; 16% cited restrictions on the number of midwife-attended births; and 67% cited restrictions on midwives scope of practice in hospitals. [52]

The proposed changes would improve continuity of care for midwifery clients and reduce the number of referrals and transfers to physicians improving their availability and improving access for women who require the expertise of a specialist.

17. How would the proposed change in scope of practice affect current members of the profession? Of other health professions? Of the public? Describe the effect the proposed change in scope of practice might have on:

a. Practitioner availability

Please see questions 13, 15 e and k, 34 b.

b. Education and training programs;

Please see questions 26 through 29, 34 d and e.

c. Enhancement of quality of services;

Please see questions 13, 15 a, d, l and j, 34 a.

d. Costs to patients or clients;

Please see question 34 a.

e. Access to services;

Please see questions 15 a, c, l and m, 34 a.

f. Service efficiency;

Please see questions 13, 22, 34 a, b, and c.

g. Inter-professional care delivery;

Please see questions 14, 15 h, and 34 b.

h. Economic issues; and

Please see question 34 b.

i. Other impacts.

18. Are members of your profession in favour of this change in scope of practice? Please describe any consultation process and the response achieved.

As far back as June 2001, the CMO and the AOM sponsored a symposium on the Ontario Model of Midwifery. Prior to the symposium, a survey was distributed to all midwives to assist with planning for discussions. A scope of practice discussion and report took place at the symposium. This report included suggested areas for expansion; on this list were access to antibiotics, expansions to lab tests for PIH, and blood work for fathers and drug screens, among others. Since that time, the CMO held a member forum in 2004 where input from members on expansion of the scope was again discussed, and much of the content of our current drug regulation amendment proposal and laboratory tests resulted from member input at this event. Also, as part of our Strategic Planning

process in October 2007 we polled members on the elements of this proposal (as we were preparing to approach HPRAC with these requests in the new year). As part of the regulatory amendment process, we have consulted our members on the proposed drug regulation and laboratory test amendments. Finally, we surveyed our members in May 2008 in preparation for this submission (see appendix E).

In our experience our members have a good understanding of what is important to their clients; they support changes that will enhance their ability to provide continuity of care to their clients, and that will enable them to deliver the most effective treatment in a timely manner. In other words, they support changes that will improve the timeliness and efficiency of care to their clients, but not at the expense of the quality of that care. Through these consultations and discussions, members have expressed concern about maintaining a focus on normal birth, increased workload, and the issue of compensation for expanded activities. However, the most frequent response was with respect to ensuring that midwives are adequately prepared through additional education and training to include these new activities. The CMO has begun planning to ensure the appropriate educational opportunities are available and accessible to our members to support these proposed expansions.

The AOM also engaged in member consultations as part of the development of their 2007-2010 strategic plan. Through this process, the membership endorsed the following goals, available on the AOM website,[53] which pertain to broader scope of practice:

- Explore optional models of care that could result in more flexibility in the current model of care
- Advocate for revised drug and lab regulations
- Advocate for appropriate alternate funding models that protect quality midwifery care and increase the availability of midwifery care
- Explore “full scope of practice” issues with the membership and develop a plan to address the outcomes of this exploration with CMO, hospitals and other stakeholders

The endorsement of the above goals shows that members desire more flexibility in the current scope, and that they would like the option to explore broader scope of practice areas. Enabling broader scope of practice in the legislation will create future opportunities for consultation on specific scope policies, without being hampered by the lengthy process of legislative change.

19. Describe any consultative process with other professions that might be impacted by these proposed changes.

The proposed changes to the midwifery scope of practice will result in fewer discussions, consultations, and transfers of care between midwives and physicians. The CMO's *Indications for Mandatory Discussion, Consultation and Transfer of Care* document, which has proven to be a dynamic and effective tool for midwives and physicians, will be amended accordingly. Midwives and other health care professionals will be educated regarding the changes to current consultative processes.

20. How will the risk of harm to the patient or client be affected by the proposed change in scope of practice?

Midwives are self-regulated health professionals, and are therefore understood to be capable of making the clinical risk of harm judgments required of any health care professional in the provision of care. Self-regulation means that a profession is responsible for defining and monitoring the practice of its members in the public interest and in accordance with governing legislation. As the regulatory body of the profession of midwifery, the CMO already assesses the risk of harm associated with the scope of practice, and will continue to act in that capacity as changes are made. Specifically, the CMO's *Indications for Mandatory Discussion, Consultation and Transfer of Care* document is a valuable tool that clearly outlines the clinical situations wherein midwives are required to consult with a physician. This document is a cornerstone of the profession and the collaborative relationships that midwives develop with physicians.

The proposed changes will ensure that transfers of care take place only when clinically indicated and the expertise of an obstetrician is necessary; resulting in better continuity of care. The World Health Organization (WHO) has recently identified nine vital areas of risk for patients in health care; communication during patient handovers is third on the list.

A fundamental aspect of midwifery care is the promotion and protection of normal birth. Midwifery care results in the decrease in clinical interventions in pregnancy and childbirth, as compared to other primary care providers, and therefore decreases the risk of harm to clients.

The proposed changes to midwives' scope will allow more women to access midwifery care, thereby affecting the overall rates of interventions throughout the province. For example, women living in rural and remote communities will be able to see their midwife for well-woman care (e.g. pap tests, contraception, etc.) to which they otherwise may not have access, due to the severe shortage of nurses and physicians in many parts of the province. The changes we are proposing will also increase continuity of care for midwifery clients and increase point of care service to women and infants. This, too, is proven to result in better maternal and infant outcomes. [54]

While the CMO and other midwifery stakeholders are well situated to mitigate the risk of harm to midwifery clients, supports from the broader system are required to fully integrate the proposed scope of midwifery care into the maternity care system. For example, although we are proposing that midwives be granted the authority (which is already within their current full scope, but limited in some hospitals) to manage inductions, augmentations, and epidurals, they should not be expected to fulfill these tasks (or any of the proposed changes) without the proper nursing and hospital administrative support. As one member commented: "We can't be expected to safely manage an augmentation when we've been awake for 20 hours." Midwifery care, with its focus on continuous care and its considerable on-call burden, is incongruent with other health care professionals operating within the hospital environment. Therefore, an enhanced education strategy for other health care providers and hospital administrators will be required.

Finally, the CMO has a rigorous Quality Assurance Program (appendix L), consisting of six components: data collection, professional development, peer case review, client satisfaction evaluation, self-assessment, and practice audits. Each of these components contributes to decreasing the risk of harm for midwifery clients in Ontario.

21. What other regulated and unregulated professions are currently providing care with the competencies requested as an expansion to your scope of practice? By what means are they performing it? (under delegation, supervision or on their own initiative?)

Professions who currently have access to the additional controlled acts we are requesting:

- Communicating a diagnosis:

  Physicians, Chiropodists, Chiropractors, Naturopaths (in the as yet to be proclaimed *Naturopathy Act*), Dentists and Optometrists, with respect to their specific scopes of practice (RNEC's have a proposal before the Ministry of Health and Long-Term Care)

- Putting an instrument, hand or finger beyond the larynx:

  Physicians, Respiratory Therapists ("intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx") and Nurse Practitioners

- Putting an instrument, hand or finger beyond the anal verge:

  Physicians, Naturopaths (in the as yet to be proclaimed Naturopathy Act), Nurse Practitioners and Medical Radiation Technologists ("administering

contrast media through or into the rectum or an artificial opening into the body")

Each profession is performing the above acts under their own authority.

22. Specify the circumstances (if any) under which a member of the profession should be required to refer a patient/client to another health professional, both currently and in the context of the proposed change in scope of practice.

Midwives routinely refer clients to another appropriate health professional as the needs of the client dictate. This is to ensure that the client receives the most appropriate care. Further, the CMO's *Indications for Mandatory Discussion, Consultation and Transfer of Care* standard details the clinical scenarios wherein midwives are currently required to consult with, and/or transfer care to a physician. It will be amended accordingly.

23. If this request is in relation to a current supervisory relationship with another regulated health profession, please explain why this relationship is no longer in the public interest. Please describe the profession's need for independence/autonomy in practice.

N/A

24. Does the proposed change in scope of practice require the creation of a new controlled act or an extension of or change to an existing controlled act? Does it require delegation or authority to perform an existing controlled act or subset of an existing controlled act?

Please refer to question 12 for further details.

The proposed changes require:

Clarification of two current authorized acts:

Putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the post-partum period.

Performing episiotomies and amniotomies and repairing episiotomies and lacerations, not involving the anus, anal sphincter, rectum, urethra and periurethral area.

Extension of two existing authorized acts:

"Performing a procedure on tissue below the dermis"
Taking blood samples from newborns by skin pricking or from women from veins or by skin pricking.

Managing labour and conducting spontaneous normal vaginal deliveries.

The addition of three existing controlled acts:

Putting an instrument, hand or finger beyond the larynx.

Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.

Putting an instrument, hand or finger beyond the anal verge.

The proposed controlled acts will not require delegation to perform. Rather, they are proposed with the intention to remove the need for delegation for the performance of controlled acts (or aspects of controlled acts) that are a routine component of primary maternity care.

25. If the proposed change in scope of practice involves an additional controlled act being authorized to the profession, specify the circumstances (if any) under which a member of the profession should be permitted to delegate that act. In addition, please describe any consultation process that has occurred with other regulatory bodies that have authority to perform and delegate this controlled act.

We do not anticipate that any of the proposed additional controlled acts would be delegated by a midwife to a member of another profession. The proposed changes to midwives' scope of practice were circulated to the colleges regulated under the *Regulated Health Professions Act*.

26. Are the entry-to-practise (didactic and clinical) education and training requirements of the profession sufficient to support the proposed change in scope of practice? What methods are used to determine this sufficiency? What additional qualifications might be necessary?

The changes proposed in this submission have been in development for several years among midwifery stakeholders. The AOM, the International Midwifery Pre-Registration Program, and the Ontario Midwifery Education program all express

support for the amendments, and have the demonstrated capacity to meet the educational requirements of the profession.

The Ontario Midwifery Education Program, which consists of baccalaureate programs at Laurentian University, McMaster University and Ryerson University, support the suggested changes to the midwifery scope of practice. As does the International Midwifery Preregistration Program (Ryerson University), which is Ontario's bridging program for internationally educated midwives.

The MEP reports that, in general, students are already being educated, at least in a theoretical introduction, for most of the proposed changes to midwives' scope of practice. They are well positioned to provide additional clinical experience for students with recent curriculum changes (see appendix J), which increase the number and type of interprofessional placements. They believe that any of the kinds of changes proposed can be accommodated by the MEP with sufficient time for planning and development, as well as support for equipment, learning models, clinical learning placements, etc.

The chart below details how the proposed changes are either included in or could be added to the current MEP curriculum.

Amendments to the RHPA	
Authorize midwifery profession access to classes of drugs	• MEP students learn and are examined on drug classes within a specific pharmacotherapy course. The use of appropriate prescription or administration of drugs is included in ongoing and increasingly complex clinical scenarios that students encounter in their tutorial sessions. In addition, clinical practice in prescribing and administering drugs is provided throughout clinical placements.
Amendments to the Midwifery Act	
Revise scope of practice statement to remove limiting language, i.e. "spontaneous" normal vaginal	• The MEP places an emphasis on management of spontaneous vaginal birth, however- particularly in the senior years of the program - students receive instruction that provides an understanding of the appropriate use of other birth modes including vacuum, forceps and Caesarean section. As part of the Society of Obstetrician and Gynecologist of Ontario ALARM course, which is part of the core curriculum, students are introduced to the practical aspects of the application of vacuum extraction as well

	as forceps. While some students are able to access clinical experience through current community placements, the program does not currently include any required experience with Cesarean section surgical assist. These competencies could be added to the program. The MEP would need to build in an experience component for these activities (i.e., vacuum delivery and surgical assist); something that would be readily accomplished given changes to the curriculum that include an increase in interprofessional clinical placements that will facilitate providing these experiences.
Addition of authorized acts to the Midwifery Act:	
intubation, umbilical vein catheterisation	• Intubation and umbilical catheterisation are part of the revised Neonatal RP training, and our students will be learning and practicing this as part of that training. The students take this course in the second year of the program, and then are required to recertify in the course annually thereafter. They are expected to participate in neonatal resuscitation as they encounter situations where this intervention is required within their clinical placement experiences.
communicating a diagnosis-within midwifery scope of practice (i.e. results of screening and diagnostics and follow-up treatment)	• Our graduates are quite practiced in communicating findings of screening and diagnostics to clients and as part of consultation processes. The MEP would need to re-frame this process as part of formulating diagnosis and ensure that the language used in the process is consistent with that used by other professions to enable clear communication.
manual removal of placenta, repair of 3rd/4th degree tear vacuum assisted delivery, well-woman care prescribe birth control well baby care past 6	• The MEP teaches manual removal of placenta, and where the occasion arises, students would be able to practice this. Likewise, 3rd degree tears are part of the current curriculum. The program provides the theoretical basis for understanding of fourth degree tear repair, of assisted delivery, and of birth control. Additional theoretical and practice experience in the areas of some aspects of well woman care such as some methods of birth control

weeks vaccinations	(prescribing of birth control, fitting of caps IUD insertion), pregnancy termination, and issues of normal menopause would need to be added. Aspects of well baby care past 6 weeks including vaccinations, infant nutrition and recognizing the unwell baby would require additional course work and clinical experience. Again, with the current interprofessional courses, the MEP is well positioned to make the needed additions.
Clarify for inclusion: scalp clip/PH	• Students now have a sound knowledge of scalp clip application and scalp Ph sampling. They may have experience with these procedures in some practices.
Allow pre-conception counseling	• Additional focus on the purpose and focus of pre-conceptual counseling would need to be added to the curriculum.
Amendments to *Midwifery Act* regulations	
Drug regulation amendments	• As mentioned above, students of the MEP are well versed in pharmacotherapy, and the additions to the drug regulation would not be challenging for graduates of the program. Practice in the prescribing of such drugs will come with the implementation of the regulation, as students gain their clinical experience. Methods of drug administration will need to be reviewed to ensure that all methods are adequately addressed as part of current curriculum. Enhanced emphasis on drug dose calculation and management of narcotic administration could be beneficial.
Amendments to other legislation	
Amendments to the Laboratory and Specimen Collection Centre Licensing Act	• Students are well acquainted with these topics.
Amend to allow midwives to direct to appropriate level of care facility	• Ensuring that all students are familiar with the *Ambulance Act* is part of the current curriculum. Changes to the act to ensure that it is uniformly understood across the province will be helpful.

As well, the Canadian Midwifery Regulators Consortium (CMRC) has developed and implemented a national registration exam for all Canadian midwifery

applicants for registration. “The Canadian Midwifery Registration Exam (CMRE) is a national written examination designed to assess applicants for midwifery registration to ensure that they meet entry-level competency standards set out in the Canadian Competencies for Midwives (appendix M). Its goal is to ensure that midwives gaining registration are competent and safe practitioners providing a consistent standard of care across Canada.”[55] The Canadian Competencies that form the basis for the examination must, by necessity, reflect the common standards across the country. Ontario’s differences due to delays in regulatory changes have required that certain questions be left out of the exam, leaving them to be assessed by each province.

27. Do members of the profession currently have the competencies to perform the proposed scope of practice? Does this extend to some or all members of the profession?

Members who are already in practice may or may not have the knowledge and skills to perform within the proposed changes to scope, based on their original training and their activities and experiences since registration. Many Ontario midwives have worked in birth centres and projects in the northern and remote parts of our country; the experiences in these communities often provide greater clinical challenges. Approximately one-quarter of our members obtained their original training outside of Canada and many of them have worked in places where midwives have a very broad scope. However, we plan to require all currently registered members to undergo training and certification with respect to the proposed changes to assess and ensure the competency of each member.

The IMPP has the demonstrated capacity, and is willing and committed, to develop continuing education workshops and Distance Education courses to support changes to midwifery's scope of practice, as well as to develop remedial individualized courses to address challenges experienced by midwives adapting to enhanced scope of practice.

The AOM has the ability to provide continuing education through e-modules and workshops with content that is both theoretical and clinical. They have an established record of providing continuing education to midwives.

28. What effect will the proposed change in scope of practice have on members of your profession who are already in practice? How will they be made current with the changes, and how will their competency be assessed? What quality improvement/quality measurement programs should or will be put into place? What educational bridging programs will be necessary for current members to practise with the proposed scope?

Members who are currently practicing will require continuing education in some of the proposed competencies. They may or may not have the knowledge and skills to perform within the proposed changes to scope, based on their original training and their activities and experiences since registration; therefore, the CMO has approached our educational program colleagues to explore continuing education opportunities for our members.

The appropriate courses will be made available to our members quickly and with tangible measures in place to evaluate the members' acquisition of the knowledge/skill. The International Midwifery Pre-registration Program is currently about to launch a number of distance education courses, including pharmacology. As far back as 2004 we discussed their capacity to have continuing education content available across the province through their distance education capabilities. The IMPP, the MEP and the AOM have expressed their support and willingness to work with the CMO on the development of high quality educational opportunities to support members' acquisition of the skills needed to incorporate the proposed changes. These programs can be made a mandatory component of the Quality Assurance Program continuing education requirements.

29. How should the College ensure that members maintain competence in this area? How should the College evaluate the membership's competence in this area? What additional demands might be put on the profession?

Currently the CMO ensures that members maintain competence and competencies through several mechanisms. Members are required through the annual renewal of their registration to maintain current certification in obstetrical emergency skills, neonatal resuscitation and cardiopulmonary resuscitation. The registration regulation also contains requirements for members to attend a minimum number of births, both in the hospital and in the home, in a given period of time in order to maintain registration.

The Quality Assurance Program requires annual reporting on a member's fulfillment of requirements; we have consistently had excellent member compliance with this program. We have the ability to make specific courses mandatory as part of the program requirements and already have the procedures in place to monitor compliance. Further, through the QAP practice audit process we annually select members and their practices at random to undergo a complete audit of their midwifery practice. We will put the necessary requirements and monitoring in place through our QAP to ensure member compliance and competence.

We do not anticipate that the proposed changes will create significant additional demands on the profession. To the contrary, we believe the recommended

changes will assist in the provision of a seamless delivery of services to the client.

30. Describe any obligations or agreements on trade and mobility that may be affected by the proposed change in scope of practice for the profession. What are your plans to address any trade/mobility issues?

The CMO is one of the six parties to the Midwifery Mutual Recognition Agreement that came into effect July 1, 2001. The other current parties are British Columbia, Alberta, Manitoba, Northwest Territories and Quebec. The MRA allows provinces to place limitations or conditions on an applicant's registration only if it is to address a significant difference in competency required for registration and practice in the accepting jurisdiction. Of all the provinces that are signatories, Ontario is the only province that does not allow midwives to perform neonatal intubation for the purposes of resuscitation of the newborn. The requested scope of practice expansion to include intubation, as well as the updating of our drug regulation and laboratory tests, will bring Ontario midwives in line with the other regulated provinces and will mean that Ontario midwives will not need to have conditions imposed on their license when they register in these other provinces (for a full review of the jurisdictional differences see question 32).

Public education

31. How do you propose to educate or advise the public of this change in scope of practice?

Midwives have an established history of effective communication with their clients. The proposed changes to scope of practice will be incorporated into the information midwives currently share with clients at the outset of, and throughout care. The CMO will support members in conveying this information to their clients using the same tools and mechanisms that are currently in use (e.g. regular college communiqués, ongoing updates to the registrant's binder, targeted communications by fax, web site and e-mail, and through quality assurance requirements).

Communication with and education of the public was identified as a strategic priority for the CMO at the beginning of its 2008 – 2011 planning cycle. As such, a review of the CMO's communications strategy and goals is currently underway. Part of this process includes reviewing the approach of other health professional colleges, as well as other regulatory bodies. It also includes reviewing and incorporating best practices in communication with the public; mapping out the current CMO communications approach against the established goals of the Patient Relations Program; identifying gaps; and making recommendations for strengthening the website. The enhanced and increased communications initiatives that emerge from this review will be used to address the need to communicate any changes in the midwifery scope of practice to the public.

Further, the AOM maintains regular contact with consumers and consumer groups. Since the summer of 2007, more than 500 midwifery supporters have signed up in the AOM's consumer database, and this number continues to grow. Changes to the midwifery scope of practice can be communicated easily to the public through this database, as well as through consumer support groups. Disseminating information about changes in midwifery to the public can also be done through midwifery practice groups, with whom the AOM has regular communication, and who have direct contact with clients.

Other jurisdictions

32. What is the experience in other Canadian jurisdictions? Please provide copies of relevant statutes and regulations.

Ontario was the first Canadian jurisdiction to regulate the profession of midwifery, and as such the College of Midwives of Ontario has paved the way for other provinces and territories to adopt legislation regulating midwives.[56] More than half of Canada's midwives practice in Ontario, and three of the six universities offering baccalaureate midwifery education programs throughout Canada are in Ontario.

Unfortunately, the Ontario model of midwifery care has remained stagnant in areas while other jurisdictions have progressed in their ability to provide cost effective, client centred services. As noted by the Ontario Maternity Care Expert Panel:

> *Ontario was the first province in Canada to regulate midwifery but both the Association of Ontario Midwives (AOM) and the College of Midwives of Ontario (CMO) report that the profession encounters great difficulty in updating regulations to reflect growing knowledge or even to reflect practice changes already in place in other provinces. The inflexibility of Ontario midwifery regulations means midwives in Ontario have difficulty keeping in step with advances in maternity care and national midwifery and medical standards of care. For example, midwives in Ontario are licensed to prescribe specific drugs according to regulation. The intent was to facilitate routine care during pregnancy, labour and birth and in the postpartum period. Unfortunately, the College has found itself unable to update the regulation in a timely manner as new drugs have been approved and adopted. This creates a serious barrier to midwives' ability to provide care in accord with best practice guidelines and, since they must turn to physicians to prescribe the more efficacious medications, to*

practice to their full scope. The pharmacopoeia of Ontario midwives is less inclusive of routine treatments than in other provinces more recently regulated. This creates frustration for all professionals involved because of the need for medical consultations in routine situations so that specific treatments can be applied (e.g. Group B Strep prophylaxis). It also creates additional costs to the system as physicians are required to provide pro forma approvals for courses of treatment that all care providers know are appropriate."[57]

The legislative and regulatory amendments we propose in this submission will bring Ontario's midwives' in line with the current midwifery scope of practice across Canada. While the framework for midwifery regulation varies according to province/territory (appendix N), the scope of practice changes can be found in at least one, but more often several, of the other jurisdiction's legislation.

Proposed Expansion	**Provinces/Territories with authority**
Specialized Scope of Practice – certification process	Manitoba ("advanced competency") BC – in current proposal ("specialized practice") Saskatchewan* ("advanced competency") Northwest Territories
Drug Regulation – Classes / Categories format	Saskatchewan BC – in current proposal Manitoba – (in some areas the drug is named) Quebec – in process
Prescribing Hormonal Contraception (oral, injection, patch)	Saskatchewan BC – in current proposal Manitoba (oral and Depo-Provera only) Northwest Territories
Prescribing / Inserting Barrier Methods of Contraception (IUD, cervical cap, etc.)	Saskatchewan BC – in current proposal Manitoba Northwest Territories
Prescribing/ Administering Antibiotics - general	Saskatchewan – access to drug class antibiotics Alberta – for GBS & mastitis BC - for GBS & mastitis – (UTI in current proposal) Northwest Territories

	Manitoba Quebec – in process
Prescribing/ Administering Antibiotics – treatment of STI's	Manitoba Saskatchewan
Intubation of the newborn	Alberta BC Manitoba Northwest Territories Quebec
Scalp PH	Saskatchewan – advanced competency
Scalp clip	Saskatchewan – advanced competency BC Northwest Territories Manitoba – advanced competency
Vacuum removal	Saskatchewan – advanced competency BC – in current proposal Northwest Territories – special training required Quebec
Umbilical vein catheterization	Saskatchewan – advanced competency BC Manitoba Northwest Territories Quebec
Emergency Manual removal of placenta	Saskatchewan – advanced competency BC Manitoba – in current proposal Quebec Northwest Territories – special training required
$3^{rd}/4^{th}$ degree tear repair	Saskatchewan – 3^{rd} degree tears only – advanced competency BC – 3^{rd} degree repair – in current proposal Manitoba – 3^{rd} - periurethral tears are also an advanced

	competency
Epidural monitoring	**Ontario** (but often limited by physician/hospital) Saskatchewan – advanced competency BC – specialized practice Manitoba – advanced competency
Monitoring of Induction/ augmentation	**Ontario** (but often limited by physician/hospital) Saskatchewan – advanced competency Manitoba – advanced competency BC - monitoring already in scope – ordering is in proposal for specialized practice
Surgical assist at c-section	Saskatchewan – advanced competency BC – in current proposal – specialized practice Northwest Territories – special training required
Communicate a diagnosis	Saskatchewan – within the scope of midwifery BC – "Make a midwifery diagnosis" – in current proposal Alberta Quebec
Well woman care past 3 months, and for healthy women in general	BC - in current proposal Manitoba – in current proposal
Well baby care - past three months for midwifery clients, and for healthy infants in general	BC – well baby care for the year following childbirth – in current proposal Manitoba – in current proposal Quebec
Preconception counseling	BC – included in proposal for well woman care Quebec
Taking blood from fathers/donors	Manitoba** Quebec
Administering suppository medications	Manitoba** Saskatchewan BC Quebec

Proposed additions to drug list (not antibiotics) – MMR varicella, childhood vaccinations (see appendix F)	BC Quebec
Proposed additions to lab tests (see appendix G)	Manitoba – in current proposal Quebec – in process
Ordering maternal/newborn ultrasounds	Saskatchewan Alberta BC – in current proposal Quebec – maternal only
Participation in hospital decision making	Saskatchewan – in discussion, assumed by College registrar to be included
Authority in ambulance	Quebec BC – midwives have same status as physician in directing an ambulance

* Saskatchewan is the most recent province to regulate midwifery (March 2008) and as such is still in the process of developing its policies and standards. They have, in the meantime, adopted those of Manitoba while in the process of finalizing them. The information above was provided to the CMO by the Saskatchewan College of Midwives registrar.

** These competencies aren't specified in Manitoba legislation but midwives do perform them.

As well, the Canadian Midwifery Regulators Consortium (CMRC) has been working with Health Canada's Office of Controlled Drugs and Substances (OCDS) since 2004 to authorize midwives under the Controlled Drugs and Substances Act. This process involved a review of the profession by OCDS to ensure that the appropriate education, standards and quality assurance provisions are in place or can be put in place to ensure the safety of the public. OCDS has recently proposed changes to regulations under the *Controlled Drugs and Substances Act* to permit midwives and other designated practitioners (e.g. NPs and podiatrists) to "possess, administer, prescribe, sell or provide and/or transport" certain controlled substances as defined by the regulation. These changes are proposed in recognition of changing practice roles, evolving scopes of practice, and the need to increase client access to care.

33. What is the experience in other International jurisdictions?

It is not a coincidence that the countries demonstrating the most positive infant/maternal outcomes are the same countries where midwifery is a well-entrenched and normalized profession (e.g. Scandinavia and other northern/western European countries, Australia, New Zealand, and the United Kingdom). [58] The scope of midwifery practice varies among these countries, but all are members of the International Confederation of Midwives' (see ICM definition of a midwife, included in Context, Philosophy & Definitions), and therefore employ a philosophy that views pregnancy and birth as normal physiological experiences, and approach the provision of care from a non-interventionist perspective. Low rates of interventions for midwife-attended births remain relatively consistent in these countries when compared to those of other care providers,[59] despite the variation in the delivery of care. For example, the primary care provider for all pregnant women in Sweden is a midwife, but almost every birth takes place in the hospital. In the Netherlands, more than 30% of all births take place in the home attended by a midwife, but midwives also attend to women in birth centres and hospitals. In the United Kingdom there is a split between independent midwives and nurse-midwives, and most births take place in the hospital. Canada was the last industrialized nation to formally recognize midwifery as a profession, and as such has faced difficulty in integrating into the dominant medical system.

The Organization for Economic Co-operation and Development (OECD) *Issue Paper on Supporting Midwifery* recognizes that "the tasks that a qualified midwife may perform vary greatly. One could say that midwives work more independently the more peripherally they are located. When there is no doctor available to perform a certain procedure, the midwife is often the natural choice. Practical experience gathered in this way has gradually resulted in wise and knowledgeable midwives in many parts of the world, and such midwives prove not only that certain 'doctors only' procedures - such as vacuum extraction - can be performed by other staff, but also that new qualities of care may develop." [60]

It is recognized internationally that primary midwifery care, as well as the promotion of 'normal' birth (i.e. non-interventionist), results in the best maternal and infant outcomes for women with low-risk pregnancies. For example, the consensus statement from the UK Maternity Care Working Party (which includes the Royal College of Gynecologists and the Royal College of Midwives, among others) notes:

> *With appropriate care and support, the majority of healthy women will give birth with a minimum of medical procedures and most women prefer to avoid interventions, provided that their baby is safe and they feel they can cope. Members of the Maternity Care Working Party are concerned about rising intervention rates and wide variations between different services in terms of planned and unplanned caesarean sections, and operative births,*

as these procedures are known to be associated with both physical and psychological morbidity. We all want mothers and babies to come through birth healthy and well-prepared for the changes, demands and emotional growth that follows.

Procedures used during labour that are known to increase the likelihood of medical interventions should be avoided where possible. For example, continuous electronic fetal monitoring during labour in low-risk women is associated with an increase in emergency caesarean section but no long-term health gain, and use of epidural anaesthetic in labour increases the need for forceps or ventouse. However, it is important that women's needs and wishes are respected and they should be able to make informed decisions about their care. And, that options are available to them. [61]

Further, the UK's National Institute for Health and Clinical Excellence (NICE) *Antenatal Care: Routine Care for the Healthy Pregnant Woman* guidelines recommend that:

"Midwife and GP-led models of care should be offered for women with an uncomplicated pregnancy. Routine involvement of obstetricians in the care of women with an uncomplicated pregnancy at scheduled times does not appear to improve perinatal outcomes compared with involving obstetricians when complications arise." [62]

Finally, it has been recommended by WHO that "Antenatal care (ANC) from midwives or general practitioners in low-risk pregnancies is cost-effective. A model of ANC with a restricted number of visits for low-risk women has been shown to be safe, more sustainable, and possibly as effective as models with higher number of visits." [63]

Costs/Benefits

34. What are the potential costs and benefits to the public and the profession in allowing this change in scope of practice? Please consider and describe the impact of any of the following economic factors:

a. Direct patient benefits/costs;

For women who have chosen to enter into a midwife's care, the proposed scope of practice changes will have the benefit of improving access to care. This will be achieved by removing barriers to midwives providing a fuller spectrum of primary care services (e.g. treatment of commonly occurring urinary tract infections) so that women do not have to seek care elsewhere. The benefits to this will be clinical (i.e. earlier treatment for the UTI and the

avoidance of potential negative outcomes related to delayed treatment); practical (i.e. not having to make the visit to a family physician to obtain a prescription); and reassuring (i.e. being able to receive care from a provider with whom they have an established relationship).

Women who must travel any distance to see a physician incur additional costs. Travel that requires an absence from work may increase cost to the woman (the absence may be unpaid) and reduced productivity at the employer. The cost of not being able to obtain the needed care related to their pregnancy or birth from a single provider could be direct financial costs.

A primary tenet of midwifery care is continuity of care, which has been documented as enhancing maternal/infant outcomes. [64] Continuity will be enhanced by every change to the midwifery scope of practice that removes the necessity of referral to a physician for the provision of 'routine' maternity care (e.g. GBS prophylaxis). There is evidence – both anecdotal and documented - that "suggests that the expanded midwifery model supports continuity of midwifery care and leads to normal vaginal deliveries and enhanced outcomes for women." [65]

These enhanced outcomes include such benefits as increasing the likelihood that a woman will be able to breastfeed her infant successfully and for a longer period of time (thereby reducing costs to the client). The related benefits to the child are well documented and a cornerstone of the province's public health programs.

b. Benefits and costs to the broader health care service delivery system;

The proposed changes will benefit the broader health care service delivery system in a number of ways. These include:

- Providing direct cost savings to the health care system.

  An article published in the University of Toronto Medical Journal entitled *Modern Midwifery in Ontario: An Effective Model of Healthcare* (2005) cites that each time a woman chooses a midwife, it saves the health care system between $800 and $1,800. If we extrapolate these savings to the approximately 6,000 women who had a hospital birth and the 4,000 women who had a home birth and who received midwifery care last year, one could this would amount to a savings of approximately twelve million dollars ($12,000.000).[66]

- Enhancing midwives' ability to participate in interprofessional care.

  Collaborative practice is more successful when all practitioners are working to fullest extent of scope and skill set. Studies of successful

collaborative practice have shown increased benefits for clients, including the improvement of status, a more efficient care process, and more positive ratings of their care.[67]

- Decreasing the duplication of care currently created the need for consultation for prescriptions that are within a midwife's skill set to provide. Each visit to a physician costs.
- Relieving pressure on already stretched family physician and specialist resources.

  Both the Ontario College of Family Physicians and their national counterpart have noted that there continues to be a downward slope of newly qualified physicians entering family practice, as well as family physicians doing obstetrics. The OCFP notes that "with fewer than two hundred and sixty trained and licensed family physicians entering practice in Ontario each year, and the annual attrition of family physicians exceeding this number, there seems to be no way to address the identified shortages[68]". Moreover, "the Janus Report includes the finding that half of the physicians in Toronto and 73% in Ontario reported that there were insufficient numbers of family doctors. [The] members also reported (71% in Toronto and 66% in the rest of Ontario) that there were insufficient specialists."

  The decreased quality work/life balance for physicians has been noted by the OCFP, which stated that the "reduction in supply, the increased attrition, and the practice of most new graduates of doing locums for the family physicians has caused an erosion of the working conditions for remaining physicians. The increased workload makes it difficult to provide the broad scope of services and practice according to the four principles of family medicine. The Janus report states that "the average family doctor in Ontario works seventy hours a week and takes call once every five or six days."[69]

- Relieving pressure on obstetricians and allowing their valuable and limited time and resources to be directed toward high-risk pregnancies.

  We have already noted that the CFPC reports that 18.2% of family physicians rate the access that their patients have to obstetricians as fair and that 7.3% rate this access as poor. It is reasonable to assume that access will become even more difficult as the number of births in Ontario rise.

- Enabling midwives to act as primary reproductive health care providers, with the accompanying focus on, and benefit of, health and wellness, throughout their involvement with each client and over a longer period (i.e. pre-conception and beyond 6 weeks post-partum).

  In the United States, nurse-midwives provide "safe and cost-effective health care in a primary care context with an emphasis on disease

prevention and health promotion and with a focus on vulnerable and underserved populations since the inception of their profession in 1925" (Sullivan p.451). The same approach has been utilized in Canada, but within a much narrower scope of practice. Still, both systems of midwifery care have resulted in similar outcomes regarding high client satisfaction and consistently positive clinical results.

- Reducing the number of interventions and hospital admissions.

  Midwives promote a non-interventionist approach to maternal and infant health care, within strict safety guidelines. It has been well-documented that fewer techno-medical interventions in pregnancy and childbirth mean savings to the health care system.

  More specific examples of these savings include:

  - Services such as epidurals and inductions are becoming increasingly common for complicated and uncomplicated deliveries which may have implications for the costs of obstetrical care. Even without further interventions, inductions are more costly to the health care system.
  - Rates of medical and surgical inductions rose 53% from 1991/1992 to 1999/2000 and continue to rise to reach 21.3% of all deliveries in 2003/2004.
  - Hospitals typically spend over 60% more to care for a mother who has a caesarean section birth than they do for a mother who has a vaginal delivery, according to a new report by the Canadian Institute for Health Information (CIHI).
  - In 2002–2003, average hospital costs ranged from about $2,800 for vaginal deliveries to $4,600 for C-sections and $7,700 for major procedures, such as hysterectomies and surgical repairs following delivery. Canada's C section rate was 24% in 2002–2003, up from 17% in 1992–1993.

- Contributing to the Ministry of Health and Long-Term Care's ability to plan for and allocate health human and other system resources.

  Midwives, who are funded for an entire course of care, not for individual services, and who are dedicated maternity care providers, are a predictable and reliable resource within the provincial system.

- Contributing to better access to care in underserviced areas.

  It has been noted that expansion of the midwifery role "may also be seen as beneficial to the health-care system in reducing costs and providing professional and technical skills where a doctor is not present. The use of midwives in an extended or expanded role responds to issues of recruitment and retention of doctors in acute care facilities. It may also

provide better access to services and an improved level of care for the consumer in the geographically isolated areas."[70]

c. Benefits and costs associated with wait times;

As noted in question 15, the Wait Times Expert Panel concluded that delays in accessing a primary care provider often lead people to seek care at emergency departments and walk-in clinics." [71] The cost of these visits represents an additional avoidable and unnecessary burden to the province's health system. We believe that it would be reasonable to expect that the proposed changes to scope, by allowing women – specifically those with limited or no access to a family physician – better access to more direct service from their midwife, would decrease the number of women who made visits to walk-in clinics and emergency departments.

Given that we know that access to obstetricians is not always optimal (5.9% of family physicians surveyed by the CCFP didn't know how accessible ob/gyns were to their patients; 7.3% indicated access was poor; 18.2% indicated fair) and that only 10% of FP/GPs are doing obstetrical on-call, increased access to services through a midwife can logically be assumed to have the benefit of reducing wait times for prenatal care. [72]

"I am writing to pass on information from our annual review of client satisfaction questionnaires…. In the last two years, we have received comments indication that midwives should be able to prescribe medications that are presently outside of our pharmacopoeia. …another client indicated that she had mastitis on Christmas Eve, her midwife clearly identified the problem…. Treatment was delayed by a day due to the difficulty of accessing medical care during the holiday. The client believes that it is inappropriate for a skilled primary caregiver not to be able to prescribe this treatment. We hope these examples demonstrate the current needs of Ontario midwifery clients and can assist the College in your work to change the drug regulation."

Letter from Midwives Collective of Toronto
Jan 27, 2005

d. Workload, training and development costs;

Professional development funding is available to registered midwives through their funding agreement with the Ministry of Health and Long-Term Care. Additional costs would be borne by the individual but could be used as a tax deduction.

A comprehensive plan to ensure that members receive the necessary education and support will be developed with the intent of providing flexibility and not over-burdening individuals. System issues such as compensation will need to be part of this plan and will involve input from Ministry and other stakeholders.

e. Costs associated with educational and regulatory sector involvement.

Since the CMO will be working with the province's midwifery education programs to ensure that all current members of the CMO and all future graduates of the programs have the level of skill and experience needed to practice safely within any expanded scope, there will be education requirements that will have to be met. However, we do not think that these will be significant or that they will represent a significant burden for the following reasons:

- the current MEP curriculum addresses or could readily be modified to address the additional competencies that will be required by the proposed changes
- Ryerson University, through the International Midwifery Preregistration program, has the capacity to develop and offer a variety of distance education programs to meet the needs of practising midwives who require additional education;
- the close working relationship between CMO, the AOM and the MEP allows efficient collaboration around any new or emerging educational requirements;
- the existing, well-established infrastructure for clinical placements;
- a proposal from the MEP to develop educational specialists and recent work undertaken by the IMPP to develop centres of excellence for IMPP placements will create, within the next year, additional resources for students and midwives who require additional clinical experiences;
- the availability of other continuing education options (e.g., those offered by the Michener Institute for Applied Health Sciences).

The CMO has a rigorous quality assurance program that requires members to submit evidence of on-going recertification. Continuing competence related to the proposed scope changes will be built into the existing quality assurance infrastructure with little additional cost to the regulator.

35. Is there any other relevant information that HPRAC should consider when reviewing your proposed request for a change in scope of practice?

The provincial health care system has a resource in midwifery that, with an adoption of a few simple changes, could greatly decrease costs and increase the quality of, and access to, maternity care in the province.

We have the opportunity to regain the position once held by Ontario as a leader in this field and meet (or exceed) the best practices of other jurisdictions. The women of Ontario want this service; the midwives desire to provide it; and we the regulators are capable of ensuring safe, consistent and appropriate delivery.

"…an interprofessional care model has many advantages since all professions have their strengths, and they can be combined to provide excellent prenatal, intrapartum and postpartum care."

Member comment, regarding advantages or disadvantages to interprofessional care, SPS survey, Oct 2007

Endnotes

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Index of Appendices

APPENDIX A

College of Midwives of Ontario
Philosophy of Care

COLLEGE OF MIDWIVES OF ONTARIO

ORDRE DES SAGES-FEMMES DE L'ONTARIO

January 1994

PHILOSOPHY OF MIDWIFERY CARE IN ONTARIO

- Midwifery care is based on a respect for pregnancy as a state of health and childbirth as a normal physiologic process and a profound event in a woman's life.

- Midwifery care respects the diversity of women's needs and the variety of personal and cultural meanings which women, families and communities bring to the pregnancy, birth, and early parenting experience.

- The maintenance and promotion of health throughout the childbearing cycle are central to midwifery care. Midwives focus on preventive care and the appropriate use of technology.

- Care is continuous, personalized and non-authoritarian. It responds to a woman's social, emotional and cultural as well as physical needs.

- Midwives respect the woman's right to choice of caregiver and place of birth in accordance with the Standards of Practice of the College of Midwives. Midwives are willing to attend birth in a variety of settings, including birth at home.

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

- Midwifery care includes education and counselling, enabling a woman to make informed choices.

- 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.

- Midwives regard the interests of the woman and the fetus as compatible. They focus their care on the mother to obtain the best outcomes for the woman and her newborn.

- Fundamental to midwifery care is the understanding that a woman's caregivers respect and support her so that she may give birth safely, with power and dignity.

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APPENDIX B

College of Midwives of Ontario
Statement on
Interprofessional Care

COLLEGE OF MIDWIVES OF ONTARIO
ORDRE DES SAGES-FEMMES DE L'ONTARIO

November 2007

College of Midwives of Ontario
Statement on Interprofessional Care

The College of Midwives of Ontario supports interprofessional care for its potential contribution to improved delivery and quality of care. The CMO will undertake activities to facilitate midwives' participation in interprofessional care.

Midwives have a regulatory framework that requires consultation and referral to physicians and other caregivers when appropriate; therefore midwives have day-to-day experience with collaborative relationships.

Midwives are the only maternity care profession group whose sole activity is primary maternity care; therefore midwives have extensive experience with models and methods for delivery of primary maternity care in a team of caregivers.

The Multidisciplinary Collaborative Primary Maternity Care Project (MCP2) definition of the multidisciplinary collaborative primary maternity care model:

> *"The model is designed to promote the active participation of each discipline in providing quality care. It is woman-centred, respects the goals and values of women and their families, provides mechanisms for continuous communication among caregivers, optimizes caregiver participation in clinical decision-making (within and across disciplines), and fosters respect for the contribution of all disciplines."*

and the *Principles of the Multidisciplinary Collaborative Primary Maternity Care Model*, (MCP2, May 2006), reflect and embody the foundational principles of the midwifery profession in Ontario. Midwives choosing to participate in interprofessional care projects will offer expertise in the application of these principles and practices.

APPENDIX C

College of Midwives of Ontario
Indications for Mandatory Discussion, Consultation and Transfer of Care Guideline

approved December 2, 1999
effective June 15, 2000

INDICATIONS FOR MANDATORY DISCUSSION, CONSULTATION AND TRANSFER OF CARE

As a primary caregiver, the midwife together with the client is fully responsible for decision-making. The midwife is responsible for writing orders and carrying them out or delegating them in accordance with the standards of the College of Midwives.

The midwife discusses care of a client, consults, or transfers primary care responsibility according to the Indications for Mandatory Discussion, Consultation and Transfer of Care.[1] The responsibility to consult with a family physician/general practitioner, obstetrician and/or specialist physician lies with the midwife. It is also the midwife's responsibility to initiate a consultation within an appropriate time after detection of an indication for consultation. The severity of the condition and the availability of a physician(s) will influence these decisions.

The informed choice agreement between the midwife and client should outline the extent of midwifery care, in order to make clients aware of the scope and limitations of midwifery care. The midwife should review the Indications for Mandatory Discussion, Consultation and Transfer of Care with the client.

DEFINITIONS

Category 1: Discuss with another midwife or with a physician

It is the midwife's responsibility to initiate a discussion with or provide information to another midwife or physician, with whom the care is shared, in order to plan care appropriately.

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[1] *For a discussion of how this document is used to guide decisions about choice of birth place, see Indications for Planned Place of Birth.*

Category 2: Consult with a physician

It is the midwife's responsibility to initiate a consultation and to clearly communicate to the consultant that she is seeking a consultation. A consultation refers to the situation where a midwife, in light of her professional knowledge of the client and in accord with the standards of practice of the College of Midwives, or where another opinion is requested by the client, requests the opinion of a physician competent to give advice in this field. The midwife should expect that:

> The consultation involves addressing the problem that led to the referral, an in-person assessment of the patient, and the prompt communication of the findings and recommendations to the patient and the referring professional.
>
> Following the assessment of the patient by the consultant(s), discussion can occur between the health professional and consultant regarding future patient care.[2]

The consultation can involve the physician providing advice and information and/or providing therapy to the woman/newborn or prescribing therapy to the midwife for the woman/newborn.

Consultation must be documented by the midwife in her records in accord with the regulations of the College of Midwives.

After consultation with a physician, primary care of the client and responsibility for decision-making together with the client either:

a) continues with the midwife, or
b) is transferred to a physician.

Once a consultation has taken place and the consultant's findings, opinions and recommendations are communicated to the client and the midwife, the midwife must discuss the consultant's recommendations with the client and ensure the client understands which health professional will have responsibility for primary care.

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[2] *"Clinical Practice Parameters and Standards for Consultation and Transfer of a Woman/Newborn in or from a Birth Centre Where Only Midwives Provide Primary Care, to a Physician/Health Facility," College of Physicians and Surgeons of Ontario, December 23, 1993.*

Where urgency, distance or climatic conditions make an in-person consultation with a physician not possible, the midwife should seek advice from the physician by phone or other similar means. The midwife should document this request for advice, in her records, in accord with the requirement of the College of Midwives and discuss with the client the advice received.

The consultant may be involved in, and responsible for, a discrete area of the client's care, with the midwife maintaining overall responsibility within her scope of practice. Areas of involvement in client care must be clearly agreed upon and documented by the midwife and the consultant.

The College of Midwives has agreed that:

> One health professional has overall responsibility for a patient at any one time and the patient's care should be co-ordinated by that health professional whose identity should be clearly known to all of those involved and documented in the records of the referring health professional and consultant. Responsibility could be transferred temporarily to another health professional, or be shared between health professionals according to the patient's best interests and optimal care; however, transfer or sharing of care should only occur after discussion and agreement among patients, referring health professionals, and consultants.[3]

Category 3: Transfer to a physician for primary 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 subsequent decision-making. When primary care is transferred to a physician, the midwife may provide supportive care[4] within her scope of practice, in collaboration with the physician and the client.

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[3] *"Clinical Practice Parameters and Standards for Consultation and Transfer of a Woman/Newborn in or from a Birth Centre Where Only Midwives Provide Primary Care, to a Physician/Health Facility," College of Physicians and Surgeons of Ontario, December 23, 1993.*

[4] *Supportive care is defined in the Standard on Supportive Care.*

INDICATIONS: Initial History and Physical Examination

Category 1:

- adverse socio-economic conditions
- age less than 17 years or over 35 years
- cigarette smoking
- grand multipara (para 5)
- history of infant over 4500 g
- history of one late miscarriage (after 14 completed weeks) or preterm birth
- history of one low birth weight infant
- history of serious psychological problems
- less than 12 months from last delivery to present due date
- obesity
- poor nutrition
- previous antepartum hemorrhage
- previous postpartum hemorrhage
- one documented previous low segment cesarean section
- history of essential or gestational hypertension
- known uterine malformations or fibroids

Category 2:

- current medical conditions for example:[5] cardiovascular disease, pulmonary disease, endocrine disorders, hepatic disease, neurologic disorders
- family history of genetic disorders
- family history of significant congenital anomalies
- history of cervical cerclage
- history of repeated spontaneous abortions
- history of more than one late miscarriage or preterm birth
- history of more than one low birth weight infant
- history of gestational hypertension with proteinuria and adverse sequelae
- history of significant medical illness
- previous myomectomy, hysterotomy or cesarean section other than one documented previous low segment cesarean section
- previous neonatal mortality or stillbirth
- rubella during first trimester of pregnancy

---

[5] *Refer to Guidelines to Antepartum Consultations for Clients of Midwives to Anaesthesia, July 1996.*

- significant use of drugs or alcohol
- age less than 14 years

Category 3:
- any serious medical condition, for example: cardiac or renal disease with failure or insulin dependent diabetes mellitus

INDICATIONS: Prenatal Care

Category 1:
- presentation other than cephalic at 36 completed weeks
- no prenatal care before 28 completed weeks
- uncertain expected date of delivery
- uncomplicated spontaneous abortion less than 12 completed weeks

Category 2:
- anemia (unresponsive to therapy)
- documented post term pregnancy (42 completed weeks)
- fetal anomaly
- inappropriate uterine growth
- medical conditions arising during prenatal care, for example: endocrine disorders, hypertension, renal disease, suspected significant infection, hyperemesis
- placenta previa without bleeding
- polyhydramnios or oligohydramnios
- gestational hypertension
- isoimmunization
- serious psychological problems[6]
- sexually transmitted disease
- twins
- vaginal bleeding other than transient spotting
- presentation other than cephalic, unresponsive to therapy, at 38 completed weeks

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[6] *Notwithstanding the requirement for consultation with a physician, consultation may be with another appropriate health care professional; for example, a mental health worker.*

Category 3:

- cardiac or renal disease with failure
- insulin dependent diabetes
- multiple pregnancy (other than twins)
- gestational hypertension with proteinuria and/or adverse sequelae
- symptomatic placental abruption
- vaginal bleeding, continuing or repeated
- placenta previa after 28 completed weeks

INDICATIONS: During Labour and Birth

Category 1:

- no prenatal care
- non-particulate meconium

Category 2:

- breech presentation
- preterm labour (34 - 37 completed weeks)
- prolonged active phase
- prolonged rupture of membranes
- prolonged second stage
- retained placenta
- suspected placenta abruption and/or previa
- third or fourth degree tear
- twins
- unengaged head in active labour in primipara
- preterm prelabour rupture of membranes (PPROM) between 34 and 37 completed weeks
- particulate meconium
- gestational hypertension

Category 3:

- active genital herpes at time of labour
- preterm labour (less than 34 completed weeks)
- abnormal presentation (other than breech)
- multiple pregnancy (other than twins)
- gestational hypertension with proteinuria and/or adverse sequelae
- prolapsed cord or cord presentation
- placenta abruption and/or previa
- severe hypertension

- confirmed non-reassuring fetal heart patterns, unresponsive to therapy
- uterine rupture
- uterine inversion
- hemorrhage unresponsive to therapy
- obstetric shock
- vasa previa

INDICATIONS: Post Partum (Maternal)

Category 2:

- suspected maternal infection e.g. breast, abdomen, wound, uterine, urinary tract, perineum
- temperature over 38° C (100.4° F) on more than one occasion
- persistent hypertension
- serious psychological problems[7]

Category 3:

- hemorrhage unresponsive to therapy
- postpartum eclampsia
- thrombophlebitis or thromboembolism
- uterine prolapse

INDICATIONS: Post Partum (Infant)

Category 1:

- feeding problems[8]
- failure to pass urine or meconium within 24 hours of birth

Category 2:

- 34 to 37 weeks gestational age
- infant less than 2,500 g
- less than 3 vessels in umbilical cord
- excessive moulding and cephalhematoma

- abnormal findings on physical exam

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[7] *Notwithstanding the requirement for consultation with a physician, consultation may be with another appropriate health care professional; for example, a mental health worker.*

[8] *Notwithstanding the requirement for discussion with a physician or midwife, discussion may be with another appropriate health care professional; for example, a lactation consultant.*

- excessive bruising, abrasions, unusual pigmentation and/or lesions
- birth injury requiring investigation
- congenital abnormalities, for example: cleft lip or palate, congenital dislocation of hip, ambiguous genitalia
- abnormal heart rate or pattern
- abnormal cry
- persistent abnormal respiratory rate and/or pattern
- persistent cyanosis or pallor
- jaundice in first 24 hours
- suspected pathological jaundice after 24 hours
- temperature less than 36° C, unresponsive to therapy
- temperature more than 37.4° C, axillary, unresponsive to non-pharmaceutical therapy
- vomiting or diarrhea
- infection of umbilical stump site
- significant weight loss (more than 10% of body weight)
- failure to regain birth weight in three weeks
- failure to thrive
- failure to pass urine or meconium within 36 hours of birth
- suspected clinical dehydration

Category 3:

- APGAR lower than 7 at 5 minutes
- suspected seizure activity
- major congenital anomaly requiring immediate intervention, for example: omphalocele, myelomeningocele
- temperature instability

APPENDIX D

College of Midwives of Ontario
Scope of Practice Review for
Midwifery in Ontario
Consultation Survey Questions

Scope of Practice Review for Midwifery in Ontario - Members

1. CMO Survey - Introduction and Instructions

The College of Midwives of Ontario is pleased to be working on a scope of practice review for midwifery in Ontario, as requested by the Health Professions Regulatory Advisory Council (HPRAC). In June of 2007, Minister Smitherman requested that HPRAC provide advice on facilitating interprofessional care in Ontario. In formulating this advice, HPRAC is undertaking scope of practice reviews for those professions that are most directly involved in interprofessional care, including midwifery.

We are asking all members to provide us with input on the proposed framework for the review. Your input will demonstrate broad member participation and will be valuable in ensuring that our submission to HPRAC is comprehensive and that it most accurately reflects the memberships' interests and opinions.

Please refer to the matrix chart and glossary documents that were emailed to members May 5th 2008 in responding to this survey. The questions require Yes/No responses, and there is room to provide comments as well. It should take between 15 and 30 minutes of your time, and all feedback will be anonymous.

While the deadline for completing the survey is May 23rd, we encourage you to submit your responses as soon as possible so that we are able to incorporate your comments as we are working on the scope of practice review.

Thank you for your time and effort!

Scope of Practice Review for Midwifery in Ontario - Members

2. Midwifery Act

The proposed revisions have been developed with input from a variety of sources: formal consultations with members over the last several years; informal information gathered through members on issues related to scope of practice, hospital privileges, interprofessional collaboration, and the midwifery model; current and emerging clinical best practices; and the regulation of midwifery in other Canadian and international jurisdictions.

These changes are proposed with the intention to:

a. reflect current and emerging maternity care practices;
b. provide more flexibility for members;
c. allow responsiveness to community needs;
d. support members' participation in interprofessional care;
e. enable midwives to contribute to solving the maternity care crisis;
f. support efficient use of the health care system;
g. allow timely access to care.

1. Revision to Scope of Practice Statement

Current Scope of Practice Statement:
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.

Proposed Change:
Revise to allow well-woman/well-baby (>6 weeks) care.

Question:
Do you agree with the proposed revision/addition?

- [ ] Yes
- [ ] No

Comments

2. Revision to Scope of Practice Statement

Proposed Change:
Revise to allow pre-conception counseling.

Question:
Do you agree with the proposed revision/addition?

- [ ] Yes
- [ ] No

Comments:

3. Revision to Scope of Practice Statement

Proposed Change:
Revise by removing "spontaneous"

Question:
Do you agree with the proposed revision/addition?

- [ ] Yes
- [ ] No

Comments

4. Clarification of Activities within current Authorized Acts

Proposed Change:
Authorize "beyond labia": for manual removal of placenta

Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

Comments:

5. Clarification of Activities within current Authorized Acts

Proposed Change:
Authorize "beyond labia": for vacuum

Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

Comments:

6. Expansion of current Authorized Acts

Proposed Change:
Authorize "beyond the dermis": for scalp clip

Question:
Do you agree with the proposed revision / addition?

- ◯ Yes
- ◯ No

Comments:

7. Expansion of current Authorized Acts

Proposed Change:
Authorize "beyond the dermis": for scalp Ph

Question:
Do you agree with the proposed revision / addition?

- ◯ Yes
- ◯ No

Comments

8. Expansion of current Authorized Acts

Proposed Change:
Authorize "beyond the dermis": for taking blood from fathers/donors

Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

Comments:

9. Expansion of current Authorized Acts

Proposed Change:
Remove "spontaneous" from Authorized Act of managing labour

Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

Comments:

10. Addition of Controlled Acts under the Regulated Health Professions Act

Proposed Change:
Add Controlled Act "beyond the larynx": for intubation

Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

Comments:

11. Addition of Controlled Acts under the Regulated Health Professions Act

Proposed Change:
Add Controlled Act "communicating a diagnosis": within midwifery scope

Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

Comments:

12. Addition of Controlled Acts under the Regulated Health Professions Act

Proposed Change:
Add Controlled Act "beyond the anal verge": as part of routine repair procedures

Question:
Do you agree with the proposed revision / addition?

- ◯ Yes
- ◯ No

Comments:

13. Addition of Controlled Acts under the Regulated Health Professions Act

Proposed Change:
Add Contolled Act "beyond the anal verge": for administering suppository medications

Question:
Do you agree with the proposed revision / addition?

- ◯ Yes
- ◯ No

Comments:

14. Other Additions

Proposed Change:
Add umbilical-vein catheterization: as part of routine NRP standard of care

Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

Comments:

15. Other Additions

Proposed Change:
Add 3º / 4º tear repair

Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

Comments:

Scope of Practice Review for Midwifery in Ontario - Members

3. Regulations under the Midwifery Act

NOTE: The Health Systems Improvements Act (HSIA) authorizes classes of drugs for midwives, HPRAC review to take place September 2008.

The proposed revisions have been developed with input from a variety of sources: formal consultations with members over the last several years; informal information gathered through members on issues related to scope of practice, hospital privileges, interprofessional collaboration, and the midwifery model; current and emerging clinical best practices; and the regulation of midwifery in other Canadian and international jurisdictions.

These changes are proposed with the intention to:

a. reflect current and emerging maternity care practices;
b. provide more flexibility for members;
c. allow responsiveness to community needs;
d. support members' participation in interprofessional care;
e. enable midwives to contribute to solving the maternity care crisis;
f. support efficient use of the health care system;
g. allow timely access to care.

1. Drug Regulation

Proposed Change:

Add antibiotics for the treatment of: mastitis, GBS, bacterial vaginosis and UTI's.

Question:

Do you agree with the proposed revisions/additions?

- ◯ Yes
- ◯ No

Comments:

2. Drug Regulation

Proposed Change:
Add MMR vaccine

Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

Comments

3. Drug Regulation

Proposed Change:
Add Varicella immunoglobulin

Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

Comments

4. Future amendments to Drug Regulation

Proposed Change:
Add childhood vaccinations

Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

Comments

5. Future amendments to Drug Regulation

Proposed Change:
Add antibiotics for treatment of STIs

Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

Comments

Scope of Practice Review for Midwifery in Ontario - Members

4. Other Legislation

The proposed revisions have been developed with input from a variety of sources: formal consultations with members over the last several years; informal information gathered through members on issues related to scope of practice, hospital privileges, interprofessional collaboration, and the midwifery model; current and emerging clinical best practices; and the regulation of midwifery in other Canadian and international jurisdictions.

These changes are proposed with the intention to:

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c. allow responsiveness to community needs;
d. support members' participation in interprofessional care;
e. enable midwives to contribute to solving the maternity care crisis;
f. support efficient use of the health care system;
g. allow timely access to care.

1. Amendment to the Laboratory and Specimen Collection Centre Licensing Act

Proposed Change:
Add cord blood gases, drug screen, PIH diagnostic test, and father/donor blood tests.

Question:
Do you agree with the proposed revisions/additions?

- ◯ Yes
- ◯ No

Comments

2. Amendment to O. Reg 107/96 (Regulated Health Professions Act)

Proposed Change:
Revise Section 4 to authorize midwives to order maternal postpartum ultrasounds and newborn follow-up ultrasounds.

Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

Comments:

3. Amendment to the Ambulance Act

Proposed Change:
Amend/clarify: to allow proper authority for midwives to direct ambulance to hospital where privileges are held.

Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

Comments:

4. Amendment to the Public Hospital Act

Proposed Change:
Revise in order to allow midwives' participation in hospital Medical Advisory Committees and other decision-making committees.
Question:
Do you agree with the proposed revision/addition?

- ◯ Yes
- ◯ No

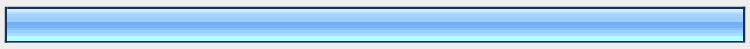
Comments

APPENDIX E

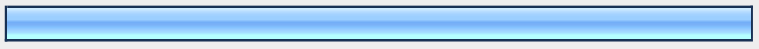
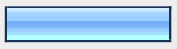
College of Midwives of Ontario
Scope of Practice Review for
Midwifery in Ontario
Consultation Survey
Summary of Member Responses

Scope of Practice Review for Midwifery in Ontario - Members

1. Revision to Scope of Practice Statement Current Scope of Practice Statement: 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. Proposed Change: Revise to allow well-woman/well-baby (>6 weeks) care. Question: Do you agree with the proposed revision/addition?

		Response Percent	Response Count
Yes		**81.4%**	215
No		19.3%	51
		Comments	81
		answered question	**264**
		skipped question	**2**

2. Revision to Scope of Practice Statement Proposed Change: Revise to allow pre-conception counseling. Question: Do you agree with the proposed revision/addition?

		Response Percent	Response Count
Yes		**82.4%**	215
No		18.0%	47
		Comments:	47
		answered question	**261**
		skipped question	**5**

3. Revision to Scope of Practice Statement Proposed Change: Revise by removing "spontaneous" Question: Do you agree with the proposed revision/addition?

	Response Percent	Response Count
Yes	**85.7%**	222
No	14.7%	38
Comments		49
answered question		**259**
skipped question		**7**

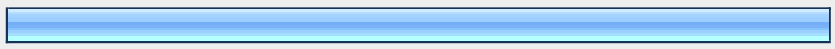
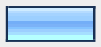
4. Clarification of Activities within current Authorized Acts Proposed Change: Authorize "beyond labia": for manual removal of placenta Question: Do you agree with the proposed revision/addition?

	Response Percent	Response Count
Yes	**96.2%**	251
No	4.2%	11
Comments:		43
answered question		**261**
skipped question		**5**

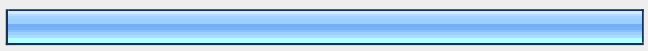
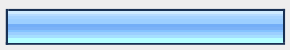
5. Clarification of Activities within current Authorized Acts Proposed Change: Authorize "beyond labia": for vacuum Question: Do you agree with the proposed revision/addition?

	Response Percent	Response Count
Yes	**75.5%**	197
No	24.9%	65
Comments:		50
answered question		**261**
skipped question		**5**

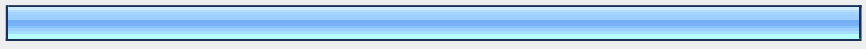
6. Expansion of current Authorized Acts Proposed Change: Authorize "beyond the dermis": for scalp clip Question: Do you agree with the proposed revision/addition?

		Response Percent	Response Count
Yes		**90.9%**	240
No		9.5%	25
	Comments:		42
	answered question		**264**
	skipped question		**2**

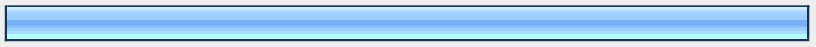
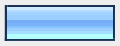
7. Expansion of current Authorized Acts Proposed Change: Authorize "beyond the dermis": for scalp Ph Question: Do you agree with the proposed revision/addition?

		Response Percent	Response Count
Yes		**70.1%**	185
No		30.3%	80
	Comments		41
	answered question		**264**
	skipped question		**2**

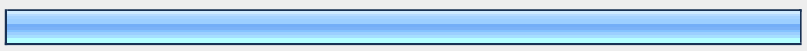
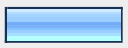
8. Expansion of current Authorized Acts Proposed Change: Authorize "beyond the dermis": for taking blood from fathers/donors Question: Do you agree with the proposed revision/addition?

		Response Percent	Response Count
Yes		**94.3%**	250
No		6.0%	16
	Comments:		38
	answered question		**265**
	skipped question		**1**

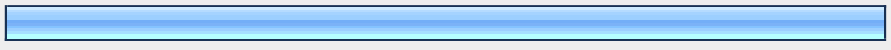
9. Expansion of current Authorized Acts Proposed Change: Remove "spontaneous" from Authorized Act of managing labour Question: Do you agree with the proposed revision/addition?

		Response Percent	Response Count
Yes		**88.8%**	229
No		11.6%	30
	Comments:		36
	answered question		**258**
	skipped question		**8**

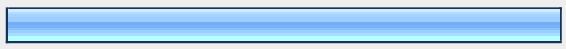
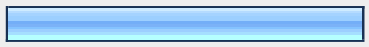
10. Addition of Controlled Acts under the Regulated Health Professions Act Proposed Change: Add Controled Act "beyond the larynx": for intubation Question: Do you agree with the proposed revision/addition?

		Response Percent	Response Count
Yes		**87.8%**	230
No		12.6%	33
	Comments:		59
	answered question		**262**
	skipped question		**4**

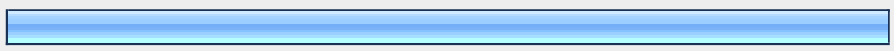
11. Addition of Controlled Acts under the Regulated Health Professions Act Proposed Change: Add Controled Act "communicating a diagnosis": within midwifery scope Question: Do you agree with the proposed revision/addition?

		Response Percent	Response Count
Yes		**97.2%**	247
No		3.1%	8
	Comments:		21
	answered question		**254**
	skipped question		**12**

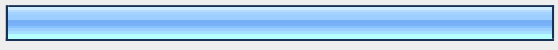
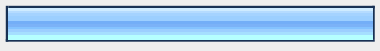
12. Addition of Controlled Acts under the Regulated Health Professions Act Proposed Change: Add Controlled Act "beyond the anal verge": as part of routine repair procedures Question: Do you agree with the proposed revision/addition?

		Response Percent	Response Count
Yes		**61.1%**	160
No		39.3%	103
	Comments:		46
	answered question		**262**
	skipped question		**4**

13. Addition of Controlled Acts under the Regulated Health Professions Act Proposed Change: Add Contolled Act "beyond the anal verge": for administering suppository medications Question: Do you agree with the proposed revision/addition?

		Response Percent	Response Count
Yes		**97.3%**	255
No		3.1%	8
	Comments:		18
	answered question		**262**
	skipped question		**4**

14. Other Additions Proposed Change: Add umbilical-vein catheterization: as part of routine NRP standard of care Question: Do you agree with the proposed revision/addition?

		Response Percent	Response Count
Yes		**60.2%**	157
No		40.2%	105
	Comments:		45
	answered question		**261**
	skipped question		**5**

15. Other Additions Proposed Change: Add 3^0 / 4^0 tear repair Question: Do you agree with the proposed revision/addition?

	Response Percent	Response Count
Yes	46.7%	122
No	**53.6%**	140
Comments:		56
answered question		**261**
skipped question		**5**

16. Drug Regulation Proposed Change: Add antibiotics for the treatment of: mastitis, GBS, bacterial vaginosis and UTI's. Question: Do you agree with the proposed revisions/additions?

	Response Percent	Response Count
Yes	**98.9%**	259
No	1.1%	3
Comments:		71
answered question		**262**
skipped question		**4**

17. Drug Regulation Proposed Change: Add MMR vaccine Question: Do you agree with the proposed revision/addition?

	Response Percent	Response Count
Yes	**89.7%**	234
No	10.3%	27
Comments		30
answered question		**261**
skipped question		**5**

18. Drug Regulation Proposed Change: Add Varicella immunoglobulin Question: Do you agree with the proposed revision/addition?

	Response Percent	Response Count
Yes	**89.2%**	232
No	10.8%	28
Comments		19
answered question		**260**
skipped question		**6**

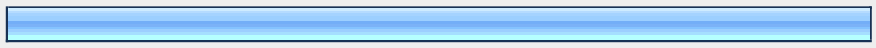
19. Future amendments to Drug Regulation Proposed Change: Add childhood vaccinations Question: Do you agree with the proposed revision/addition?

	Response Percent	Response Count
Yes	**61.7%**	161
No	38.3%	100
Comments		49
answered question		**261**
skipped question		**5**

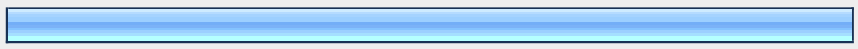
20. Future amendments to Drug Regulation Proposed Change: Add antibiotics for treatment of STIs Question: Do you agree with the proposed revision/addition?

	Response Percent	Response Count
Yes	**90.5%**	237
No	9.5%	25
Comments		33
answered question		**262**
skipped question		**4**

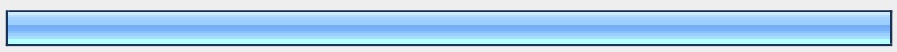
21. Amendment to the Laboratory and Specimen Collection Centre Licensing Act Proposed Change: Add cord blood gases, drug screen, PIH diagnostic test, and father/donor blood tests. Question: Do you agree with the proposed revisions/additions?

		Response Percent	Response Count
Yes		**95.3%**	246
No		4.7%	12
	Comments		33
	answered question		**258**
	skipped question		**8**

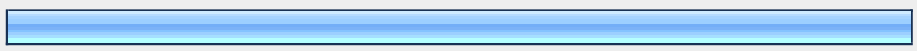
22. Amendment to O. Reg 107/96 (Regulated Health Professions Act) Proposed Change: Revise Section 4 to authorize midwives to order maternal postpartum ultrasounds and newborn follow-up ultrasounds. Question: Do you agree with the proposed revision/addition?

		Response Percent	Response Count
Yes		**93.5%**	244
No		6.5%	17
	Comments:		37
	answered question		**261**
	skipped question		**5**

23. Amendment to the Ambulance Act Proposed Change: Amend/clarify: to allow proper authority for midwives to direct ambulance to hospital where privileges are held. Question: Do you agree with the proposed revision/addition?

		Response Percent	Response Count
Yes		**97.7%**	255
No		2.3%	6
	Comments:		36
	answered question		**261**
	skipped question		**5**

24. Amendment to the Public Hospital Act Proposed Change: Revise in order to allow midwives' participation in hospital Medical Advisory Committees and other decision-making committees. Question: Do you agree with the proposed revision/addition?

		Response Percent	Response Count
Yes		**100.0%**	260
No		0.0%	0
	Comments		32
	answered question		**260**
	skipped question		**6**

APPENDIX F

Proposed Amendments to the
College of Midwives of Ontario
Designated Drugs Regulation

Proposed Amendments to the CMO's
DESIGNATED DRUGS REGULATION

BOLD = PROPOSED DRUG

1. a) For the purposes of paragraph 3 of section 4 of the Act, the following substances are designated as substances that a member may administer by injection on the member's own responsibility:

   Ampicillin - for the purpose of the prevention of neonatal group B streptococcal disease
   Carbetocin
   Carboprost tromethamine
   Cefazolin - for the purpose of the prevention of neonatal group B streptococcal disease
   Clindamycin - for the purpose of the prevention of neonatal group B streptococcal disease
   Chloroprocaine – for the purpose of local anaesthesia for episiotomy and/or the repair of tears
   Dimenhydrinate
   Diphenhydramine hydrochloride
   Epinephrine hydrochloride
   Ergonovine maleate
   Erythromycin- for the purpose of the prevention of neonatal group B streptococcal disease
   Hepatitis B immune globulin
   Hepatitis B vaccine
   Intravenous fluids
   Lidocaine hydrochloride with or without epinephrine – for the purpose of local anaesthesia for episiotomy and/or the repair of tears
   Measles-mumps-rubella virus vaccine
   Oxytocin
   Penicillin G - for the purpose of the prevention of neonatal group B streptococcal disease
   Phytonadione
   RhD immune globulin
   Vancomycin - for the purpose of the prevention of neonatal group B streptococcal disease
   Varicella Zoster immune globulin

2. For the purposes of paragraph 3 of section 4 of the Act, the following substances are designated as substances that a member may administer by inhalation on the member's own responsibility:

   Nitrous oxide
   Therapeutic oxygen

3. For the purposes of paragraph 3 of section 4 of the Act, a member may use or administer by injection or inhalation any substance on the order of a member of the College of Physicians and Surgeons of Ontario.

4. For the purposes of paragraph 7 of section 4 of the Act, the following substances are designated as substances that a member may prescribe on the member's own responsibility:

Acyclovir (oral)
Amoxicillin-clavulanic acid – for the purpose of treating mastitis
Azithromycin (oral)
Cephalexin – for the purpose of treating mastitis
Ciprofloxacin (oral)
Clotrimazole
Clindamycin (oral)
Cloxacillin (oral)
Diclofenac (oral)
Domperidone – for the promotion of lactation
Doxycycline
Doxylamine succinate-pyridoxine hydrochloride
Ergonovine maleate (oral)
Erythromycin (oral)
Erythromycin ophthalmic ointment
Folic acid (oral; greater than 1mg/dose)
Hepatitis B immune globulin
Hepatitis B vaccine
Hydrocortisone anorectal therapy compound
Metronidazole (oral)
Miconazole
Misoprostol (rectal)
Mupirocin-betamethasone valerate-miconazole (topical)
Naproxen (oral)
Nitrofurantoin – for the treatment of urinary tract infections
Nystatin
Phytonadione
RhD immune globulin
Sulfamethoxazole-trimethoprim (oral)
Trimethoprim – for the treatment of urinary tract infections
Valacyclovir (oral)

5. A member may prescribe, administer or order any drug or substance that may be lawfully purchased or acquired without a prescription.

APPENDIX G

Proposed Amendments to the College of Midwives of Ontario Laboratory Testing and Diagnostics Guideline

Proposed Amendments to the CMO's
LABORATORY TESTING AND DIAGNOSTICS Guideline

Chemistry

1) *Liver Enzymes*
    a. *AST (Aspartate aminotransferase)*
    b. *ALT (Alanine aminotransferase)*
    c. *Alkaline phosphatase*
    d. LDH (lactate dehydrogenase)

2) Blood urea nitrogen (BUN)

3) Creatinine

4) 24 hour urine collection - protein

5) Thyroid Function testing
    a. TSH – Serum thyroid stimulating hormone
    b. Free T4
    c. Free T3

6) Urine, blood, meconium and hair - drug abuse screen

7) Cord Blood Gases (arterial and venous)

8) Blood Culture "infant"

9) Serum Uric acid

10) Serum B12

11) Serum chloride, serum potassium, serum sodium

Coagulation

1) Prothrombin Time (PT also known as INR)

2) Partial thromboplastin time (PTT)

3) D-dimers

4) Fibrinogen

Hematology

1) Hemoglobin Electrophoresis

2) Galactocemia

Microbiology

1) Viral Antibodies, IgG and IgM
    a. Other from TORCH series
    b. Coxsackie virus

2) Equipment testing cultures (Autoclave, speculums and tape measures)

Other

1) TB testing

2) Tay-Sachs “trilogy”

3) Placental pathology

4) Cytogenic studies for cord blood and tissues (chromosome analysis)

Diagnostics

1) Postpartum ultrasounds

2) Fetal echocardiograms

3) Follow-up neonatal ultrasounds (from prenatal ultrasound i.e.: renal)

Testing for the father of the fetus

1) Blood group

2) Hemoglobin Electrophoresis including CBC

3) Tay-Sachs “trilogy”

APPENDIX H

International Confederation
of Midwives
Essential Competencies for Basic
Midwifery Practice

INTERNATIONAL CONFEDERATION OF MIDWIVES

ESSENTIAL COMPETENCIES FOR BASIC MIDWIFERY PRACTICE 2002

INTRODUCTION

The International Confederation of Midwives (ICM) is a federation of midwifery associations representing midwives in 72 nations of the world. The ICM works closely with all UN agencies in support of Safe Motherhood, primary health care strategies for the world's families, and the definition and preparation of the midwife. In keeping with the aims of the ICM, the ICM/WHO/FIGO international *Definition of the Midwife* (1992), the ICM *International Code of Ethics for Midwives* (1993), the ICM *Global Vision for Women and Their Health* (1996) and requests from member associations, the ICM has taken the lead in defining these essential competencies for midwives.

Throughout this document, the term "competencies" is used to refer to both the broad statement heading each section as well as the basic knowledge, skills and behaviours required of the midwife for safe practice in any setting. They answer the question: "What does a midwife do?" *and are evidence-based.* (See Appendix 1)

It is fully understood that these competencies may be considered maximum in some areas of the world, and minimum in other areas. Some knowledge and skills have been separated into a category, "additional". This allows for variation in the preparation and practice of midwives throughout the world, depending on the needs of their local community and/or nation.

Likewise, in recognition that midwives receive their knowledge and skills from several different educational pathways, these competencies are written for generic use by midwives and midwifery associations responsible for the education and practice of midwifery in their country or region. The essential competencies are guidelines for those interested in developing midwifery education, and information for those in government and other policy arenas who need to understand who a midwife is, what a midwife does, and how the midwife learned to be a midwife.

It is expected that the document will undergo continual evaluation as it is used world-wide and as the health care needs of childbearing women and families change.

KEY MIDWIFERY CONCEPTS

The key midwifery concepts that define the unique role of midwives in promoting the health of women and childbearing families include: partnership with women to promote self-care and the health of mothers, infants and families; respect for human dignity and for women as persons with full human rights; advocacy for women so that their voices are heard; cultural sensitivity, including working with women and health care providers to overcome those cultural practices that harm women and babies;

a focus on health promotion and disease prevention which views pregnancy as a normal life event. Midwives recognise that equity of status for women will bring the greatest impact on global maternal-child health by ensuring adequate nutrition, clean water and sanitation; so they are committed to the improvement of basic living conditions as well as providing competent midwifery services.

SCOPE OF MIDWIFERY PRACTICE

The scope of midwifery practice used throughout this document is built upon the ICM/WHO/FIGO international *Definition of the Midwife* (1992). Midwifery practice includes the autonomous care of the girl-child, the adolescent and the adult woman prior to, during and following pregnancy. This means that the midwife gives necessary supervision, care and advice for women during pregnancy, labour and the postpartum period. The midwife conducts deliveries on her own responsibility and cares for the newborn infant. This care includes primary health care supervision within the community (preventive measures); health counselling and education for women, the family and the community including preparation for parenthood; the provision of family planning; the detection of abnormal conditions in the mother and child; the procurement of specialised assistance as necessary (consultation or referral); and the execution of primary and secondary emergency measures in the absence of medical help. Midwifery practice is ideally conducted within a community-based health care system that may include traditional birth attendants, traditional healers, other community-based health workers, doctors, nurses and specialists in referral centres.

THE MIDWIFERY MODEL OF CARE

The Midwifery Model of Care is based on the premise that pregnancy and birth are normal life events. The Midwifery Model of Care includes: monitoring the physical, psychological, spiritual and social well-being of the woman and family throughout the childbearing cycle; providing the woman with individualised education, counselling and antenatal care; continuous attendance during labour, birth and the immediate postpartum period; ongoing support during the postnatal period; minimising technological interventions; and identifying and referring women who require obstetric or other specialist attention. This model of care is woman-centred and therein lies its accountability.

THE FRAMEWORK FOR DECISION-MAKING IN MIDWIFERY CARE

Midwives assume responsibility and accountability for their practice, applying up-to-date knowledge and skills in caring for each woman and family. The safety and overall well-being of the woman is of foremost concern to the midwife. The midwife strives to support a woman's informed choices in the context of a safe experience. The midwife's decision-making process utilises a variety of sources of knowledge and is dynamic, responding to the changing health status of each woman. Midwives involve women and their families in all parts of the decision-making process and in developing a plan of care for a healthy pregnancy and birth experience.

STEP 1: **Collect information from the woman, from the woman's and the infant's records, and from any laboratory tests in a systematic way for a complete assessment.**

STEP 2: **Identify actual or potential problems based on the correct interpretation of the information gathered in Step 1.**

STEP 3: **Develop a comprehensive plan of care with the woman and her family based on the woman's or infant's needs and supported by the data collected.**

STEP 4: **Carry out and continually update the plan of care within an appropriate time frame.**

STEP 5: **Evaluate the effectiveness of care given with the woman and her family, consider alternatives if unsuccessful, returning to STEP 1 to collect more data and/or develop a new plan.**

GUIDING STATEMENT TO MEMBER ASSOCIATIONS

The essential competencies for basic midwifery practice that follow are based on the values, vision, strategies and actions used by those who attend to the health needs of women and childbearing families. Member associations are encouraged to use this ICM statement of competencies, as needed in their countries, in the education, regulation and development of standards of practice for midwives as well as in policies needed to strengthen midwifery.

ESSENTIAL COMPETENCIES FOR BASIC MIDWIFERY PRACTICE
MAY 2002

GENERIC KNOWLEDGE, SKILLS AND BEHAVIOURS FROM THE SOCIAL SCIENCES, PUBLIC HEALTH AND THE HEALTH PROFESSIONS

Competency #1: Midwives have the requisite knowledge and skills from the social sciences, public health and ethics that form the basis of high quality, culturally relevant, appropriate care for women, newborn and childbearing families.

Basic Knowledge and Skills:

1. Respect for local culture (customs).
2. Traditional and modern routine health practices (beneficial and harmful).
3. Resources for alarm and transport (emergency care).
4. Direct and indirect causes of maternal and neonatal mortality and morbidity in the local community.
5. Advocacy and empowerment strategies for women.
6. Understanding human rights and their effect on health.
7. Benefits and risks of available birth settings.
8. Strategies for advocating with women for a variety of safe birth settings.
9. Knowledge of the community - its state of health including water supply, housing, environmental hazards, food, common threats to health.
10. Indications and procedures for adult and newborn/infant cardiopulmonary resuscitation.
11. Ability to assemble, use and maintain equipment and supplies appropriate to setting of practice.

Additional Knowledge and Skills

12. Principles of epidemiology, sanitation, community diagnosis and vital statistics or records
13. National and local health infrastructures; how to access needed resources for midwifery care.
14. Principles of community-based primary care using health promotion and disease prevention strategies.
15. National immunisation programs (provision of same or knowledge of how to assist community members to access to immunisation services)

Professional Behaviours - The midwife:

1. Is responsible and accountable for clinical decisions.
2. Maintains knowledge and skills in order to remain current in practice.
3. Uses universal/standard precautions, infection control strategies and clean technique.
4. Uses appropriate consultation and referral during care.
5. Is non-judgmental and culturally respectful.
6. Works in partnership with women and supports them in making informed choices about their health.
7. Uses appropriate communication skills.
8. Works collaboratively with other health workers to improve the delivery of services to

women and families.

PRE-PREGNANCY CARE AND FAMILY PLANNING METHODS

Competency #2: Midwives provide high quality, culturally sensitive health education and services to all in the community in order to promote healthy family life, planned pregnancies and positive parenting.

Basic Knowledge of:

1. Growth and development related to sexuality, sexual development and sexual activity.
2. Female and male anatomy and physiology related to conception and reproduction.
3. Cultural norms and practices surrounding sexuality, sexual practices and childbearing.
4. Components of a health history, family history and relevant genetic history.
5. Physical examination content and investigative laboratory studies that evaluate potential for a healthy pregnancy.
6. Health education content targeted to reproductive health, sexually transmitted infections (STIs), HIV/AIDS and child survival.
7. Natural methods for child spacing and other locally available and culturally acceptable methods of family planning.
8. Barrier, steroidal, mechanical, chemical and surgical methods of contraception and indications for use.
9. Counselling methods for women needing to make decisions about methods of family planning.
10. Signs and symptoms of urinary tract infection and common sexually transmitted infections in the area.

Additional Knowledge of:

11. Factors involved in decisions relating to unplanned or unwanted pregnancies.
12. Indicators of common acute and chronic disease conditions specific to a geographic area of the world, and referral process for further testing/ treatment.
13. Indicators of and methods of counselling/referral for dysfunctional interpersonal relationships including sexual problems, domestic violence, emotional abuse and physical neglect.

Basic Skills:

1. Take a comprehensive history.
2. Perform a physical examination focused on the presenting condition of the woman.
3. Order and/or perform and interpret common laboratory studies such as haematocrit, urinalysis or microscopy.
4. Use health education and basic counselling skills appropriately.
5. Provide locally available and culturally acceptable methods of family planning.
6. Record findings, including what was done and what needs follow-up.

Additional Skills:

7. Use the microscope.
8. Provide all available methods of barrier, steroidal, mechanical, and chemical methods of contraception.
9. Take or order cervical cytology smear (Pap test)

CARE AND COUNSELLING DURING PREGNANCY

Competency #3: Midwives provide high quality antenatal care to maximise the health during pregnancy and that includes early detection and treatment or referral of selected complications.

Basic Knowledge of:

1. Anatomy and physiology of the human body.
2. Menstrual cycle and process of conception.
3. Signs and symptoms of pregnancy.
4. How to confirm a pregnancy.
5. Diagnosis of an ectopic pregnancy and multiple fetuses.
6. Dating pregnancy by menstrual history, size of uterus and/or fundal growth patterns.
7. Components of a health history.
8. Components of a focused physical examination for antenatal visits.
9. Normal findings [results] of basic screening laboratory studies defined by need of area of the world; eg. iron levels, urine test for sugar, protein, acetone, bacteria.
10. Normal progression of pregnancy: body changes, common discomforts, expected fundal growth patterns.
11. Normal psychological changes in pregnancy and impact of pregnancy on the family.
12. Safe, locally available herbal/non-pharmacological preparations for the relief of common discomforts of pregnancy.
13. How to determine fetal well-being during pregnancy including fetal heart rate and activity patterns.
14. Nutritional requirements of the pregnant woman and fetus.
15. Basic fetal growth and development.
16. Education needs regarding normal body changes during pregnancy, relief of common discomforts, hygiene, sexuality, nutrition, work inside and outside the home.
17. Preparation for labour, birth and parenting.
18. Preparation of the home/family for the newborn.
19. Indicators of the onset of labour.
20. How to explain and support breastfeeding.
21. Techniques for increasing relaxation and pain relief measures available for labour.
22. Effects of prescribed medications, street drugs, traditional medicines and over-the-counter drugs on pregnancy and the fetus.
23. Effects of smoking, alcohol use and illicit drug use on the pregnant woman and fetus.
24. Signs and symptoms of conditions that are life-threatening to the pregnant woman; eg. pre-eclampsia, vaginal bleeding, premature labour, severe anaemia.

Additional Knowledge of:

25. Signs, symptoms and indications for referral of selected complications and conditions of pregnancy: eg. asthma, HIV infection, diabetes, cardiac conditions, post-dates pregnancy.
26. Effects of above named chronic and acute conditions on pregnancy and the fetus.

Basic Skills:

1. Take an initial and ongoing history each antenatal visit.
2. Perform a physical examination and explain findings to woman.
3. Take and assess maternal vital signs including temperature, blood pressure, pulse.
4. Assess maternal nutrition and its relationship to fetal growth.
5. Perform a complete abdominal assessment including measuring fundal height, position, lie and descent of fetus.
6. Assess fetal growth.
7. Listen to the fetal heart rate and palpate uterus for fetal activity pattern.
8. Perform a pelvic examination, including sizing the uterus and determining the adequacy of the bony structures.
9. Calculate the estimated date of delivery.
10. Educate women and families about danger signs and when/how to contact the midwife.
11. Teach and/or demonstrate measures to decrease common discomforts of pregnancy.
12. Provide guidance and basic preparation for labour, birth and parenting.
13. Identify variations from normal during the course of the pregnancy and institute appropriate interventions for:
    a. low and/or inadequate maternal nutrition
    b. inadequate fetal growth
    c. elevated blood pressure, proteinuria, presence of significant oedema, severe headaches, visual changes, epigastric pain associated with elevated blood pressure
    d. vaginal bleeding
    e. multiple gestation, abnormal lie at term
    f. intrauterine fetal death
    g. rupture of membranes prior to term
14. Perform basic life saving skills competently.
15. Record findings including what was done and what needs follow-up.

Additional Skills:

16. Counsel women about health habits; eg. nutrition, exercise, safety, stopping smoking.
17. Perform clinical pelvimetry [evaluation of bony pelvis].
18. Monitor fetal heart rate with doppler.
19. Identify and refer variations from normal during the course of the pregnancy, such as:
    a. small for dates [light]/large for dates [heavy] fetus
    b. suspected polyhydramnios, diabetes, fetal anomaly (eg. oliguria)

c. abnormal laboratory results
d. infections such as sexually transmitted infections (STIs), vaginitis, urinary tract, upper respiratory
e. fetal assessment in the post-term pregnancy

20. Treat and/or collaboratively manage above variations from normal based upon local standards and available resources.
21. Perform external version of breech presentation.

CARE DURING LABOUR AND BIRTH

Competency #4: Midwives provide high quality, culturally sensitive care during labour, conduct a clean and safe delivery, and handle selected emergency situations to maximise the health of women and their newborn.

Basic Knowledge of:

1. Physiology of labour.
2. Anatomy of fetal skull, critical diameters and landmarks.
3. Psychological and cultural aspects of labour and birth.
4. Indicators that labour is beginning.
5. Normal progression of labour and how to use the partograph or similar tool.
6. Measures to assess fetal well-being in labour.
7. Measures to assess maternal well-being in labour.
8. Process of fetal passage [descent] through the pelvis during labour and birth.
9. Comfort measures in labour: eg. family presence/assistance, positioning, hydration, emotional support, non-pharmacological methods of pain relief.
10. Transition of newborn to extra-uterine life.
11. Physical care of the newborn - breathing, warmth, feeding.
12. Promotion of skin-to-skin contact of the newborn with mother when appropriate.
13. Ways to support and promote uninterrupted [exclusive] breastfeeding.
14. Physiological management of the 3rd stage of labour.
15. Indications for emergency measures: eg. retained placenta, shoulder dystocia, atonic uterine bleeding, neonatal asphyxia.
16. Indications for operative delivery: eg. fetal distress, cephalo-pelvic disproportion.
17. Indicators of complications in labour: bleeding, labour arrest, malpresentation, eclampsia, maternal distress, fetal distress, infection, prolapsed cord.
18. Principles of active management of 3rd stage of labour.

Basic Skills:

1. Take a specific history and maternal vital signs in labour.
2. Perform a screening physical examination.
3. Do a complete abdominal assessment for fetal position and descent.
4. Time and assess the effectiveness of uterine contractions.
5. Perform a complete and accurate pelvic examination for dilation, descent, presenting part, position, status of membranes, and adequacy of pelvis for baby.
6. Follow progress of labour using the partograph or similar tool for recording.
7. Provide psychological support for woman and family.
8. Provide adequate hydration, nutrition and comfort measures during labour.

9. Provide for bladder care.
10. Promptly identify abnormal labour patterns with appropriate and timely intervention and/or referral.
11. Perform appropriate hand manoeuvres for a vertex delivery.
12. Manage a cord around the baby's neck at delivery.
13. Cut an episiotomy if needed.
14. Repair an episiotomy if needed.
15. Support physiological management of the 3rd stage of labour.
16. Conduct active management of the 3rd stage of labour including:
    a. Administration of uterotonic agents
    b. Controlled cord traction
    c. Uterine massage after delivery of the placenta, as appropriate
17. Guard the uterus from inversion during 3rd stage of labour.
18. Inspect the placenta and membranes for completeness.
19. Estimate maternal blood loss.
20. Inspect the vagina and cervix for lacerations.
21. Repair vaginal/perineal lacerations and episiotomy.
22. Manage postpartum haemorrhage.
23. Provide a safe environment for mother and infant to promote attachment.
24. Initiate breastfeeding as soon as possible after birth and support exclusive breastfeeding.
25. Perform a screening physical examination of the newborn.
26. Record findings including what was done and what needs follow-up.

Additional Skills:

27. Perform appropriate hand manoeuvres for face and breech deliveries.
28. Inject local anaesthesia.
29. Apply vacuum extraction or forceps.
30. Manage malpresentation, shoulder dystocia, fetal distress initially.
31. Identify and manage a prolapsed cord.
32. Perform manual removal of placenta.
33. Identify and repair cervical lacerations.
34. Perform internal bimanual compression of the uterus to control bleeding.
35. Insert intravenous line, draw bloods, perform haematocrit and haemoglobin testing.
36. Prescribe and/or administer pharmacological methods of pain relief when needed.
37. Administer oxytocics appropriately for labour induction or augmentation and treatment of postpartum bleeding.
38. Transfer woman for additional/emergency care in a timely manner.

POSTNATAL CARE OF WOMEN

Competency #5: Midwives provide comprehensive, high quality, culturally sensitive postnatal care for women.

Basic Knowledge of:

1. Normal process of involution and healing following delivery [including after an abortion].

2. Process of lactation and common variations including engorgement, lack of milk supply, etc.
3. Maternal nutrition, rest, activity and physiological needs (eg. bladder).
4. Infant nutritional needs.
5. Parent-infant bonding and attachment; eg. how to promote positive relationships.
6. Indicators of sub-involution eg. persistent uterine bleeding, infection.
7. Indications of breastfeeding problems.
8. Signs and symptoms of life threatening conditions; eg. persistent vaginal bleeding, urinary retention, incontinence of faeces, postpartum pre-eclampsia.

Additional Knowledge of:

9. Indicators of selected complications in the postnatal period: eg. persistent anaemia, haematoma, embolism, mastitis, depression, thrombophlebitis.
10. Care and counselling needs during and after abortion.
11. Signs and symptoms of abortion complications.

Basic Skills:

1. Take a selective history, including details of pregnancy, labour and birth.
2. Perform a focused physical examination of the mother.
3. Assess for uterine involution and healing of lacerations/repairs.
4. Initiate and support uninterrupted [exclusive] breastfeeding.
5. Educate mother on care of self and infant after delivery including rest and nutrition.
6. Identify haematoma and refer for care as appropriate.
7. Identify maternal infection, treat or refer for treatment as appropriate.
8. Record findings including what was done and what needs follow-up.

Additional Skills:

9. Counsel woman/family on sexuality and family planning post delivery.
10. Counsel and support woman who is post-abortion.
11. Evacuate a haematoma.
12. Provide appropriate antibiotic treatment for infection.
13. Refer for selected complications.

NEWBORN CARE (up to 2 months of age)

Competency #6: Midwives provide high quality, comprehensive care for the essentially healthy infant from birth to two months of age.

Basic Knowledge of:

1. Newborn adaptation to extra-uterine life.
2. Basic needs of newborn: airway, warmth, nutrition, bonding.
3. Elements of assessment of the immediate condition of newborn; eg. APGAR scoring system for breathing, heart rate, reflexes, muscle tone and colour.
4. Basic newborn appearance and behaviours.

5. Normal newborn and infant growth and development.
6. Selected variations in the normal newborn; eg. caput, moulding, mongolian spots, haemangiomas, hypoglycaemia, hypothermia, dehydration, infection.
7. Elements of health promotion and prevention of disease in newborn and infants.
8. Immunisation needs, risks and benefits for the infant up to 2 months of age.

Additional Knowledge of:

9. Selected newborn complications, eg. jaundice, haematoma, adverse moulding of the fetal skull, cerebral irritation, non-accidental injuries, causes of sudden infant death.
10. Normal growth and development of the preterm infant up to 2 months of age.

Basic Skills:

1. Clear airway to maintain respirations.
2. Maintain warmth but avoid overheating.
3. Assess the immediate condition of the newborn; eg. APGAR scoring or other assessment method.
4. Perform a screening physical examination of the newborn for conditions incompatible with life.
5. Position the infant for breastfeeding.
6. Educate parents about danger signs and when to bring the infant for care.
7. Begin emergency measures for respiratory distress (newborn resuscitation), hypothermia, hypoglycaemia, cardiac arrest.
8. Transfer newborn to emergency care facility when available.
9. Record findings, including what was done and what needs follow-up.

Additional Skills:

10. Perform a gestational age assessment
11. Educate parents about normal growth and development, child care.
12. Assist parents to access community resources available to the family.
13. Support parents during grieving process for congenital birth defects, loss of pregnancy, or neonatal death.
14. Support parents during transport/transfer of newborn.
15. Support parents with multiple births.

Appendix 1. Background to the evidence-base of the competencies

Between 1995 and 1999 a modified Delphi Technique was carried out for seven rounds to establish the Provisional Essential Competencies for Basic Midwifery Practice. As agreed by the International Council (the Confederation's governing body) in 1999, the competencies were field-tested by 17 ICM member associations throughout 2001. The extensive field testing was undertaken by 1,271 practising midwives, 77 educator groups (total of 312 educators), and 79 senior level midwifery student groups (total of 333 individuals) from 22 countries; and 25 regulators from 20 countries. A total of 214 individual competency statements within six domains were presented for consideration

and comment. Almost all of the competencies were supported by a great majority of the persons/groups involved in the testing, with many receiving universal support. In April 2002 the ICM International Council discussed and adopted the Essential Competencies for Basic Midwifery Practice, therewith establishing it as an official ICM document.

APPENDIX I

Facility Standards & Clinical
Practice Parameters
Free Standing Birth Centres
For Midwives Providing
Primary Care

Independent Health Facilities

Facility Standards & Clinical Practice Parameters

Free Standing Birth Centres

FOR MIDWIVES
PROVIDING PRIMARY CARE

The College of Midwives of Ontario

May 1995

Table of Contents

The College of Midwives of Ontario
(May 1995)

The College of Midwives of Ontario
(May 1995)

Preface

The College of Midwives of Ontario
(May 1995)

Preface

This document specifies facility standards and clinical practice parameters for free standing birth centres where midwives provide primary care as required by the College of Midwives of Ontario (CMO). These standards are consistent for midwives in all facility arrangements.

This is a document of the CMO, produced after a process of discussion and review with the Joint Standards Committee. This committee, supported by the Ministry of Health, was comprised of representatives from the CMO, College of Nurses of Ontario (CNO), the College of Physicians and Surgeons of Ontario (CPSO) and Independent Health Facilities Branch, Ontario Ministry of Health. Subsequent revisions or additions to this document may be made directly by the CMO.

This document should be read in conjunction with those documents listed in Appendix A.

REMOTE SETTINGS

The CMO has defined remote settings as those located at a distance from a hospital with surgical facilities (i.e. facilities for operative delivery) of over thirty minutes journey by a method of transportation ordinarily used for health care purposes in the area. Further standards which apply in remote settings are outlined in "*Expanded Clinical Practice Parameters & Facility Standards for Free Standing Birth Centres in Remote Settings Where Midwives Provide Primary Care*, CMO February 1995".

This document should be read in conjunction with those documents listed under "Remote" in Appendix A.

The College of Midwives of Ontario
(May 1995)

Independent Health Facilities

Facility Standards & Clinical Practice Parameters

Free Standing Birth Centres

FOR MIDWIVES
PROVIDING PRIMARY CARE

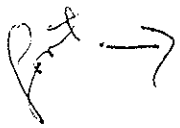
VOLUME I

FACILITY STANDARDS

The College of Midwives of Ontario
(May 1995)

Chapter 1 Organization and Administration

Overview



The freestanding birth centre has a mission statement, goals and policies which promote high quality services responsive to the needs of the population served consistent with the model of midwifery care as described in the standards of the College of Midwives of Ontario.

The CMO believes that midwives should offer their services only in those free standing birth centres which operate solely on a not-for-profit basis.

Client Services

A free standing birth centre provides a comfortable environment for women anticipating a normal pregnancy, labour and birth, and has provisions for client safety, privacy, and comfort. Normally, it is physically located outside a hospital[1]. All free standing birth centres have a prearranged relationship for consultation with appropriate health care professionals and for transfer of care to a hospital(s)[2] with 24 hour obstetrical and neonatal care services.

Every effort is made to provide services in both official languages in those areas of the province designated as bilingual areas. This includes all written

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[1]*See the College of Midwives of Ontario "Expanded Clinical Practice Parameters and Facility Standards For Birth Centres in Remote Settings Where Only Midwives Provide Primary Care" (Page 1 - Location) for the variations allowed in remote settings.*

[2]*Such arrangements with hospitals for transfer of care could, for example, address issues such as documentation, relationships between health professionals and other matters of mutual interest.*

information and signs. Every effort is made in these areas to hire bilingual personnel.

A free standing birth centre provides:

- orientation to the facility and its services;
- information, both written in plain language and on audiotape, including criteria for admission to, and continuation in the free standing birth centre program of care;
- access to translation services and sign language interpretation.

Midwives who provide care in the free standing birth centre are responsible for prenatal care, intrapartum care, postpartum care and follow up to six weeks after the birth whether in the birth centre or in another setting.

Other services may also be offered in the free standing birth centre such as:

- prenatal education
- parenting classes

Interventions that may be available in the free standing birth centre are:

- vacuum extraction[3]
- nitrous oxide[4]

The following are examples of those interventions and services which are **NOT** part of normal pregnancy and childbirth and not offered in free standing birth centres where midwives provide primary care:

- intrapartum and/or postpartum care for those women without midwifery prenatal care;
- continuous electronic fetal monitoring;
- pharmaceutical augmentation or induction of labour;
- epidural and/or regional and/or general anaesthesia;
- forceps (for operative delivery);
- caesarean section.

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[3]*The use of vacuum extraction by midwives is currently being researched by the College of Midwives' Standards Committee. Equipment to allow vacuum extraction on site by a physician during consultation is required in all Birth Centres (see page 10).*

[4]*See Volume II, Clinical Practice Parameters, Chapter ?? - Equipment, Supplies and Medication.*

Governance

A free standing birth centre responds to the needs of the community in which it is located and is run under the direction of the licensee which will be a not for profit corporation with a community based Board of Directors. Any governing board of a free standing birth centre must include a balance of consumers, the public, related health professionals and appropriate agencies from the community and midwives and staff of the free standing birth centre.

Organization and Administration

There is a written organization chart which delineates the current responsibilities, both clinical and administrative, within the facility.

There are mechanisms to ensure all staff have the opportunity to participate in planning, decision-making and the formulation of policies which affect the facility.

There is an orientation program, a staff development program and a continuing education program for all staff.

All staff receive written evaluations of their performance on an annual basis, or as defined by the facility.

Fire and emergency drills are held regularly.

There are mechanisms in place for staff to review the results of quality management activities, to plan corrective actions, and to monitor effectiveness of action, if required.

There are written agreements for contracted and/or purchased services obtained from individuals or other facilities and they are reviewed annually.

Contracts for clinical placement of student health professionals are approved by the facility operator and professional staff responsible for the provision of services to women/newborns.

Whenever possible, unnecessary duplication of services available in the community is avoided and there are agreements, policies and procedures for interaction with other agencies, institutions and individuals for services to women/newborns.

There are policies and procedures for the use of the facility by outside parties.

There is a plan for informing the community of the services provided in the birth centre.

The birth centre carries liability insurance.

Chapter 2 Staffing a Facility

Overview

Care is provided by qualified health professionals. There are sufficient ancillary and administrative personnel to ensure efficient operation of the administration of the centre, appropriate educational and support programs, cleaning, maintenance and any other services offered.

General Principles

Health professionals providing services in the birth centre:

- have current certificates of registration with the relevant College in the province of Ontario
- provide evidence of the knowledge and skills required to provide the services offered by the birth centre
- have malpractice insurance coverage to a level acceptable to the birth centre.

There are adequate numbers of professional and support staff on duty and o call to meet the demands for services routinely provided, and in periods of high demand or emergency, to assure the woman's/newborn's safety and satisfaction.

Health professionals trained in maternal cardiopulmonary resuscitation and newborn resuscitation are present at each birth.

Health professionals who may be exposed to blood have full immunization against hepatitis B or documentation of refusal.

Personnel records are maintained and secured for confidentiality on all employed, attending, consulting and contracted staff and include, but are not limited to, the following:

- qualifications
- current certificate of registration where indicated
- health examinations where required
- malpractice insurance carrier
- evidence of malpractice claims
- annual performance evaluations and/or peer review
- evidence of current training and certification for maternal cardiopulmonary resuscitation and newborn resuscitation.

There is a staff orientation and development program and staff participate in continuing education programs.

Quality Advisor

The facility has a designated Quality Advisor who is appointed from the professional staff of the facility. The Quality Advisor of a free standing birth centre where midwives provide primary care will be a registered midwife. The Quality Advisor also chairs the Advisory Committee as required by the regulations under the Independent Health Facilities Act (57/92).

A written agreement between the Quality Advisor and the facility exists.

Responsibilities

The Quality Advisor advises the facility operator with regard to the quality of services provided and is responsible for advising the facility operator on the professional aspects of the facility which includes, but is not limited to, the following:

- establishment and maintenance of a safe environment for staff and women/newborns
- supervision of all clinical and professional activities
- selection and appointment of staff and the annual review of privileges granted to each member of staff

- the accuracy and reliability of the equipment used in providing care
- maintenance of all necessary records
- establishment of a quality management program
- completion of College of Midwives of Ontario assessment plan as required under *Independent Health Facilities Act*

Note: *Whenever the Quality Advisor has reasonable grounds to believe the conduct of the facility is such that might jeopardize the safety of women/newborns and where, in the judgement of the Quality Advisor, there is a constraint placed upon correcting the perceived deficiencies by actions taken or not taken by the facility operator, then the Quality Advisor reports these concerns in writing to the Director, Independent Health Facilities. If the Quality Advisor considers it necessary, he or she may notify the Registrar, College of Midwives of Ontario.*

Quality Advisory Committee

The facility has a Quality Advisory Committee as required by the regulations under the *Independent Health Facilities Act (57/92)*. The committee consists of health professionals who provide services in or in connection with the independent with health facility.

Responsibilities

The committee whose chair is the Quality Advisor will have a mechanism in place to regularly solicit input from consumers, related health professions and appropriate agencies from the community, as well as from the professional and non-professional staff of the facility.

Qualifications of Midwives and Maintenance of Privileges

Midwives may apply for practice privileges in free standing birth centres. Midwives providing care in free standing birth centres practice the model of midwifery care as described in *Volume II, Clinical Practice Parameters, Chapter ??.14*

Consultant Personnel

Consultant Personnel may include midwives, family practitioners, obstetrician/gynaecologists, paediatrician/neonatologists, social workers, lactation consultants, prenatal educators, chiropractors and nutritionists.

Other Regulated Health Professionals

A free standing birth centre may employ or refer to other regulated health professionals. Some may be involved on a collegial or consultative basis in the care of the midwife's clients. These health professionals are currently registered to practice their profession in Ontario and function within the scope of practice outlined by their College.

Chapter 3 Developing Policies and Procedures

Overview

Policies and procedures are written, updated annually and dated accordingly, and are available for reference by all staff and representative(s) of the facility designated to receive the woman/newborn in the event of an emergency.

Facility Emergency Protocols

The facility will have a pre-arranged relationship and an emergency plan with local emergency health services. Written emergency protocols (eg. fire) are available to all midwives and staff. Fire and emergency drills are held regularly.

The facility will have written policies and procedures on the emergency transfer of woman/newborn including the requirement that prior arrangements for the care of the woman/newborn be made with a receiving health facility in the event of an emergency. These prior arrangements include:

- an agreement to follow the Guidelines for Woman/Newborn Transport (see Volume II, Clinical Practice Parameters, Chapter ??)
- the designation of who in the birth centre is responsible for contacting the receiving health facility, and who in the receiving facility is to receive the woman/newborn following transport
- the specific kind of documentation to be used to facilitate transfer
- the role of the health professional in the receiving health facility.

There are procedures to address the situation where the referring health professional either has privileges or does not have privileges in the receiving health facility.

Policies and procedures are written and include, but are not limited to, the following:

- communication and linkages with the community for care and support of the woman/newborn
- admission and discharge of woman/newborn
- woman/newborn identification, necessary prenatal tests and examination and health record documentation
- maintenance of health records
- infection control/body substance precautions
- storage of medications and emergency drugs
- safety practices/workplace hazardous materials information system (WHMIS)
- management of woman/newborn emergencies including suitable equipment as listed in *Chapter 5, ~~Facilities~~, Equipment, ~~and~~ Supplies* + Medication 12
- internal disaster procedures including fire
- personnel policies including the following:
  - content and maintenance of records on all employed, attending, consulting and contract staff
  - conditions of employment
  - respective obligations of facility operator and employee
  - benefits
  - affirmative action
  - grievance procedures

Chapter 4 Health Records

Overview

Heath records provide a format for continuity of care and documentation of legible, uniform, complete and accurate maternal and newborn information readily accessible to health care professionals and maintained in a system that protects confidentiality, provides for storage, retrieval and prevention of loss.

Health records are maintained as required by the Regulations under the *Independent Health Facilities Act (57/92)* and by the regulations under the *Midwifery Act, 1991* and the *Regulated Health Professions Act, 1991.*

Health Records

Health care records are maintained in a confidential and secure manner.

Every entry in a mother or newborn's health record is dated and signed.

Records include, but are not limited to, the following:

- client's name and home address, date of birth, health number
- name(s) of attending health professional
- a client history of past health, family health, allergy status
- a complete antenatal history, a summary of previous births and an assessment of risk status
- documentation of an appropriate referral of a woman ineligible for giving birth in a birth centre
- a complete physical examination of the client
- dated reports of examinations, tests or consultations, including any imaging media examinations
- reports of treatment including any physician's operative report
- any consents and documentation of advice given by the health professionals and all discussions with the mother relevant to care
- a record of labour, birth and immediate post partum care including any

medications administered to the mother with name, time, dosage, route of administration and signature of the health professional who administered the medication

- documentation of any consultations made prior to or during the labour, birth or neonatal period, including the reason for consultation, the name of the consultant, the outcome of the consultation

- documentation of any transfer of care to a consultant made during birth or the neonatal period including the reason for transfer, the name of the consultant, the name of the facility of the consultant and the outcome of the transfer

- a physical examination of the newborn including an APGAR rating and recording of newborn care and assessment

- any treatments or medications given to the newborn including name, time, dosage, route of administration and signature of the health professional who administered the medication

- a discharge summary of the client and the newborn including plans for follow-up care

The client's health record or a copy of it is retained for as long as is required by regulations.

No person is allowed to examine a client's health record or be given any information, copy or item from a client's health record except as required by any act or regulation made under an act or as required by the regulations *Patient Records* section under the *Independent Health Facilities Act*.

Copies from a client's health record are provided on request to the client, a personal representative who is authorized by the client to obtain copies from the health record, or if the client is dead, the client's legal representative.

A health professional may for the purpose of providing health care or assisting in the provision of health care to a client be allowed to examine the client's health record or obtain any information, copy or item contained in the health record.

The persons described below may be provided with information or copies from a health record if anything which could identify the client is removed. This applies to:

- any person if the information or copies are to be used for health administration, planning, health research or epidemiological studies, and the use is in the public interest as determined by the Minister or by the College of Midwives of Ontario

Statistics

A free standing birth centre uses the information documented in the health care records to compile annual statistical information.

The College of Midwives of Ontario
(May 1995)

Chapter 5 Facilities, Equipment and Supplies

Overview

A free standing birth centre is equipped to provide a safe environment for an uncomplicated labour and birth. It is also equipped for the management of obstetrical emergencies and emergency transfers.

There is space for furnishings, equipment and supplies to comfortably accommodate the childbearing families and the staff providing services.

Physical Facility and Equipment

The facility meets all construction, fire, safety, health codes and zoning regulations appropriate to an Independent Health Facility.

The facility maintains a record of routine periodic inspections by the Health Department, Fire Department, Building inspectors and other officials concerned with public safety. The facility is also barrier free[5] and accessible to emergency stretchers.

Smoking is prohibited in the facility.

The facility is neat and clean.

The facility accommodates clients for the immediate postpartum stay, normally 3 to 4 hours after birth, but possibly longer based on individual client, community and environmental factors.

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[5] *as per "Public Works Canada - Accessibility Evaluation Guide" (ISBN 0-662-19476-4)*

Additional space is available for services including, but not limited to:

- business operations
- secure health records storage
- secure pharmacological storage
- waiting/reception rooms
- TDD/TTY telephones
- family room and play area for children
- conference rooms
- kitchen facilities
- bath and toilet facilities for labouring women
- toilet facilities for individuals accompanying the woman
- appropriate access to parking
- utility/work areas, storage areas
- staff area, including hand washing, bathing and sleeping facilities

Equipment and space is available in or to the birth centre to provide for:

- sound proofing between rooms
- internal communication system
- portable lighting and heating sources
- emergency lighting and heating sources
- hot water heaters with adequate water pressure, hot water and tub facilities to ensure that all women have access to hot water as an analgesia for labour
- sterilization facilities
- audiovisual, computer and modem, FAX machine and photocopier
- laundry equipment

Biomedical Waste

Provision for disposal and transport of biomedical waste is made according to current regulations and guidelines. All staff, including housekeeping, are trained in "*University Precautions for Body Fluids*" under the Environmental Protection Act.

Medications

A drug inventory control system is in place. Periodic inspections of all drugs is conducted to ensure restocking takes place and all outdated drugs are replaced.

Supplies are available to administer medications and intravenous fluids as indicated in Chapter 27, *Volume II, Clinical Practice Parameters*. Nitrous oxide will be restricted to emergency use only in free standing birth centres.

Birth Equipment

Equipment necessary to care for women anticipating a normal labour and birth, and for newborns is on site in a free standing birth centre. This includes but is

not limited to that indicated in the *Chapter ??, Volume II, Clinical Practice Parameters.*

Birth equipment on site includes, but is not limited to that necessary to perform the following procedures:

- physical assessment of mother and baby, including intermittent auscultation of fetal heart tones with a fetoscope or ultrasound amplified fetoscope
- collection of laboratory specimens (blood, urine, cultures and smears)
- amniotomy
- episiotomy and episiotomy/laceration repair
- vacuum extraction in an emergency situation[6]
- sharps disposal
- biomedical waste disposal
- sterilization of instruments
- resuscitation of mother and newborn including portable or wall suction and portable or wall oxygen
- transport of mother and/or baby to another facility
- administration of intravenous fluids as appropriate.
- portable lighting and portable heat sources are on site
- weighing the newborn
- such equipment and supplies as necessary to comply with universal precautions

Equipment is available, in a readily accessible manner, to allow health

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[6] *The use of vacuum extraction by midwives is currently being researched by the College of Midwives' Quality Assurance Committee. Equipment to allow vacuum extraction on site by a physician during consultation is required in all free standing birth centres (see Chapter ??).*

professionals to respond to potential and actual emergency situations in the facility during the antepartum, intrapartum and postpartum periods.

Suitable equipment for both maternal and newborn emergencies is required. Equipment may include but is not limited to:

- intravenous supplies
- medications used for maternal bleeding, maternal seizure, maternal or newborn resuscitation
- blood collection equipment
- oxygen and suction
- nitrous oxide/50% oxygen
- equipment for maternal-fetal transport by ambluance (see Appendix ??)

B

Independent Health Facilities

Facility Standards & Clinical Practice Parameters

Free Standing Birth Centres

FOR MIDWIVES
PROVIDING PRIMARY CARE

Volume 2

Clinical Practice Parameters

Chapter 6 Philosophy of Midwifery Care in Ontario (see References)

- Midwifery care is based on a respect for pregnancy as a state of health and childbirth as a normal physiologic process and a profound event in a woman's life.

- Midwifery care respects the diversity of women's needs and the variety of personal and cultural meanings which women, families and communities bring to the pregnancy, birth, and early parenting experience.

- The maintenance and promotion of health throughout the childbearing cycle are central to midwifery care. Midwives focus on preventive care and the appropriate use of technology.

- Care is continuous, personalized and non-authoritarian. It responds to a woman's social, emotional and cultural as well as physical needs.

- Midwives respect the woman's right to choice of caregiver and place of birth in accordance with the Standards of Practice of the College of Midwives. Midwives are willing to attend birth in a variety of settings, including birth at home.

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

- Midwifery care includes education and counselling, enabling a woman to make informed choices.

- 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.

- Midwives regard the interests of the woman and the fetus as compatible. They focus their care on the mother to obtain the best outcomes for the woman and her newborn.

- Fundamental to midwifery care is the understanding that a woman's caregivers respect and support her so that she may give birth safely, with power and dignity.

Chapter 7 The Model of Practice

(see References)

What is a Midwife?

On December 31, 1993 the Regulated Health Professions Act (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.[7] Midwifery services must be made available to a woman by 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.[8]
>
> 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

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

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

who is responsible if she is not on call.[9] 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 circumstances need to apply to the College of Midwives for approval of alternate practice arrangements.[10]"

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.

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

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

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,

> "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 Site 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 College of Midwives of Ontario
(May 1995)

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 College of Midwives of Ontario
(May 1995)

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 Polytechnic 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.

The College of Midwives of Ontario
(May 1995)

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, *Philosophy of Midwifery Care in Ontario*, 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.

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

Temporary Alternate Practice Arrangement Within the Model of Practice (see References)

A midwife will plan her practice in accord with the Proposed Profession-Specific Regulations Regarding the Model of Practice which states:

> *"The midwife follows the woman throughout a full course of care from pregnancy to postpartum and attends the birth in the setting chosen by the woman."*

In order to provide continuity of care and choice of birth place in a midwifery practice, primary care is normally shared by a small group of midwives with two of these midwives present at each birth. The College of Midwives recognizes that alternate practice arrangements may be needed in some circumstances where this is not possible.

The College of Midwives of Ontario has identified two temporary alternate practice arrangements:

1) where the midwife needs to arrange shared primary care[11] with someone not authorized under both the *Regulated Health Professions Act, 1991* and the *Midwifery Act, 1991*;
2) where the midwife needs to work with a second birth attendant[12] not authorized under both the *Regulated Health Professions Act, 1991* and the *Midwifery Act, 1991*.

If a midwife determines that she will need a temporary alternate practice arrangement, she will complete the application *Temporary Alternate Practice Arrangements Within the Model of Midwifery Practice*.

Applications will be considered according to individual circumstances, based on the following criteria:

1) Demonstrated need for temporary alternate practice arrangements. For example:
   a) insufficient number of midwives to provide on call coverage for clients;
   b) geographically remote locations;
   c) practice covers large geographic area;

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[11]See *Shared Care with a Consulting Health Professional*, College of Midwives of Ontario, 1994.

[12]See *Second Birth Attendant Not Authorized Under Both the Regulated Health Professions Act, 1991 and the Midwifery Act, 1991*; and *Guidelines for Second Birth Attendant*, College of Midwives of Ontario, 1994.

d) serving communities with special needs;
e) recently established midwifery practice.

2) Evidence that the temporary alternate practice arrangements are consistent with the model of midwifery practice in Ontario.

3) Demonstrated support from the community.

The temporary alternate practice arrangements will be reviewed every six months.

Chapter 8 Informed Choice (see References)

Informed choice is an underlying principle of midwifery care in Ontario. Women have the right to receive information and be involved in the decision making process throughout their midwifery care. In the College of Midwives of Ontario's "Philosophy of Midwifery Care in Ontario" document, the childbearing woman is recognized as the primary decision maker. The interactive process of informed choice involves the promotion of shared responsibility between the midwife and her client. Midwives encourage and give guidance to clients wishing to seek out resources to assist them in the decision making process. It is the responsibility of the midwife to facilitate the ongoing exchange of current knowledge in a non-authoritarian and co-operative manner, including sharing what is known and unknown about procedures, tests and medications.

The College of Midwives of Ontario requires that registered midwives provide each potential client with the following information at the onset of their care:

- education and experience in midwifery of the midwives in the practice
- services provided, including:
  - scope of practice
  - philosophy of midwifery care in Ontario
  - choice of birth place
- contact information, including change of appointment procedure, time off, off call coverage, back up arrangements
- Temporary Alternate Practice Arrangements, if applicable
- standards of practice and protocols, including:
  - continuity of care
  - consultation and transfer of care
  - supportive care
- role and responsibilities of the client
- confidentiality and access to clients' records
- student and supervised practice arrangements

The College of Midwives of Ontario requires registered midwives to provide each client with the following information throughout the course of care:

- potential benefits and risks of, and alternatives to, procedures, tests and medications

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- relevant research evidence
- community standards and practices.

Chapter 9 Indications for Planned Place of Birth (see References)

There is an important distinction to be made between a woman's choice of the caregiver she wishes to attend her during pregnancy and childbirth, and her choice of the location in which she plans to give birth.

A woman may choose a midwife to provide care. As outlined in the document **"Indications for Mandatory Discussion, Consultation and Transfer of Care"**, in certain circumstances, discussion of the care "plan" is required with the other midwife or physician involved in the primary care of the client. In other listed circumstances, consultation with a physician is required; and in still other listed circumstances transfer of care to a physician is required.

Similarly, a woman may choose to give birth at home, in an out-of-hospital birth centre, or in hospital. A midwife providing primary care will provide or make accessible to her client all the information the woman wishes or requires to make an informed decision about the appropriate place for her to plan to give birth. Where consultation has taken place, this information will include the recommendation of the consultant.

When care has been transferred to a physician either because it has been required as a mandatory transfer of care or because of some other complicating condition, it is unlikely out-of-hospital birth will be considered appropriate.

When the midwife is providing primary care, she will support the woman's choice, after the client has carefully considered the information and recommendations. Notwithstanding this, birth should be planned to take place in hospital in the circumstances of multiple birth, breech presentation, preterm labour prior to 37 weeks of pregnancy, and documented post-term pregnancy of more than 43 completed weeks. Other situations in which hospital birth should be planned would be assessed prenatally, with appropriate consultation as detailed in **"Indications for Mandatory Discussion, Consultation and Transfer of Care"**.

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Chapter 10 Indications for Mandatory Discussion, Consultation and Transfer of Care (see References)

As a primary caregiver, the midwife together with the client, is fully responsible for decision-making. The midwife is responsible for writing orders and carrying them out or delegating them in accord with the standards of the College of Midwives.

The midwife discusses care of a client, consults, or transfers primary care responsibility according to the Indications for Mandatory Discussion, Consultation and Transfer of Care.[13] The responsibility to consult with a family physician/general practitioner, obstetrician and/or specialist physician lies with the midwife. It is also the midwife's responsibility to initiate a consultation within an appropriate time after detection of an indication for consultation. The severity of the condition and the availability of a physician(s) will influence these decisions.

The informed choice agreement between the midwife and client should outline the extent of midwifery care, in order to make clients aware of the scope and limitations of midwifery care. The midwife should review the Indications for Mandatory Discussion, Consultation and Transfer of Care with the client.

DEFINITIONS

Category 1:Discuss with the midwife (midwives) or with the physician(s) who is(are) sharing primary care.[14]

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[13] For a discussion of how this document is used to guide decisions about choice of birth place, see Indications for Planned Place of Birth.

[14] Primary care is normally shared by two midwives. (See Number of Midwife Attendants at Birth.) In exceptional circumstances, primary care may be shared by a midwife and a physician. (See Shared Care with a Consulting Health Professional and Second Birth Attendant not Authorized under both the RHPA 1991 and Midwifery Act 1991.)

Discussion with or providing information to the midwife(midwives) or physician(s) who is(are) sharing primary care in order to plan care appropriately.

Category 2: Consult with a physician

It is the midwife's responsibility to initiate a consultation and to clearly communicate to the consultant that she is seeking a consultation. A consultation refers to the situation where a midwife, in light of her professional knowledge of the client and in accord with the standards of practice of the College of Midwives, or where another opinion is requested by the client, requests the opinion of a physician competent to give advice in this field. The midwife should expect that:

> The consultation involves addressing the problem that led to the referral, in an in person assessment of the patient, and the prompt communication of the findings and recommendations to the patient and the referring professional.
>
> Following the assessment of the patient by the consultant(s), discussion can occur between the health professional and consultant regarding future patient care.[15]

The consultation can involve the physician providing advice and information and/or providing therapy to the woman/newborn or prescribing therapy to the midwife for the woman/newborn.

Consultation must be documented by the midwife in her records in accord with the regulations of the College of Midwives.

After consultation with a physician, primary care of the client and responsibility for decision-making together with the client either:

a) continues with the midwife, or
b) is transferred to a physician.

Once a consultation has taken place and the consultant's findings, opinions and recommendations are communicated to the client and the midwife, the midwife must discuss the consultant's recommendations with the client and ensure the client understands which health professional will have responsibility for primary care.

Where urgency, distance or climatic conditions make an in-person consultation with a physician not possible, the midwife should seek advice from the physician by phone or other similar means. The midwife should

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[15] This definition is identical to that described in the College of Physicians and Surgeons of Ontario, "Clinical Practice Parameters and Standards for Consultation and Transfer of a Woman/Newborn In or From a Birth Centre (Where Only Midwives Provide Primary Care, To a Physician/Health Facility)," December 1994.

document this request for advice, in her records, in accord with the requirement of the College of Midwives and discuss with the client the advice received.

The consultant may be involved in, and responsible for, a discrete area of the client's care, with the midwife maintaining overall responsibility within her scope of practice. Areas of involvement in patient care must be clearly agreed upon and documented by the midwife and the consultant.

The College of Midwives has agreed that:

> One health professional has overall responsibility for a patient at any one time and the patient's care should be coordinated by that health professional whose identity should be clearly known to all of those involved and documented in the records of the referring health professional and consultant....Responsibility could be transferred temporarily to another health professional, or be shared between health professionals according to the patient's best interests and optimal care; however, transfer or sharing of care should only occur after discussion and agreement among patients, referring health professionals, and consultants.

Category 3: **Transfer to a physician for primary 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 subsequent decision-making. When primary care is transferred to a physician, the midwife may provide supportive care[16] within her scope of practice, in collaboration with the physician and the client.

INDICATIONS: Initial History and Physical Examination

Category 1:

- adverse socio-economic conditions
- age less than 17 years or over 35 years
- cigarette smoking
- grand multipara (para 5)
- history of genital herpes
- history of infant over 4500 gm.
- history of one late miscarriage (after 14 weeks) or preterm birth
- history of one low birth weight infant

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[16] Supportive care is defined in the standard on Supportive Care.

	-	history of serious psychological problems
	-	less than 12 months from last delivery to present due date
	-	obesity
	-	poor nutrition
	-	previous antepartum hemorrhage
	-	previous postpartum hemorrhage
	-	one documented previous low segment cesarean section
Category 2:	-	current medical conditions for example:[17], [18] cardiovascular disease, pulmonary disease, endocrine disorders, hepatic disease, neurologic disorders
	-	family history of genetic disorders, hereditary disease and/or congenital anomalies
	-	history of cervical cerclage
	-	history of essential or pregnancy induced hypertension
	-	history of more than one late miscarriage or preterm birth
	-	history of more than one low birth weight infant
	-	history of repeated spontaneous abortions
	-	history of significant medical illness
	-	known uterine malformations or fibroids
	-	previous myomectomy, hysterotomy or cesarean section other than one documented previous low segment cesarean section
	-	previous neonatal mortality or still birth
	-	rubella during first trimester of pregnancy
	-	significant use of drugs or alcohol
	-	age less than 14 years
Category 3:	-	any serious medical condition, for example: cardiac or renal disease with failure or insulin dependent diabetes mellitus

INDICATIONS: Prenatal Care

Category 1:	-	breech presentation at 4 weeks prior to due date

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[17] Notwithstanding the requirement for discussion with a physician or midwife, discussion may be with another health care profession, e.g.: mental health worker, lactation consultant.

[18] Refer to Guidelines to Antepartum Consultation for clients of Midwives to Anaesthesia, draft 1994.

- no prenatal care before 28 weeks gestation
- uncertain expected date of delivery

Category 2:

- anaemia
- documented post term pregnancy (42 completed weeks)
- fetal anomaly
- inappropriate uterine growth
- medical conditions arising during prenatal care, for example: endocrine disorders, hypertension, renal disease, suspected significant infection, hyperemesis
- placenta previa without bleeding
- polyhydramnios or oligohydramnios
- pregnancy induced hypertension
- isoimmunization
- serious psychological problems[19]
- sexually transmitted disease
- transverse lie at 4 weeks prior to due date
- twins
- vaginal bleeding other than transient spotting
- breech presentation at term

Category 3:

- cardiac or renal disease with failure
- insulin dependent diabetes
- multiple pregnancy (other than twins)
- proteinuric pre-eclampsia or eclampsia
- symptomatic placental abruption
- vaginal bleeding, continuing or repeated

INDICATIONS: During Labour and Delivery

Category 1:

- no prenatal care
- thin meconium

Category 2:

- breech presentation
- preterm labour (34 - 37 completed weeks)
- prolonged active phase
- prolonged rupture of membranes
- prolonged second stage
- retained placenta
- suspected placenta abruption and/or previa
- third or fourth degree tear
- twins

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[19] Notwithstanding the requirement for consultation with a physician or midwife, consultation may be with another appropriate health care professional, e.g.: mental health worker, lactation consultant.

- unengaged head in active labour in primipara

Category 3:

- abnormal fetal heart patterns unresponsive to therapy
- abnormal presentation (other than breech)
- active genital herpes at time of labour
- multiple pregnancy, other than twins
- placenta abruption and/or previa
- preterm labour (less than 34 completed weeks)
- prolapsed cord
- proteinuric pre-eclampsia or eclampsia
- severe hypertension
- thick meconium
- uterine rupture

INDICATIONS: Post Partum (Maternal)

Category 2:

- breast infection
- wound infection
- persistent hypertension
- serious psychological problems[20]
- signs of uterine infection
- temperature over 38°C (100.4°F) on more than one occasion
- signs of urinary tract infection

Category 3:

- haemorrhage unresponsive to therapy
- obstetric shock
- post partum eclampsia
- thrombophlebitis or thromboembolism
- uterine prolapse

INDICATIONS: Post Partum (Infant)

Category 1:

- feeding problems[21]

Category 2:

- abnormal findings on physical exam
- abnormal neurological signs

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[20] Notwithstanding the requirement for consultation with a physician or midwife, consultation may be with another appropriate health care professional, e.g., mental health worker, lactation consultant.

[21] Notwithstanding the requirement for consultation with a physician or midwife, consultation may be with another appropriate health care professional, e.g.: mental health worker, lactation consultant.

- infant less than 2,500 gms. (5 lbs.)
- less than 3 vessels in umbilical cord
- excessive molding and cephalhematoma
- insufficient weight gain in two weeks
- 34 to 37 weeks gestational age
- failure to pass urine or meconium within 24 hours of birth
- excessive bruising, abrasions, unusual pigmentation and/or lesions
- temperature less than 36 C rectal, unresponsive to therapy
- fever unresponsive to therapy
- jaundice in first 24 hours
- suspected pathological jaundice after 24 hours
- persistent cyanosis or pallor
- abnormal cry
- persistent abnormal respiratory rate and/or pattern
- suspected infection of umbilical stump site
- suspected congenital abnormalities, for example: cleft lip or palate, congenital dislocation of hip, ambiguous genitalia
- abnormal heart rate or pattern
- feed intolerance with vomiting or diarrhea
- birth injury requiring investigation

Category 3:

- APGAR lower than 7 at 5 minutes
- suspected seizure like activity
- significant weight loss
- failure to regain birth weight in three weeks
- major congenital anomaly requiring immediate intervention, for example: omphalocele, myelomeningocele
- pattern of temperature instability

When the Client Requests Care Outside Midwifery Standards of Practice (see References)

When a midwife (or team of midwives) advises a client that a certain course of action must be followed in order to comply with midwifery standards of practice or the midwife's judgement of safe care, and the client refuses to follow that advice, the midwife should:

1. advise the client not only of the standard or her judgement but also of the rationale behind the standard or her particular judgement in

iii. follow steps 1. - 3. outlined above.

Where a client continues to refuse transfer of care, the midwife may find herself called upon to deal with an urgent situation.

Chapter 11 Transfer from the Birth Centre (see References)

Overview

A free standing birth centre develops liaisons with local hospitals, consultants and emergency services. Optimum safety is ensured with the maximum cooperation between all health care providers and services including hospitals' emergency services and staff of the birth centre.

Non-emergency Transports

The majority of transports from out of hospital births into hospital are in non-emergency situations. In non-emergencies, consultation and transfer of care may take place via the arrangements the attending midwife has with the hospitals at which she has admitting privileges. At least one midwife at each birth should have privileges to a local hospital. Non-emergency transports will generally not use emergency services.

Emergency Transports

In emergencies, the staff of the free standing birth centre will make every effort to ~~guidelines~~ accommodate a speedy transfer of care. If a birth centre has emergency transfer arrangements with more than one hospital, staff should ensure transfer to the closest practical hospital occurs. See Sample "*Maternal Consultation*" - *Transfer Record*" Form (CPSO), Appendix 22 and *Recommended Equipment for Maternal-Fetal Transport by Ambulance* (CPSO), Appendix 22.

Guidelines for Maternal/Newborn Transport

These guidelines are identical to those approved by the College of Nurses and the College of Physicians and Surgeons.

In those situation where the health and safety of the woman and/or newborn are at

risk, the woman/newborn are offered transfer by the most expeditious means to the receiving facility. If the woman refuses transfer, she confirms this in writing.

In general, transport should be considered when resources immediately available to the woman, fetus or newborn in the birth centre are not adequate to manage anticipated complications.

Policies and procedures are written and in place for the emergency management of the woman/newborn and prior arrangements for the care of the woman/newborn have been made with the receiving health facility in the event of an emergency. These prior arrangements include the designation of who in the birth centre is responsible for contacting the receiving health facility, and who in the receiving health facility is to receive the woman/newborn following transport.

To arrange transfer, the referring health professional contacts the receiving physician at the receiving facility and exchanges information about:

- the presenting problem
- maternal and fetal/newborn well being
- strategies for stabilization or intervention, and
- a plan for transport, including treatment or assessment en route

The referring health professional discusses the situation with the woman and her family, and encourages a supporting person(s) to accompany the woman and/or newborn.

The referring health professional will also accompany the woman/newborn if appropriate.

The receiving facility documents the request for transfer on a standardized form. Information on this form includes:

- woman/newborn name and identifying information
- reason for transfer request
- current condition of the woman/newborn
- decisions regarding treatment and transport
- health professional accompanying woman/newborn

A standardized maternal/newborn transfer form or its equivalent is completed (see Appendix *E, Sample Neo-natal Pre-transport Record.*

Prenatal records and labour records, laboratory and ultrasound assessments and other pertinent records accompany the woman/newborn. If possible, these records are faxed to the receiving facility prior to the transport.

Where possible, treatments as recommended by the receiving physician are instituted.

Emergency equipment to accompany the woman/newborn is available in the birth centre and checked regularly (see Appendix *D, Recommended Equipment for*

Maternal-Fetal Transport by Ambulance).

The health professional assesses the woman/fetus/newborn prior to transport including:

- vaginal bleeding
- meconium staining
- temperature, pulse, respiration, blood pressure
- fetal heart rate
- state of membranes
- lie
- presentation
- dilatation of cervix
- uterine contractions - strength, frequency, duration

Frequency of monitoring of vital signs during transit is determined relative to maternal/fetal/newborn condition.

Supplemental inspired oxygen is administered if thought appropriate.

Assessments are documented on the maternal/newborn transfer form.

Note: In the event of an emergency during transport, the accompanying health professional or ambulance personnel contacts and updates the receiving hospital and/or a more appropriate facility about:

- *the presenting problem*
- *maternal and fetal/newborn well being*
- *strategies for stabilization or intervention, and*
- *a plan for transport, including treatment or assessment en route*

Contraindication for Transport of Women/Newborns

Contraindications for transport include:

- mother's or newborn's condition is not sufficiently stabilized for transport
- delivery is imminent
- weather conditions hazardous for travel

Fetoscope
Doppler fetoscope
Stethoscope
Blood pressure cuff
Thermometer
Two hemostats
Effective portable suction equipment
One pair blunt-ended scissors for cord
One pair of scissors for episiotomy
Infant resuscitation bag and mask
Suturing instruments
Baby scale

Cord clamps or ties
Urinalysis supplies
Antiseptic solution
Sterile gloves
Sterile lubricant
Syringes
Needles
Suture material
Urinary catheter
Cord blood tubes
Sharps and points waste container
IV supplies
Maternal oxygen masks
Oral airways

Oxytocic drugs
Local anaesthetic
Oxygen - sufficient for transport of mother and baby
Eye prophylaxis
Vitamin K
IV fluids

Regulation Made Under the *Midwifery Act, 1991:* Designated Drugs (see References)

1.-(1) For the purposes of paragraph 3 of section 4 of the Act, the following substances are designated as substances that a member may administer by

injection on the member's own responsibility:

Dimenhydrinate
Diphenhydramine hydrochloride
Epinephrine hydrochloride
Hepatitis B immune globulin
Hepatitis B vaccine
Intramuscular ergonovine maleate
Intramuscular or intravenous oxytocin
Intravenous fluids
Lidocaine hydrochloride with or without epinephrine
Phytonadione
RhD immune globulin

(2) For the purposes of paragraph 3 of section 4 of the Act, the following substances are designated as substances that a member may administer by injection on order of a member of the College of Physicians and Surgeons of Ontario:

Antibiotics
Epidural analgesia (continuous infusion maintenance)
Narcotic antagonists
Narcotics
Oxytocics intravenous infusion

2. For the purposes of paragraph 3 of section 4 of the Act, the following substances are designated as substances that a member may administer by inhalation on the member's own responsibility:

Nitrous oxide
Therapeutic oxygen

3. For the purposes of paragraph 7 of section 4 of the Act, the following drugs are designated as drugs that may be prescribed by a member on the member's own responsibility:

Clotrimazole
Doxylamine succinate-pyridoxine hydrochloride
Erythromycin ophthalmic ointment
Hepatitis B immune globulin
Hepatitis B vaccine
Hydrocortisone anorectal therapy compound
Miconazole
Nystatin
Oral ergonovine maleate
Phytonadione
RhD immune globulin

4. The following drugs may be used by a member in the course of engaging in the practice of midwifery on order of a member of the College of Physicians and Surgeons of Ontario:

Acetaminophen with codeine
Antibiotics
Antiemetic/sedative agents with narcotic analgesics
Barbiturates
Cervical ripening agents
Sedatives

5. A member may administer, prescribe or order any drug or substance that may lawfully be purchased or acquired without a prescription.

Guidelines for Regulation Made Under the *Midwifery Act, 1991:* Designated Drugs

(see References)

(1) ON THE MEMBER OF THE COLLEGE OF MIDWIVES OF ONTARIO'S OWN RESPONSIBILITY, Section 1.(i), 2., 3. and 5.

Under the *Midwifery Act, 1991*[22], midwives are able to independently administer or prescribe drugs and other substances which they need for their clients, whether in the community, hospital, or other sites of midwifery practice. Midwives are able to independently write orders for and administer drugs and other substances which they need for their clients.[23] Institutions may have their own rules regarding drug ordering and administering, and midwives must comply with these rules when working within the institution. In all cases, the independent use of drugs must fall within the scope of midwifery practice.

The following are guidelines to the list of drugs and substances which midwives are able to independently administer, prescribe or order for their clients in the community, hospital, or other sites of midwifery practice. This list is meant to be inclusive. Midwives would not be permitted to independently administer, prescribe or order any other drugs or substances unless changes are made to the

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[22] *Regulated Health Professions Act, 1991* and the *Midwifery Act, 1991*, Designated Drugs Regulation.

[23] Regulation made under the *Drug and Pharmacy Act*, Section 118(2) and (3):

(2) Nothing in this Act prevents any person from selling or dispensing a drug to a person authorized under a health profession Act as defined in the *Regulated Health Professions Act, 1991* to dispense, prescribe or administer drugs.

(3) No thing in this part (sic) prevents any person from selling, to a member of the...College of Midwives of Ontario..., a drug that the member may use in the course of engaging in the practice of his or her profession.

prescribing regulation of the *Midwifery Act, 1991.*

Antiemetics:

Doxylamine succinate - pyridoxine hydrochloride is used orally for control of severe nausea in pregnancy. Dimenhydrinate, intramuscularly, rectally, and orally, is used for the control of nausea and vomiting in pregnancy.

Antihistamine:

Intramuscular or intravenous (e.g. Diphenhydramine Hydrochloride, Benadryl^{R}) is administered by midwives as adjunctive therapy in the treatment of anaphylactic reactions. Administration of drugs, vaccines or sera have the potential to cause an anaphylactic reaction. If used for an anaphylactic reaction, an emergency consultation with a physician is required and if out-of-hospital, transfer by ambulance to a hospital. Further definitive treatment would be managed by a physician. The usual adult dose is 50 mgIM, or 25 mgIV given slowly over 3-5 minutes.

Antifungal preparations:

The use of intravaginal clotrimazole, nystatin or miconazole in treatment of candida albicans infections that are common during the prenatal period in healthy pregnant women. Midwives, while acting within their scope of practice, will be performing routine vaginal swabs and cultures for their clients. Access to these preparations will ensure that midwives can treat candida albicans infections effectively. Nystatin may be prescribed in oral or topical preparation for treatment of thrush in the newborn.

Ergonovine maleate:

Is used intramuscularly in the third stage of labour in the event of a haemorrhage uncontrolled by the use of oxytocin and provides a continual clamping down effect on the uterus. A midwife may also prescribe ergonovine maleate per os for a woman as a preventative measure.

Epinephrine hydrochloride:

Administered subcutaneously for the treatment of anaphylactic shock as a result of an allergic reaction following administration of a drug or substance. Administration of drugs, vaccines or sera have the potential to cause an anaphylactic reaction. This drug is for emergency purposes, and its use should be immediately followed by an emergency consultation and if out-of-hospital, transfer by ambulance to a hospital.

The usual initial adult dosage is 0.1- 0.5 mg (0.1-0.5 ml of a 1:1000 injection), initial doses should be small and may be increased if necessary. Single doses should not exceed 1 mg. Subcutaneous doses may be repeated at 10-15 minute intervals in cases of anaphylactic shock.

The paediatric dose is 0.01 mg/kg, with doses repeated a minimum of 20 minutes later as needed. For example, a newborn weighing 7 pounds or approximately 3.2 kg, the calculation would be 3.2 x 0.01 = 0.032 mg.

Hepatitis B immune globulin and **Hepatitis B vaccine**:

Are administered to the infants of HBsAg positive mothers within 24 hours of the birth. A second dose is given at four weeks of age and may be administered by the midwife. Doses after 6 weeks would be administered by a physician.

Hydrocortizone compound:

Is an anorectal therapy prescribed for women in ointment or suppository form for treatment of hemorrhoids.

Inhalation analgesics:

50% oxygen / 50% nitrous oxide for inhalation analgesia for relief of moderate pain during the course of normal labour. This specific drug has been included as it offers the advantage of self-administration by the woman, has minimal side effects for the mother as it is excreted quickly and therefore does not have any residual effects. It is thought to have no residual effect on the fetus. This drug is to be used only in hospital and in remote settings for emergency use only. Use in out of hospital settings is being studied by College of Midwives of Ontario.

Intravenous fluids:

Normal saline and Ringers lactate are carried by the midwife to be used in the event of a haemorrhage in the course of third stage or immediate postpartum that is not responsive to other therapies. The purpose of these fluids is strictly for emergency measure to provide a volume expander during transport for severe postpartum haemorrhage. In the event of a transport that is prolonged for communities that are longer than 20 minutes away from a hospital a Ringers lactate or colloid containing substance may be used.

RhD immune globulin:

Routinely administered in both the prenatal and postpartum to all Rh negative pregnant women in Ontario and is essential in prevention of sensitization and resultant risk to the fetus.

Lidocaine hydrochloride with or without epinephrine:

Is used to anaesthetize the perineum and vaginal walls for repair of laceration or an emergency episiotomy.

Neonatal ophthalmic prophylaxis:

Erythromycin ointment is administered in the immediate postpartum period as required by public health law in Ontario. This preparation is for the prevention of infection of the conjunctiva of newborns who may have contracted chlamydia, gonorrhoea or other bacteria.

Neonatal vitamin K1:

Used to prevent haemorrhagic disease of the newborn. Vitamin K1, Phytonadione, is offered and administered to newborns at birth in Ontario.

Oxytocin:

Is carried by all midwives for use intramuscularly or intravenously to induce intermittent uterine contractions in third stage or immediate postpartum in the event of a maternal haemorrhage or a placenta that is slow to deliver.

Therapeutic oxygen:

Administered by mask and non-rebreather bag in the course of a normal labour as therapy for abnormal fetal heart tones. One hundred percent oxygen is used in neonatal resuscitation with resuscitation bag and mask.

Drugs or substances that may be purchased or acquired without prescription:

Midwives may administer, prescribe or order for their clients drugs or substances available over-the-counter, whether in the community, hospital, or other sites of midwifery practice. This list is not meant to be all-inclusive, but to provide examples of the types of drugs which midwives might be expected to use.

Analgesics: e.g., acetylsalicylic acid, acetaminophen (plain or with up to 8 mg of codeine)
Antacids: e.g., magnesium and aluminum hydroxides
Antiemetics: e.g., diphenhydramine
Homeopathic and herbal remedies: e.g., pulsatilla, arnica, caulophyllum, echinacea, angustifolia, raspberry leaf
Laxatives: e.g., standardized senna concentrate, psyllium hydrophlic mucilloid
Oral hematinics: e.g., ferrous fumarate, sulphate or gluconate
Vitamins: e.g., multivitamin preparations with up to 1.0 mg/dose of folic acide, vitamin A with up to 10,000 IU/dose, and vitamin D with up to 1,000 IU/dose

(2) ON ORDER OF A MEMBER OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO, Section 1.(2) and 4:

After consultation with a physician and/or transfer to a physician[24], it may occasionally be in the best interest of the client for the midwife to administer the drugs listed below on the order of a physician. This would occur in accord with hospital protocols and requirements and after appropriate in-service education and/or certification. We expect that the administration of drugs by a midwife on the order of a physician would normally occur in hospital; for example, prostaglandins for induction of labour or meperidine hydrochloride for pain relief in labour.

The following list of drugs for administration by midwives on a physician's order is meant to be inclusive. Notwithstanding the above, exceptions may be made in remote areas where appropriate nursing care is not available.

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[24] Indications for Mandatory Discussion, Consultation and Transfer of Care

Acetaminophen with 8 mg to 30 mg of codeine: e.g., Tylenol 3
Antibiotics: e.g., cloxacillan
Antiemetic/sedative agents with narcotic analgesics: e.g., phenothiazines with meperidine hydrochloride
Barbiturates: e.g., secobarbital sodium
Cervical ripening agents: e.g., prostaglandins
Epidural analgesia: e.g., continuous infusion maintenance
Narcotic antagonists: e.g., naloxone hydrochloride
Narcotics: e.g., meperidine hydrochloride
Oxytocics: e.g., oxytocin intravenous infusion maintenance
Sedatives: e.g., oxazepam

Chapter 13 Laboratory Testing & Diagnostic Imaging

Laboratory Testing (see References)

Midwives will independently collect specimes and order laboratory testing for their clients as specified:

List of tests:

CLASS	CODE*	NAME
Chemistry/RIA	L030	Bilirubin - total
	L031	Bilirubin - conjugated
	L111	Glucose
	L253	Urinalysis - routine (includes microscopic)
	L311	Estriol
	L318	HCG
	L319	Hepatitis Associated Antigen or Antibody Immunoassay
	L341	TSH/PKU Newborn Screening
	L691	Alphafetoprotein Screen
	L005	Albumin quantitative
	L329	Serum Ferritin
	L309	Serum Folate
Hematology	L372	W.B.C. differential count (includes R.B.C. morphology and platelet estimate)
	L396	Platelet counts
	L417	Hematocrit
	L418	Hemoglobin
	L453	Sickle cell solubility test (screen)
	L431	Kleihauer
Immunohematology	L482	Antibody screen
	L490	Blood group - ABO and Rho (D)
	L495	Direct Anti-human globulin test
Cytology	L713	Cervicovaginal specimens

Bacteriology	L621	Antibody sensitivity
	L622	Chlamydia
	L625	Culture - cervical, vaginal (includes GC)
	L628	Culture - other swabs or pus
	L634	Culture - urine
	L637	Virus isolation
	L653	Wet preparation (for fungus, trichomonas, parasites)
	L640	Strep B rapid screen
Immunology	L655	Pregnancy Test
	L679	Virus antibodies - hemagglutination inhibition or ELISA technique (Rubella)
	L683	Non-cultural, indirect antibody or antigen assays by fluorescence, agglutination or ELISA technique (Toxoplasmosis)
		HTLV III/LAV antibody screen by ELISA technique (HIV Antibody)
		VDRL

* Note: The codes have been assigned by the Laboratory Licensing and Inspection Service, Laboratory Services Branch, Ministry of Health, when the list of tests was reviewed and approved on July 27, 1993. This list is included in the *Laboratory and Specimen Collection Centre Licensing Act.*

Diagnostic Imaging (see References)

Midwives will independently order obstetrical ultrasounds for their clients as specified.

Transvaginal obstetrical ultrasound

Transabdominal obstetrical ultrasound

NOTE: Ministry of Health classifications and codes for information purposes

J159/J459	pregnancy complete
J163/J463	pelvis or pregnancy or intercavity

Chapter 14 Quality Management

Overview

A quality management program is a planned, systematic, and comprehensive strategy which permits internal and external review of the quality of care provided in order to provide safe and responsive care to women and newborns. A free standing birth centre will develop protocols for record keeping and data collection which are compatible with those developed by the College of Midwives. Analysis of data may lead to recommendations for changes to policy or clinical practice. A free standing birth centre will have protocols which will include but not be limited to the assessment of the following areas:

- outcomes of maternal and newborn care;
- client and community satisfaction;
- compliance with the centre's stated goals;
- compliance with and effectiveness of midwives' practice protocols;
- compliance with the College of Midwives standards of practice and;
- compliance with and effectiveness of the birth centre's administration & organization protocols.

Free standing birth centres will have both clinical and organizational practice protocols. Clinical protocols will allow midwives to use clinical judgement in providing safe, responsive care for their clients and will:

1. allow for client decision-making;
2. allow the midwife to work fully within her scope;
3. be based on current available scientific evidence and take into account health care practices in local and comparable communities;
4. be dated, reviewed and updated at specific intervals.

In addition, the free standing birth centre's practice protocols will:

6. be developed by midwives practising there and reviewed and approved by the birth centre's Board of Directors.

Quality Management

Quality Management activities include the collection and analysis of data, and corrective actions if necessary relating to, but not limited to, the following:

- quality management activities related to direct woman/newborn care:

  - at least annual review of protocols, policies and procedures relating to the maternal and newborn care
  - the appropriateness of the process for determining eligibility for admission to and continuation in the birth centre program of care
  - the appropriateness of medications prescribed, dispensed or administered in the birth centre
  - the evaluation of performance of health professionals employed by or on the staff of the birth centre (peer review - self evaluation)
  - regular meetings of health professionals to review the management of care of individual women/newborns and make recommendations for improving the plan for care
  - regular review of transfers of women and newborns to hospital care to determine the appropriateness and quality of the transfer
  - regular review and evaluations of significant problems or complications of pregnancy, labour and postpartum and the appropriateness of the clinical judgement of the health professional in obtaining consultation and attending to the problem
  - regular review of all health records for legibility and completeness
  - evaluation of staff on ability to manage emergency situations by unannounced periodic drills for fire, woman/newborn emergencies, power failures, etc.

- quality management activities related to maintaining a safe environment:

  - routine testing of the efficiency and effectiveness of all equipment (e.g. sphygmomanometer, doptones, sterilizers, resuscitation equipment, transport equipment, heat source for newborn, smoke alarms, fire extinguishers)
  - routine review of housekeeping procedures and infection control
  - evaluation of maintenance policies and procedures and infection control
  - evaluation of maintenance policies and procedures for heat, ventilation, emergency lighting, waste disposal, water supply and laundry and kitchen equipment.

Staff participate in the development and implementation of quality management activities, the review of information resulting from these activities, the planning to address any deficiencies identified, and the review of the effectiveness of any corrective actions taken on the deficiencies.

Compliance With the Centre's Stated Goals

A free standing birth centre will have a mission statement. Every year the birth centre will undertake a self evaluation to assess how well it has met its stated goals. This evaluation may result in recommended changes to the centre's protocols or mission statement.

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Clinical Care Provided

A free standing birth centre will collect data on the outcome of client care. This data will include but not necessarily be limited to the following:

Outcomes

- number of spontaneous vaginal births;
- number of newborns;
- newborn birth weights;
- newborn Apgar scores;
- number of newborns breastfed;
- number and types of interventions needed
  - (i) lacerations and degree;
  - (ii) episiotomies;
  - (iii) perineal repairs;
  - (iv) artificial rupture of membranes;
  - (v) medications;
  - (vi) suction;
  - (vii) emergency procedures including neonatal resuscitations;
- time spent in centre;
- neonatal morbidity/mortality;
- maternal morbidity/mortality.

Consultations With Physicians

- number;
- reasons;
- types of consultants;
- time in centre before consultation and birth;
- time in centre after consultation and subsequent birth

Consultations With Other Health Care Professionals:

- number;
- reasons;
- types of consultants.

Transfer to Hospital

- number of women transferred out of the birth centre to hospital;
- times of: initiation of transfer,
  departure from birth centre,
  arrival at hospital, and

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transfer of care if applicable;

- reasons for transfers to hospital;
- number of women transferred to hospital where care was transferred to a physician. Identify type of consultant;
- name(s) of hospital(s);
- outcomes of women transferred out of the birth centre;
- outcomes of babies transferred out of the birth centre.

Client and Community Satisfaction

A free standing birth centre will collect data in the areas of client and community satisfaction. This data will include but not necessarily be limited to the following:

- number of women:
  requesting care in centre,
  accepted in centre, and
  referred elsewhere and reasons for the referrals;
- number of babies cared for;
- demographic information about the client population;
- ongoing evaluation of care by each woman registered at the birth centre:
  during her prenatal period
  during her early post partum
  6 - 12 months after birth;
- number of births at which family and/or other support people were present;
- number of births at which siblings were present;
- regular input by childbearing women from the larger community;
- intermittent, confidential case review by midwives and the birth centre's Board of Directors;
- information about how the centre is being used, e.g. orientation sessions, educational programmes, support group.

Compliance with Midwifery Practice Protocols

It is expected that midwives will need to use clinical judgement in providing safe, responsive care for their clients in a free standing birth centre. All midwives with practice privileges in the birth centre must have written practice protocols acceptable to the Board of Directors of the birth centre. These protocols will

outline the roles of the first and second midwives throughout the care provided and include the following areas:

Labour and Birth

- pre-labour rupture of membranes at term;
- nutrition in labour;
- Monitoring: First Stage of Labour;
  Second Stage of Labour;
  Third Stage of Labour;
- Lack of Progress: First Stage of Labour;
  Second Stage of Labour;
- meconium stained amniotic fluid;
- artificial rupture of membranes;
- episiotomy;
- medications - administration;
- gases - administration;
- vaginal birth after cesarean;
- retained placenta.

Immediate Postpartum Guidelines

- immediate postpartum care of mother;
- immediate postpartum care of baby;
- medications: eye prophylaxis;
  Vitamin K prophylaxis.

Emergency

- fetal distress;
- antepartum haemorrhage;
- prolapsed cord;
- undiagnosed breech;
- undiagnosed twins;
- shoulder dystocia;
- postpartum haemorrhage;
- neonatal resuscitation;
- vacuum extraction.

Perinatal Death

- death & bereavement.

Midwives work in teams and function as primary caregivers within their scope of practice and according to the Standards developed by their College. Each birth should be planned with the understanding that two midwives will be in attendance, except in those situations approved by the College of Midwives of Ontario as alternate practice arrangements.[25] This second attendant should be competent and knowledgeable to attend birth and follow the midwifery model of care.

All midwives providing services in a free standing birth centre:

- are currently registered to practice their profession in Ontario and function within the scope of practice outlined by the College of Midwives in accordance with the registration regulations, including;
    - maintenance of CPR and NPR qualifications
    - maintenance of malpractice insurance
    - maintenance of active practice requirements
        - attendance over a one year period at the equivalent of at least 20 births, ten of whom the midwife attended as primary midwife with five of the births occurring in a hospital and five in a residence, remote clinic or remote birth centre,
        - demonstrates compliance with standards of care at the facility where the midwife has active admitting privileges
        - participate in any ongoing education as per the College of Midwives of Ontario's requirements including any clinical placements required to remain competent and confident to work in all settings including hospital, home and birth centre.
- have access to laboratory services in accordance with the College of Midwives of Ontario's *Laboratory Testing* (Appendix 5) and *Diagnostic Imaging* (Appendix 6)

[25] *According to Temporary Alternate Practice Arrangements within the Model of Midwifery Practice (see appendix 3).*

- have access to consultation with appropriate specialists including physicians as per the College of Midwives of Ontario's *Indications for Mandatory Discussion, Consultation and Transfer of Care* (Appendix 7);

Compliance With the College of Midwives Standards of Practice

Review of practice privileges in a free standing birth centre will take place yearly and will include an evaluation of each midwife and her compliance with the College of Midwives of Ontario's Standards of Practice, including the consultation and transfer of care standards.

Midwives practising in the birth centre will hold regular peer review. All cases involving significant morbidity or mortality will be the subject of peer review.

A free standing birth centre will collect data on the midwifery model of practice. This data will include but not necessarily be limited to the following:

- number of births attended by two midwives;
- number of births attended by one midwife and a non-midwife second birth attendant.

Administrative and Organizational Protocols

A free standing birth centre will have administrative and organizational protocols which include but are not necessarily limited to the following:

- client registration;
- informed choice;
- admission and discharge processes;
- maintenance of equipment and supply check;
- other services for clients;
- liability insurance;
- confidentiality;
- midwifery emergency back-up.

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References

1. *Philosophy of Midwifery Care in Ontario*
   College of Midwives of Ontario standard, January 1994

2. *The Midwifery Model of Practice*
   College of Midwives of Ontario policy, January 1994
   · revised October 1994

3. *Temporary Alternate Practice Arrangements within the Model of Midwifery Practice*
   College of Midwives of Ontario standard, January 1994

4. *Informed Choice*
   College of Midwives of Ontario standard, December 1994

5. *Indications for Planned Place of Birth*
   College of Midwives of Ontario standard, January 1994

6. *Indications for Mandatory Discussion, Consultation and Transfer of Care*
   College of Midwives of Ontario standard, February 1994
   · revised December 1994

7. *When the Client Requests Care Outside Midwifery Standards of Practice*
   College of Midwives of Ontario standard, January 1994

8. *Equipment, Supplies and Medication*
   College of Midwives of Ontario standard, January 1994

9. *Regulation Made Under the Midwifery Act, 1994: Designated Drugs*
   Regulated Health Professions Act, 1991, proclaimed December 1994

10. *Guidelines for Regulation Made Under the Midwifery Act, 1991: Designated Drugs*
    College of Midwives of Ontario, January 1994

11. *Laboratory Testing*
    College of Midwives of Ontario guideline, January 1994

12. *Diagnostic Imaging*

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APPENDIX A

Joint CMO/CNO/CPSO Document

- *Facility Standards for Free Standing Birth Centres Where Both Midwives and Physicians Provide Primary Care* (▸▸or whatever the name will be)

Ministry of Health

- *Independent Health Facilities Act, 1989*
  - *Regulation 57/92*

Other CMO Documents

- *Clinical Practice Parameters for Free Standing Birth Centres*, College of Midwives of Ontario (▸▸or whatever the name will be)

CNO Documents

- *Clinical Practice Parameters for Nurses Providing Care to Women/Newborns in Birth Centres Where Midwives Provide Primary Care*, CNO, November 3, 1994

- *Clinical Practice Parameters for Nurses Providing Care to Women/Newborns in Birth Centres Where Both Physicians and Midwives Provide Primary Care*, CNO November 3, 1994

CPSO Documents

- *Clinical Practice Parameters for Physicians Providing Primary Care (▸▸and Consulting Services) to Women/Newborns in Birth Centres*, CPSO, ▸▸Draft, November 1994

- *Clinical Practice Parameters & Facility Standards for Physicians Providing Consulting Services and Participating in Transfer of Care of a Woman/Newborn from a Birth Centre Where Midwives Provide Primary Care*, CPSO, June 1994

REMOTE SETTINGS

CMO documents

- *Facility Standards for Free Standing Birth Centres Where Midwives Provide Primary Care*

- *Clinical Practice Parameters for Free Standing Birth Centres*"

CNO document

- *Clinical Practice Parameters for Nurses Providing Care to Women/Newborns in Remote Birth Centres*, CNO, November 3, 1994

CPSO document

- *Clinical Practice Parameters & Facility Standards for Physicians Providing Consulting Services and*

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Chapter 11 Transfer from the Birth Centre (see References)

Overview

A free standing birth centre develops liaisons with local hospitals, consultants and emergency services. Optimum safety is ensured with the maximum cooperation between all health care providers and services including hospitals' emergency services and staff of the birth centre.

Non-emergency Transports

The majority of transports from out of hospital births into hospital are in non-emergency situations. In non-emergencies, consultation and transfer of care may take place via the arrangements the attending midwife has with the hospitals at which she has admitting privileges. At least one midwife at each birth should have privileges to a local hospital. Non-emergency transports will generally not use emergency services.

Emergency Transports

In emergencies, the staff of the free standing birth centre will make every effort to guidelines?accommodate a speedy transfer of care. If a birth centre has emergency transfer arrangements with more than one hospital, staff should ensure transfer to the closest practical hospital occurs. See Sample "*Maternal Consultation*" - *Transfer Record*" Form (CPSO), Appendix C and *Recommended Equipment for Maternal-Fetal Transport by Ambulance* (CPSO), Appendix B.

Guidelines for Maternal/Newborn Transport

These guidelines are identical to those approved by the College of Nurses and the College of Physicians and Surgeons.

In those situation where the health and safety of the woman and/or newborn are at risk, the woman/newborn are offered transfer by the most expeditious means to the receiving facility. If the woman refuses transfer, she confirms this in writing.

In general, transport should be considered when resources immediately available to the woman, fetus or newborn in the birth centre are not adequate to manage anticipated complications.

Policies and procedures are written and in place for the emergency management of the woman/newborn and prior arrangements for the care of the woman/newborn have been made with the receiving health facility in the event of an emergency. These prior arrangements include the designation of who in the birth centre is responsible for contacting the receiving health facility, and who in the receiving health facility is to receive the woman/newborn following transport.

To arrange transfer, the referring health professional contacts the receiving physician at the receiving facility and exchanges information about:

- the presenting problem
- maternal and fetal/newborn well being
- strategies for stabilization or intervention, and
- a plan for transport, including treatment or assessment en route

The referring health professional discusses the situation with the woman and her family, and encourages a supporting person(s) to accompany the woman and/or newborn.

The referring health professional will also accompany the woman/newborn if appropriate.

The receiving facility documents the request for transfer on a standardized form. Information on this form includes:

- woman/newborn name and identifying information
- reason for transfer request
- current condition of the woman/newborn
- decisions regarding treatment and transport
- health professional accompanying woman/newborn

A standardized maternal/newborn transfer form or its equivalent is completed (see Appendix D, *Sample Neo-natal Pre-transport Record.*

Prenatal records and labour records, laboratory and ultrasound assessments and other pertinent records accompany the woman/newborn. If possible, these records are faxed to the receiving facility prior to the transport.

Where possible, treatments as recommended by the receiving physician are instituted.

Emergency equipment to accompany the woman/newborn is available in the birth centre and checked regularly (see Appendix B, *Recommended Equipment for Maternal-Fetal Transport by Ambulance*).

The health professional assesses the woman/fetus/newborn prior to transport including:

- vaginal bleeding
- meconium staining
- temperature, pulse, respiration, blood pressure
- fetal heart rate
- state of membranes
- lie
- presentation
- dilatation of cervix
- uterine contractions - strength, frequency, duration

Frequency of monitoring of vital signs during transit is determined relative to maternal/fetal/newborn condition.

Supplemental inspired oxygen is administered if thought appropriate.

Assessments are documented on the maternal/newborn transfer form.

Note: *In the event of an emergency during transport, the accompanying health professional or ambulance personnel contacts and updates the receiving hospital and/or a more appropriate facility about:*

- *the presenting problem*
- *maternal and fetal/newborn well being*
- *strategies for stabilization or intervention, and*
- *a plan for transport, including treatment or assessment en route*

Contraindication for Transport of Women/Newborns

Contraindications for transport include:

- mother's or newborn's condition is not sufficiently stabilized for transport
- delivery is imminent
- weather conditions hazardous for travel

APPENDIX J

Midwifery Education Program
Curriculum

MIDW 3xxx - Laurentian
MIDWIF - McMaster
MWF 305 - Ryerson

SESSION DATES begins fall 2009

COORDINATOR/TUTORS

COURSE OUTLINE

The focus of Interdisciplinary Maternity Care is on developing skills for interdisciplinary practice; knowledge of other health care providers scopes of practice and roles in the maternity care system, variations of normal during pregnancy, labour and birth, and the postpartum; and common interventions and complications. Students should be able to apply research findings to clinical situations in their placement (MIDW 3xxx, Community Placements: Designated Populations) and in class. Clinical scenarios will be used for tutorial discussions with faculty tutors. Care management competencies will be developed through the use of an on-line care management workbook. 6 credits, Pre-requisite MIDW 2004, Co-requisite MIDW 3xxx (Community Placements: Designated Populations)

COURSE OBJECTIVES

Through participation in on-line synchronous and asynchronous learning activities and related assignments, students will:

1. Apply the principles of informed choice, effective communication, and teaching/counseling.

2. Demonstrate knowledge of the components and organization of maternity care with particular emphasis on variations of normal and common interventions and complications.

3. Demonstrate skills at promoting and preserving normal physiologic birth.

4. Demonstrate an understanding of the principles of interdisciplinary practice and apply them to common midwifery situations.

5. Demonstrate knowledge of the roles and scopes of practice of other health professions and care-providers involved in maternity care.

6. Demonstrate knowledge of the regulations and standards of midwifery practice for intrapartum care and apply them to clinical situations, particularly in situations which involve collaboration or consultation with other health professionals.

7. Demonstrate the acquisition of knowledge about the development and management of variations in normal findings and common abnormal situations in pre, intra, and postpartum care of mother and newborn.

8. Demonstrate knowledge of common emergency situations and their first level management.

COURSE COMPONENTS

On-line and Web-conference Tutorials

Ten on line "classes" explore structured clinical situations. In addition, once per month students gather for a three hour session that involves a clinical check-in where students bring learning issues from their clinical placement course to be explored by the group. Final exams are held at designated sites. ***For the Designated Exam and Tutorial Site Chart please refer to Learnlink.*** You will receive instructions for the webconferencing sessions by email.

Each online "class" focuses on a structured clinical situation which provides an opportunity for students to learn about midwifery care, focusing on common variations and interprofessional collaboration and consultation. Students identify learning issues and objectives for each situation and bring relevant information to class for discussion

This style of case-based (problem-based) learning relies on each student taking responsibility to be prepared and contribute by sharing papers, resources etc. In this way, groups function very much like a midwifery practice group, with students taking professional responsibility for contributing and supporting each other's learning.

The Content outline describes both the specific learning issues for each scenario and the general reflective practice themes.

Students will complete a Care Management Workbook as part of this course.

REQUIRED TEXTS AND RESOURCES

NB. These lists are NOT exhaustive, as there are many additional valuable resources for learning that students are expected to explore as part of their course work (for tutorial discussion and papers). Approximately 75% of exam questions will be based on the following list of core texts and resources.

AOM Clinical Practice Guidelines (available on line).

Baskett, TF. Essential Management of Obstetric Emergencies. 4th ed. Clinical Press Ltd. Bristol, 2004.

Bickley LS, Szilagy,PG. Bates guide to physical examination and history taking. Philadephia: Lippincott Wilkins and Williams; 9th ed. 2005.

Cochrane Library Pregnancy and Childbirth Group (available on line).

College of Midwives of Ontario Registrant's Booklet. Toronto: College of Midwives, (most recent edition).[1]

Cunningham FG, Leveno KJ, Bloom SL, Hauth JC, Gilstrap LC, Wenstrom KD. Williams obstetrics 22nd ed. New York: McGraw-Hill; 2005 (may be online through your university library).

Enkin M, Keirse MJNC, Neilson J, Crowther C, Duley L, Hodnett E, Hofmeyr J. A guide to effective care in pregnancy and childbirth. 3rd ed. Toronto: Oxford University Press; 2000. (available on line - use in conjunction with the online Cochrane Library)

Fraser DM, Cooper MA, editors. Myles textbook for midwives. 14th ed. Edinburgh: Churchill Livingstone; 2003.

Johnson Ruth, Taylor Wendy. Skills for Midwifery Practice. Toronto: Churchill Livingston; 2006.

Riordan J, Breastfeeding and human lactation. 3RD ed. Boston: Jones and Bartlett Publishers; 2004.

Sawchuck D, Sprague A, Trepanier MJ, editors. Fetal Health Surveillance in Labour 3rd ed. Ottawa: The Canadian perinatal regionalization coalition; 2002.

Simkin P, Ancheta RS. Labour progress handbook: early interventions to treat and prevent dystocia. New York: Blackwell Science, 2000.

SOGC Clinical Practice Guidelines (available on line).

Tappero EP, Honeyfield ME. Physical assessment of the newborn: A comprehensive approach to the art of physical examination. 3rd ed. Santa Rosa, CA: NICU Ink; 2003.

N.B. ***Most students will also find it useful to have access to a medical dictionary and a laboratory manual.***

RECOMMENDED TEXTS

American Academy of Family Physicians. Advanced life support on obstetrics (ALSO) course syllabus. American Academy of Family Physicians: Leawood Kansas, 2000.[2]

Association of Ontario Midwives. Emergency skills workbook. Association of Ontario Midwives: Toronto, 2002.

Hale T. Medications and mothers' milk. Latest ed. Amarillo(Texas): Pharmasoft.

[1] The CMO Registrant's binder can be ordered from the College of Midwives of Ontario at admin@cmo.on.ca or visit the website at www.cmo.on.ca. The cost of the binder is $75.00 and a "Registrant Binder Subscription Form" must be completed in order to have one ordered. This document and other CMO documents are available on the website.

[2] The ALSO manual can be purchased by Midwifery Education Program students for $90.00 by emailing Deborah Blois at dblois@cfpc.ca

Health Canada. Family-centred maternity and newborn care: national guidelines. Ottawa: Minister of Public Works and Government Services; 2000. (only available online at www.hc/sc.gc.ca)

Kelnar CJH, Harvey D, Simpson C. The sick newborn baby. Oxford: Oxford University Press; 2007.

Lawrence RA, Lawrence RM. Breastfeeding: a guide for the medical profession. 6th edition. St. Louis: Mosby; 2005.

Pairman S et al. Midwifery: Preparation for Practice. Sydney, Churchill Livingstone; 2006.

Seidel HM, Rosenstein BJ, Pathak A. Primary Care of the Newborn. 3rd ed. Mosby, 2001.

Society of Obstetricians and Gynaecologists of Canada. Advances in labour and risk management (ALARM) course syllabus 14th edition. Society of Obstetricians and Gynaecologists of Canada: Ottawa 2003 (older editions also acceptable).[3]

Woods JR, Woods JLE. Loss during pregnancy or in the newborn period: principles of care with clinical cases and analyses. Pitman (NJ): Jannehi; 1997.

GRADING

This is a graded course.
Students must pass both the

I.Tutorial Participation and Papers:

Participation in tutorials and online discussions	30%
Clinical Issue Paper #1	10%
Clinical Condition Summary (10%) and Informed Choice Discussion (20%)	10%
Clinical Issue Paper #2	10%
Final Examination	40%

II: Self-study Workbook

Midwifery Care Management Workbook 10% each of ten assignment

1. Class Participation

[3] The ALARM manual can be ordered online at http://www.sogc.org/cme/alarm_e.asp. Or by contacting Trisha Cruise, at 613-730-4192 ext 326 or by email at tcruise@sogc.com. The latest edition (14th 2007) is $300.00 members/$750.00 for non-members. Earlier editions may be available at a lower cost.

Criteria for Evaluation:

- responsibility (participates regularily online, comments reflect preparation behavior facilitates the learning of others)
- information (brings new, relevant information to the group, appropriate level of content). Students are expected to know material from the required texts, relevant guidelines and Cochrane summaries, and several journal articles for each class
- communication (able to communicate ideas and information effectively, explanations are clear and concise, listens to others)
- critical analysis (challenges information and ideas appropriately to promote deeper understanding of the topic and reflective practice themes, use of secondary resources)
- self assessment (identifies strengths and areas for improvement and demonstrates effective action to improve, pursues own learning objectives)

2. Written Papers

A. Clinical Issues Papers

From experiences in your previous or concurrent clinical placements, the content outline and the situations presented in class, each student will identify two learning issues that she wants to explore more fully in the two clinical issues papers. Topics should be on the content outline or approved by the tutor. It is customary for students to "share" papers with each other via Learnlink.

Format and Content:

- title page including due date, date submitted, and grace days used
- double spaced and no longer than 1000 words
- brief summary of a client situation that relates to the learning issue
- synthesis of the relevant information obtained about that topic
- discussion of the implications for midwives and the client
- reference list using Vancouver style
- relevant drug cards

Criteria for Evaluation:

- learning issue is related to a tutorial situation or the content outline
- learning issue is related to a client situation encountered in a clinical placement
- knowledge of relevant concepts is appropriately applied to the situation
- presentation is clear and concise, format guidelines are followed
- critical thinking is demonstrated
- midwifery implications show understanding of scope and primary care role of midwifery
- interprofessional relationships are explored and analyzed
- the midwife's role in promoting or preserving normal birth is explored
- information search is organized and there is evidence of a thorough understanding of basic textbooks, relevant Cochrane database, AOM, CMO and SOGC guidelines, and use of at least 5 supplementary resources
- papers may not be rewritten unless specific arrangements are made with the tutor

B. Clinical Summary and Informed Choice Discussion Notes
Students choose a topic relevant to the Midwifery Care II content outline (or by agreement with your tutor). Prepare a one page clinical summary of a clinical condition eg. Prolonged labour or an intervention and a two page set of informed choice notes (maximum 1500 words total) that could serve as your notes for use in the clinical setting when discussing the issue with a client. This paper can be in point form and should be referenced. The informed choice discussion notes should "translate" this information in a way that is in accessible language and that supports the woman to make an informed decision. The College of Midwives Standard on Informed Choice (attached) should be used as a reference and to structure your paper.

Format and Content:
- title page including due date, date submitted, and grace days used
- synthesis of the relevant information obtained about that topic
- 1 page of point form notes which summarize what the midwife needs to know about the clinical condition or intervention. Possible headings will vary depending on the topic, but may include: definitions, incidence, risk factors, midwifery assessments and management, medical assessments and management, indications, contraindications.
- 1-2 pages of point form notes for an informed choice discussion using the CMO Standard on Informed Choice as a guide
- referenced using Vancouver style
- relevant drug cards should be attached

Criteria for Evaluation:
- clear and concise summary of clinical condition
- format guidelines are followed
- critical thinking is demonstrated
- shows understanding of scope and primary care role of midwifery
- shows an understanding of inter-professional practice
- information search is organized and there is evidence of a thorough understanding of basic textbooks, relevant Cochrane database, AOM, CMO and SOGC guidelines, and use of supplementary resources
- informed choice discussion is centered on decision making and uses accessible woman-centered language

Paper Submission
Papers are to be submitted electronically and are due Sept XXX, (Clinical Issue Paper 1), October XXX(CCS/ICD) and November XXX(Clinical Issue Paper 2). Program policies regarding late assignments as outlined in the Student Information Handbook will apply. Students need to ensure that papers have been received, using the LearnLink "history" function or other acknowledgement of receipt function. If late days are used, the grace days used should be noted on the cover page. Papers may not be rewritten unless specific arrangements are made with the tutor.

II. Midwifery Care Management Workbook

This self-study workbook will assist students to consolidate and advance their knowledge base and develop clinical thinking and decision-making skills. It will involve ten layered scenarios, submitted weekly throughout the term. Scenarios are based on the content outline for this course as well as on content covered in second year midwifery courses. Students will have to respond to a clinical situation as it unfolds step by step, make midwifery assessments; determine the "differential diagnosis"; make a care plan with follow up actions; and revise their care plan if necessary. Part of the assignment is to identify the resources used to understand and address clinical situation. Each scenario has a deadline for submission online to the instructor for grading.

This assignment is the equivalent workload of a one term course, therefore students should expect to spend the equivalent of about one day per week working through the scenarios, researching and writing up their response.

III. Written Examinations

Questions will include multiple choice, true/false, and short answer formats and the content will be based on the course objectives and content outline for Midwifery Care II. The examination will integrate content covered in tutorials, the Advanced Clinical Skills 1 Intensive and the workbook. At least 75% of the exam will be based on information from core texts or intensive handouts.

The final examination will be **3 hours** in length. **Students must be off-call from midnight on the last day of placement.**

Students are required to write examinations (midterm and final) at the designated University or College as notified at the beginning of the term. Requests for changes in exam site will be considered as outlined in the Policy and Information Handbook.. Laurentian students registered in the francophone stream will receive a bilingual exam and an additional 25% extra time. A letter with accompanying exam(s) will be sent to the invigilator indicating the extra time.

Program policies apply. See Examination and Presentations section of the P & I Handbook.

Content Outline 09

Prenatal Care:

- Grandmultiparity
- Women with high BMI –care in pregnancy

Labour and Birth:

- Home birth transport
- Levels of hospital care
- Psychosocial aspects of childbirth
- Grand multiparity – implications for 1st, 2nd and 3rd stage
- Caring for women with high BMI –implications for 1st, 2nd and 3rd stage

The first stage of labour

- Group B streptococcus - intrapartum prophylaxis (screening in MWI)
- Precipitous labour and birth (setting up at a fast birth, handling a birth alone, working with EMS)
- Induction of labour –intrapartum management
- Prolonged labour, augmentation
  - Intrapartum management
  - Providing safe care during long labours (midwives' shifts)
  - Role of midwife in monitoring and managing oxytocin
  - Pharmacologic - epidural pain relief, nitrous oxide and narcotics
  - Role of midwife in monitoring and managing labours with epidural
- Maternal fever in labour
- Meconium stained amniotic fluid
- Non-reassuring fetal heart rate patterns–midwifery management and consultation, working with interprofessional team in emergencies

Second stage of labour

- Slow progress in second stage
- Atypical and abnormal fetal heart in second stage –midwifery management including facilitating birth
- Forceps, vacuum delivery
- Episiotomy - indications, methods, complications
- Shoulder dystocia (role of 2nd midwife) - role of 1st and second midwife and working with interprofessional team in emergencies

Third and fourth stage of labour

- Postpartum hemorrhage- role of 1st and second midwife and working with interprofessional team in emergencies
- Repair of perineal trauma

Newborn:

- Resuscitation
- Nuchal cord
- Transient tachypnea of the newborn (TTN)
- Slow to gain (growth patterns)
- Dehydration, prevention of

Postpartum Maternal:

- Postpartum maternal fever
- endometritis
- breast infections
- wound infection
- bladder infection

- Child Protection Act
- Support for breast feeding with slow to gain baby
- Post traumatic stress after childbirth

Professional Issues

- Midwifery clinical decision-making
- Risk management and liability issues
- When clients decline recommendations or choose care outside of the community standard

Inter-professional Practice

- Scope of practice and roles of other maternity care professionals
- Principles of interprofessional practice
- Improving interprofessional relationships
- Contributing to hospital policies and protocols and interprofessional clinical practice guidelines
- Working with interprofessional practice guidelines in a midwifery context
- Participating in hospital committees, rounds etc
- Consultation and transfer of care
- Advocacy for vulnerable women within the health and social service systems
- Advocacy for normal birth and informed choice in maternity care

Draft Schedule

Week	***Situation Submission Date***	***Webconference class***	***Paper Submission Date***
1	# 1 due Sept XX (one week after end of intensive)		
2	Sept (one week later)		CI Paper 1 third Monday Sept
3		Sept XX9-12 Clinical placement check in via Elluminate	
4	3 due Oct XX		CCS/ICD Due 2nd Monday Oct
5	4 due Oct XX		
6	5 due Oct XX		
7		Oct XX 9-12 Clinical placement check in via Elluminate	
8	6 due Nov XX OR		
9	7 Nov		
10	8 Nov		CI Paper 2 due 2nd Monday Nov
11	9 Nov		
12		Nov XX 9-12 Clinical placement check in via Elluminate	
13	10 Dec		
December XX Final Exam (3 hours) 0900 - 1200			

New Course: MIDW 3xxx Advanced Clinical Skills 1 Fall term, third year, 3 credits

Description

This is a short intensive course of 6 days using workshop format to focus on emergency interventions, evidenced based managements of prenatal and intrapartum situations and intermediate level clinical skills required for the provision of full scope midwifery care. The course will use a combination of pre-readings or e-learning modules, short lectures and practical sessions using simulated clinical learning opportunities. The emphasis will be on the development of hands-on clinical skills and knowledge required to act as a primary care provider. The course may use existing course formats such as the Society of Obstetrician and Gynaecologists of Canada ALARM course. The ALARM component of the course may be offered at a separate time from rest of the course in order to meet SOGC requirements for how ALARM may be offered. Issues addressed in the course include fetal monitoring, repair of the perineum, intravenous therapy, advanced skills in pelvic examinations and conducting birth, the newborn in transition, breastfeeding challenges, pharmacological pain relief, induction of labour, and evidence-based management of common complications of pregnancy and labour. This is a graded course.

Rationale

This course will address some of the clinical skills competencies previously included in the now deleted course MIDW 3004. While some of the competencies from that course were added to MIDW 2004, others are best learned after the student has had some exposure to midwifery clinical practice. Additional skills that have not previously been part of the curriculum have been added such as the ALARM course. This is an interdisciplinary course used by midwives, family physicians, obstetricians and nurses. The goal is to prepare the student for both profession-specific and inter-professional practice situations.

MIDW 3xxx EL Community Placements: Designated Populations Fall (or Winter if needed to maximize placement availability – cannot take in the same term as MIDW 3094) 6 credits

Description

This course occurs in the third year of the Program and consists of a series of two to three different placements for a total of 8 weeks (minimum of 30 hours per week, minimum of 2 weeks in any one placement). The objective is to enhance student's understanding of the health and social services system and the social determinants of health relating to childbearing women, babies and their families. Students are required to complete a minimum of 2 weeks in an NICU or pediatric setting where well and complicated infant care is provided. Other placements ought to be focused on the care of women or babies with particular needs based on their context e.g. rural or remote communities, women's shelters, teens, particular cultural groups, incarcerated women/youth. Pre-requisite MIDW 2004, Co-requisite MIDW 3xxx (Interdisciplinary Maternity Care)

Rationale

This course will provide students with clinical practice experiences that have been challenging to provide in our existing placements. Because of the nature of midwifery practice, exposure to newborn and infant complications can be rare, yet the identification and initial care of these complications is a required competency. As the profession of midwifery continues to expand and fill maternity care gaps in the province, students must be exposed to the needs of non-mainstream populations.

MIDW 3xxx

SESSIONAL DATES

Fall term, 2009

Contact Information:

COURSE DESCRIPTION

This course occurs in the third year of the Program and consists of a series of two to three different placements for a total of 8 weeks (minimum of 30 hours per week, minimum of 2 weeks in any one placement). The objective is to enhance student's understanding of the health and social services system and the social determinants of health relating to childbearing women, babies and their families. Students are required to complete a minimum of 2 weeks in an NICU or pediatric setting where well and complicated infant care is provided. Other placements ought to be focused on the care of women or babies with particular needs based on their context e.g. rural or remote communities, women's shelters, teens, particular cultural groups, incarcerated women/youth. Pre-requisite MIDW 2004, Co-requisite MIDW 3xxx (Interdisciplinary Maternity Care)

Placement Requirements:

- The students must choose an NICU/pediatric unit, a newborn clinic or paediatrician placement
- The student may choose from a setting relating to maternity care, women's/infants health issues for populations with particular needs based on their context e.g. rural or remote communities, women's shelters, teens, particular cultural groups, incarcerated women/youth, new immigrant centres
- The student develops their own objectives *(NICU excepted)*, subject to advisor approval

In addition to perinatal care, students may expect to participate in: general health assessments of adults and young children, well women assessments, assessment and treatment of minor gynaecological problems, conception control advice and services; well infant/child assessments and services including parenting issues, immunization and minor illnesses; assessment and care in situations of family/domestic violence and abuse, sexual and family counselling; and community group educational forums.

Neonatal/pediatric Intensive Care Unit Elective Placement Objectives:

1. Observe and participate in the care of newborn infants admitted to an advanced Level 2 or Level 3 NICU. Become familiar with:
    - signs and symptoms of clinical conditions necessitating admission to NICU
    - investigation and management of common conditions seen in NICU (e.g. sepsis, prematurity, hyper-bilirubinemia, TTN/RDS/MAS, hypoglycemia, hypoxia
    - role of the members of the NICU team at high-risk births and in ongoing care of the neonate

2. Assist with the assessment and care of newborns in NICU, including the following:
    - assisting with oral feeding
    - observing screening/diagnostic tests
    - developing familiarity with the equipment used in the NICU to support the neonate (monitors, ventilators, thermal control)
    - understanding and participating in the assessment of vital signs

3. Observe procedures as available, such as:
    - intubation
    - insertion of IV lines
    - calculation and administration of fluids and medications
    - blood sampling
    - resuscitation

4. Gain an understanding of parent involvement in the NICU, for families and the support services available; for example, parent support groups, counselors, medical social work.

5. Develop an understanding of the links and interactions:
    - among members of the NICU interdisciplinary team between the team and the parent
    - among parents, the team, and the midwife

6. Become familiar with resources for bereaved families.

***NB**: **Mt. Sinai Hospital** in Toronto has established objectives for NICU placements (available on LearnLink).*

GRADING

This course is graded on a Pass/Fail basis. The Final grade is determined by the clinical evaluation ("Preceptor Evaluation of Student") that each preceptor uses to assess the student at the end of each placement. Preceptors note whether the student's level of performance was Satisfactory or Unsatisfactory. A satisfactory performance in all three placements is required for a Pass in this course.
There are no written assignments of exams.
Grades will not be submitted until **all** the clinical evaluations have been received.

ACADEMIC DISHONESTY (McMaster University Policy Statement)

Academic dishonesty consists of ***misrepresentation by deception or by other fraudulent means*** and can result in serious consequences, e.g., the grade of zero on an assignment, loss of credit with a notation on the transcript (notation reads "Grade of F assigned for academic dishonesty"), and/or suspension or expulsion from the university.

It is your responsibility to understand what constitutes academic dishonesty. For information on the various kinds of academic dishonesty, please refer to the Academic Integrity Policy, specifically Appendix 3, located at
http://www.mcmaster.ca/senate/academic/ac_integrity.htm

ONLINE BIRTH LOG

Students must use the Online Birth Log to document births attended. (Access the online log via LearnLink or directly access website http://130.113.145.170:8080/midwife/BirthLog.) At the end of **each** community placement the student must print a Completed Course Report that is to be signed by the preceptor. These signed reports must be submitted to the student=s university site at the end of the course.

APPENDIX K

College of Midwives of Ontario
Quality Assurance Regulation

Section 1

Regulation Made under the Midwifery Act, 1991
GENERAL

PART III
QUALITY ASSURANCE

DEFINITIONS AND COMPONENTS OF PROGRAM

6. In this Part,

"assessor" means an assessor appointed under section 81 of the Health Professions Procedural Code;

"Chair" means the Chair of the Quality Assurance Committee;

"Committee" means the Quality Assurance Committee;

"member" means a member who holds a general certificate of registration or a certificate of registration requiring supervision;

"practice group" means, in relation to a member, a group of one or more other members with whom the member is associated and, if the member is not associated with other members, means the member.

7. (1) The quality assurance program of the College shall include the following components:

1. Provision of clinical information.
2. Continuing education and professional development.
3. Peer case review.
4. Quality of care evaluation.
5. Self-assessment.
6. Practice audits.
7. Remediation of behaviour and remarks of a sexual nature.

(2) The quality assurance program shall be administered by the Committee.

(3) The Chair may appoint a panel to carry out any of the powers or functions of the Committee under the Act.

(4) A panel shall consist of at least three people, at least one of whom shall be a person who is not a member and who is appointed to the Committee by the Lieutenant-Governor in Council.

8. (1) Sections 9 to 19 do not apply to a member who has ceased to practise midwifery for at least one year.

(2) The Committee may, upon application, grant an exemption from any of the requirements of sections 9 to 19 to a member by reason of illness or maternity leave or in any other extenuating circumstances.

PROVISION OF CLINICAL INFORMATION

9. (1) Upon request by the Committee, a member shall provide the Committee with information relating to the care given by the member to clients. The information shall be in the form specified by the Committee.

(2) If the Committee so requests, the information provided under subsection (1) shall relate to care given to clients during a specified period of time.

(3) A member shall ensure that clients are not identified in the information provided under subsection (1).

CONTINUING EDUCATION AND PROFESSIONAL DEVELOPMENT

10. (1) A member shall participate in continuing education and other professional development activities for the purpose of maintaining and enhancing the member's knowledge, skill and judgment.

(2) A member shall maintain an annual record of his or her participation in continuing education and professional development activities and shall submit the record to the Committee on request.

(3) The record shall include,

(a) particulars of his or her learning needs as identified by the member; and

(b) the content, date, duration, location and, if applicable, the name of the sponsor of each continuing education and professional development activity engaged in by the member.

(4) The Committee may require the record to be maintained in a form provided by the Committee.

(5) The member shall retain records of continuing education and professional development activities for at least 10 years from the date the member participated in the activities.

PEER CASE REVIEW

11. (1) A member shall participate in at least six peer case reviews in every 12-month period commencing January 1 of each year.

(2) In a peer case review, a group of at least four members belonging to at least two different practice groups meet to discuss clinical care of clients.

(3) A peer case review shall be conducted in accordance with College guidelines published by the College and distributed to members and shall include the following elements:

1. A presentation of a case history and of how the case was managed by one of the members participating in the review.

2. A discussion of the application of College regulations, standards, guidelines and policies to the case.

3. The observations and feedback of the participants.

(4) A member shall maintain an annual peer case review record in which the member records the names of the members who carried out each peer case review and the date and duration of each review. The record shall be submitted to the Committee on request.

(5) A member shall keep the peer case review record for at least 10 years from the date the review was held.

QUALITY OF CARE EVALUATION

12. (1) A member shall provide every client with a quality of care evaluation form within six months of being discharged from care and request that the client complete the form and return it to the member's practice group.

(2) The evaluation form shall not identify the client.

(3) A member shall make a record of any action taken in response to a client's evaluation and shall submit the record to the College on request.

(4) The Committee may require that the quality of care evaluation form and the form of the record of action taken be in a form provided by the Committee.

(5) A member shall retain a completed evaluation form for at least 10 years from the date the evaluation form is returned to the member's practice group.

(6) A member shall retain the record of action taken in response to a client's evaluation for at least 10 years from the date the action was taken.

SELF-ASSESSMENT

13. (1) At the request of the Registrar, a member shall complete a self-assessment questionnaire provided by the Committee and return it to the College.

(2) A member who fails to return a completed self-assessment questionnaire to the College when requested to do so by the Registrar shall, if so required by the Committee, participate in a practice audit.

PRACTICE AUDIT

14. (1) Each year, the College shall select at random the names of members required to undergo a practice audit.

(2) A member shall undergo a practice audit by an assessor if his or her name is selected at random and the College may require a member to undergo a practice audit if the member has failed to return a completed self-assessment questionnaire under subsection 13 (2).

15. A practice audit shall be conducted by an assessor and may include,

(a) requiring a member to provide the assessor with such forms and other documents used in the member's practice;

(b) an examination of the member's client records; and

(c) an interview with the member.

16. (1) An assessor shall, within a period of time specified by the Committee, provide a written report of a practice audit to the Committee and to the member whose practice was the subject of the audit.

(2) The member whose practice was the subject of a practice audit may make written representations to the Committee within 14 days of receiving the written report of the practice audit.

17. (1) After considering the report and any representations made by the member, the Committee may decide,

(a) that no action is required;

(b) subject to section 19, to require the member to undertake the remediation or other action specified by the Committee to correct any deficiency disclosed by the practice audit; or

(c) to refer the member to the Executive Committee.

(2) After the member has had an opportunity to undertake the remediation or other action specified, the Committee may require the member to undergo a follow-up practice audit.

(3) The Committee shall not require that a member undergo more than one follow-up practice audit.

18. (1) Subject to section 19, the Committee may direct the Registrar to impose terms, conditions or limitations on a member's certificate of registration for a specified period not exceeding six months if the member's knowledge, skills and judgment are found to be unsatisfactory and,

(a) the member fails to undertake the remediation or other action specified by the Committee; or

(b) the member fails to successfully complete the remediation or other action specified by the Committee.

(2) If the Registrar imposes terms, conditions or limitations on a member's certificate of registration for a specified period pursuant to a direction given by the Committee under subsection (1), the Committee may direct the Registrar to remove the terms, conditions or limitations before the end of the specified period if the Committee is satisfied that the deficiency has been remedied.

19. If the Committee proposes to require a member to undertake remediation under section 17 or to direct the Registrar to impose terms, conditions or limitations on the member's certificate of registration under section 18, the Committee shall give the member written notice of the proposal and at least 14 days from the receipt of the notice to make written representations to the Committee. The Committee shall consider any representations made by the member before making a final decision under section 17 or 18.

REMEDIATION OF BEHAVIOUR AND REMARKS OF A SEXUAL NATURE

20. Sections 21 to 24 apply to matters relating to sexual abuse as defined in clause 1 (3) (c) of the Health Professions Procedural Code that are referred to the Committee by,

(a) the Complaints Committee, pursuant to paragraph 4 of subsection 26 (2) of the Health Professions Procedural Code; and

(b) the Executive Committee, pursuant to section 79.1 of the Health Professions Procedural Code.

21. (1) If a matter referred to in section 20 in respect of a member is referred to the Committee, the Committee shall require the member to undergo a psychological or other assessment to determine whether the member should undergo therapy, counselling, education or other specified measures.

(2) The person conducting the assessment shall provide a written report of the results of the assessment to the Committee and shall make such recommendations as he or she considers appropriate.

(3) The Committee shall give the member a copy of the report and recommendations together with a notice informing the member of the right to make a written submission respecting the recommendations in accordance with subsection 22 (2).

(4) After considering the report and recommendations and a submission made by the member, if any, the Committee may require the member to attend or participate in an education, counselling or therapy program or to take such other measures as may be specified by the Committee.

(5) If the member refuses to undergo an assessment as required under this section, to attend or participate in a program or to take any other measure specified by the Committee, the Committee may, subject to subsection 22 (3), direct the Registrar to

impose specified terms, conditions or limitations on the member's certificate of registration for a specified period of up to six months.

22. (1) A member has the right to make a written submission to the Committee,

(a) before the Committee requires the member to attend or participate in a program or to take any other measure specified by the Committee under subsection 21 (4); and

(b) before the Committee makes a direction under subsection 21 (5).

(2) The member shall be given at least 14 days from the day the member receives the report and recommendations under subsection 21 (3) to make written submissions to the Committee.

(3) The Committee shall give the member notice of its intention to make a direction under subsection 21 (5) and at least 14 days from the date the member receives the notice to make written submissions to the Committee.

23. The Committee shall direct the Registrar to remove the terms, conditions or limitations imposed on the member's certificate of registration under subsection 21 (5) before the end of the specified period if the Committee is satisfied that the terms, conditions or limitations are no longer needed.

24. If a term, condition or limitation has been imposed on a member's certificate of registration for a specified period under subsection 21 (5) and, at the end of the period, the member continues to refuse to undergo an assessment, to attend or participate in a program or to take any other measure specified by the Committee, the Committee shall refer the matter to the Executive Committee.

Regulation approved March 1999.

APPENDIX L

Canadian Midwifery
Regulators Consortium
Canadian Competencies
for Midwives

CANADIAN COMPETENCIES FOR MIDWIVES

Please note that while in this document we have used the generic feminine pronouns, the terms "midwife" and "midwives" are meant to include both male and female midwives.

PREAMBLE:

This document, *Canadian Competencies for Midwives* has been developed for two reasons: to provide a base for the development of national assessment processes and to provide information to internationally-educated midwives about what Canadian midwives are expected to know and do. This document outlines the knowledge and skills expected of an entry-level midwife in Canada. Entry level midwives are defined as those who have been assessed as eligible to start practising in Canada, after they meet provincial/territorial requirements, in the full scope of practice and without supervision requirements on their registration.

The *Canadian Competencies for Midwives* is compatible with provincial/territorial competency statements but it does not replace them. Since midwifery in Canada is regulated by province or territory, provincial/territorial competency documents take precedence over this national document and are the ultimate source of information about what a midwife is expected to know and do in any specific province or territory. There is a high degree of similarity in the entry-level competencies required by the various Canadian jurisdictions regulating midwifery. However, some additional competency requirements can be found in provincial and territorial documents.

CANADIAN MODEL OF MIDWIFERY PRACTICE:

While there are provincial/territorial differences in how midwifery is legislated, organized, and practised, the basic model of midwifery practice is the same across all regulated jurisdictions in Canada. Midwives provide care from early pregnancy through to at least six-weeks postpartum to women and their infants. The description below provides context for the competencies outlined in this document.

Health and Well-being

Midwifery care in Canada is based on a respect for pregnancy and childbirth as normal physiological processes. Midwives promote wellness in women, babies, and families, taking the social, emotional, cultural and physical aspects of a woman's reproductive experience into consideration.

Informed Choice

Canadian midwives respect the right of women to make informed choices about all aspects of their care. Midwives actively encourage informed decision-making by providing women with complete, relevant, and objective information in a non-authoritarian manner.

Autonomous Care Providers

Canadian midwives are fully responsible for the provision of primary health services within their scope of practice, making autonomous decisions in collaboration with their clients[1]. When midwives identify conditions requiring care that is outside of their scope of practice, they make referrals to other care providers and continue to provide supportive care. Midwives collaborate with other health professionals in order to ensure that their clients receive the best possible care.

Continuity of Care

Canadian midwives are committed to working in partnership with the women in their care. Midwives spend time with their clients in order to build trusting relationships and provide individualized care. Individual or small groups of midwives provide continuity of care to women throughout pregnancy, labour, birth, and up to at least six weeks postpartum. A midwife known to the woman is available on-call throughout her care.

Choice of Birth Setting

Canadian midwives respect the right of each woman to make an informed choice about the setting for her birth. Midwives must be competent and willing to provide care in a variety of settings, including home, birth centres, and hospitals.

Evidence-based Practice

Canadian midwives are expected to stay up-to-date with regard to research on maternity care issues, to critically appraise research, and to incorporate relevant findings into their care.

[1] Clients are women who have contracted to work with and receive care from a specific midwife or midwives.

I. GENERAL COMPETENCIES

A. The entry level midwife should have the knowledge and skills to:

1. provide care and advice to the woman and her family during pregnancy, labour, birth and the postpartum period;
2. exercise appropriate clinical judgment as an autonomous primary-care provider;
3. provide culturally appropriate and sensitive care;
4. provide education, health promotion and counseling related to childbearing, parenthood, and family planning for the woman, her family and the community;
5. facilitate informed decision making by providing the woman with both time and the necessary information to make choices during pregnancy, labour, birth and the postpartum period;
6. communicate effectively with the woman, her family and her support people;
7. develop, implement and evaluate, with the woman, an individualized plan for midwifery care;
8. provide continuity of care throughout the childbearing cycle;
9. assist the woman and her family in planning for an appropriate place of birth
10. provide care in a variety of out-of-hospital and in-hospital settings;
11. promote normal birth;
12. conduct births and care for the woman and the newborn on her own responsibility;
13. identify risk factors before and during pregnancy, labour, birth and the postpartum period; take appropriate action; and/or consult or refer as appropriate;
14. order, perform and interpret results of screening and diagnostic tests in accordance with provincial/territorial regulations and standards;
15. prescribe, order and administer pharmacologic agents in accordance with provincial/territorial regulations and standards;
16. recognize abnormal conditions, recommend and initiate treatment and/or consult or refer as appropriate;
17. critically review, appraise and apply new information, including research findings, relevant to midwifery practice;
18. provide information about care alternatives including options, risks and benefits, and assist client decision-making;
19. use technology appropriately;
20. use emergency measures when necessary;
21. limit the spread of disease by using appropriate infection control measures;
22. establish and maintain comprehensive, relevant and confidential records;
23. provide care consistent with the philosophy and ethics of midwifery care in Canadian jurisdictions;
24. assist the woman and her family to access appropriate community resources;
25. act as an advocate for the client in all aspects of her care.
26. communicate the scope of practice of a registered midwife, including limitations of practice.

SPECIFIC COMPETENCIES

II. EDUCATION AND COUNSELLING

A. The entry level midwife should have the knowledge of:

1. the principles and processes of informed decision-making;
2. the principles of adult education, communication and counseling;
3. theoretical approaches to prenatal and early parenting education;
4. the impact of life experiences on childbearing and early parenting;
5. historical, social and cultural influences on childbearing and early parenting;
6. issues related to abuse and discrimination;
7. issues related to grief and loss.

B. The entry level midwife should have the ability to:

1. be present with and attentive to the woman throughout her childbearing experience;
2. assess the well-being of the woman in the context of her family and community and provide her with information, education and support according to her needs;
3. facilitate the process of informed decision-making,
4. utilize a broad range of communication skills including reflective listening;
5. provide prenatal and early parenting education to enhance the woman's confidence and competence in childbearing and parenting;
6. assist the woman and her family in planning and preparing for the birth experience and early parenting;
7. facilitate integration of the birth experience(s) for the woman and her family;
8. provide information and resources to the woman and her family regarding self-care, normal postpartum progress, including its emotional and psychological aspects, and signs and symptoms of common postpartum complications;
9. provide information and resources to the woman and her family regarding infant growth, development, behaviour, nutrition, feeding and care, including the benefits and practice of breastfeeding.
10. counsel and support the woman and her family in responding to grief and loss during childbearing.

III. ANTEPARTUM CARE

A. The entry level midwife should have the knowledge of:

1. general anatomy and physiology including detailed knowledge of the reproductive systems;
2. physical, emotional, sexual and social factors and changes associated with pregnancy, including those likely to influence its outcome;
3. genetics, embryology and fetal development and their implications;
4. nutritional requirements during pre-conception and pregnancy;
5. the management of common discomforts of pregnancy;

6. methods for diagnosing pregnancy, establishing due date, and assessing gestational age and the progress of pregnancy;
7. screening and diagnostic tests available during pregnancy;
8. common substances and therapies used during pregnancy and their effects, side-effects and interactions;
9. environmental, occupational, biologic and pharmacologic hazards to the woman and the fetus;
10. variations of normal and abnormalities which may occur during pregnancy;
11. infections prior to and during pregnancy and their implications;
12. principles and procedures for responding to fetal malpresentation, such as external cephalic version.

B. The entry level midwife should have the ability to:

1. obtain a comprehensive health history, including both medical and psychosocial information;
2. assess nutritional intake and provide or recommend counselling as appropriate;
3. address common discomforts associated with pregnancy;
4. recommend appropriate therapies which may be used during pregnancy;
5. perform a complete physical examination of the woman;
6. perform ongoing physical assessments of the woman during pregnancy to detect abnormalities, and initiate treatment and/or consult or refer as appropriate;
7. perform a vaginal exam and assess the soft and bony structures of the pelvis, uterine size, shape, consistency and mobility, and cervical and vaginal health;
8. perform a speculum exam to assess cervical and vaginal health and obtain the necessary specimens to determine the presence of sexually transmitted infections, vaginal infections and cytological changes;
9. perform venipuncture and capillary puncture;
10. confirm pregnancy;
11. perform abdominal palpation and fundal height measurement to assess uterine size, fetal position and presentation, and to estimate fetal size, number, and gestational age;
12. assess fetal well being through such methods as fetal heart auscultation and evaluation of fetal movement.

CARE DURING LABOUR, BIRTH AND THE IMMEDIATE[2] POSTPARTUM PERIOD

IV. Intrapartum Care –

A. The entry level midwife should have the knowledge of:

1. the normal process of labour including the mechanisms of labour and birth;

[2] In this document the CMRC uses the word "immediate" to refer to the hours immediately after the birth when the midwife is providing care until mother and newborn are stable. In some Canadian jurisdictions the word "immediate" is also used in legislation to refer to the complete six-week postpartum period. Use of this definition of the word "immediate" here is not intended to contradict that broader definition.

2. maternal pelvic anatomy and anatomy of the fetal skull and its landmarks as relevant to assessing fetal position and the progress of labour;
3. physiologic changes associated with the transition from fetus to newborn;
4. indicators of maternal and fetal well-being;
5. requirements for a safe birthing environment;
6. comfort and support measures for labour and birth;
7. physiologic methods to facilitate labour;
8. normal variations and abnormalities of the fetal heart rate and methods of assessing the fetal heart in labour;
9. the principles of clean and aseptic technique and universal precautions;
10. the significance of ruptured membranes and methods for reducing risks of infection;
11. abnormalities of labour, birth and the immediate postpartum period;
12. prevention, assessment and management of exhaustion, dehydration and ketonuria during labour;
13. techniques to prevent and reduce perineal trauma;
14. indications and procedure for episiotomy;
15. indications and procedure for repair of lacerations and episiotomy;
16. prevention, recognition and management of postpartum hemorrhage;
17. pharmacological agents and other substances and therapies used during the intrapartum period;
18. emergency measures, obstetrical procedures and interventions;
19. neonatal resuscitation and stabilization.

B. The entry level midwife should have the ability to:

1. provide emotional and physical support to the labouring woman and her support people;
2. assess the onset and progress of labour and take appropriate actions;
3. recognize variations of normal and abnormal labour patterns and identify probable causes and potential interventions when indicated;
4. assess the fetal heart with a fetoscope, doppler and electronic fetal monitor, interpret findings and take action when appropriate;
5. determine status of the membranes and perform amniotomy when indicated;
6. assess amniotic fluid;
7. assess the bladder and perform urinary catheterization as necessary;
8. assess the need for pharmacologic and non-pharmacologic measures during labour, birth and the immediate postpartum period;
9. prescribe, order and administer pharmacologic agents as necessary in the intrapartum in accordance with provincial/territorial regulations and standards;
10. administer injections and inhalants, insert intravenous catheters and administer intravenous fluids and medications in accordance with the provincial/territorial regulations and standards;
11. protect the perineum, avoid unnecessary episiotomy and minimize lacerations;
12. perform an episiotomy when indicated;
13. assist and support the spontaneous vaginal birth of the baby;

14. recognize signs of separation of the placenta; assist in the delivery of, and inspect the placenta;
15. collect cord blood samples;
16. examine the perineal and vulval areas for lacerations, hematomas and abrasions and repair lacerations and episiotomies in accordance with provincial/territorial regulations and standards;
17. prevent, recognize and manage postpartum hemorrhage and maternal shock;
18. recognize maternal and newborn complications and initiate emergency measures as required;
19. provide immediate assessment and care of the newborn, including assessment of respiratory and cardiac status and temperature maintenance;
20. support the newborn's transition immediately following the birth;
21. perform neonatal resuscitation according to provincial/territorial regulations and standards;
22. assist and support the early initiation of breastfeeding.

V. CARE OF THE WOMAN DURING THE POSTPARTUM PERIOD, INCLUDING BREASTFEEDING

A. The entry level midwife should have the knowledge of:

1. maternal anatomy and physiology in the postpartum period, and the normal progress of the postpartum period;
2. anatomy of the breast, physiology of lactation and principles of effective breastfeeding, including the normal process and necessary conditions and factors for its success;
3. management of common discomforts of the postpartum period;
4. postpartum complications, including complications of breastfeeding, and their management;
5. emotional, psychological, social, cultural and sexual aspects of the postpartum period, breastfeeding and early parenting;
6. nutritional requirements of women during the postpartum period, including for lactation;
7. the health benefits of breastfeeding for mother and infant;
8. the influence of environmental, occupational, and biological factors on breastfeeding;
9. pharmacological agents and other substances and therapies used during the postpartum period and their effect on breastfeeding;
10. stimulation and suppression of lactation;
11. family planning, methods of contraception and their risks and benefits.

B. The entry level midwife should have the ability to:

1. assess the health and monitor the progress of the woman in the postpartum period;
2. assist the mother to establish and maintain breastfeeding, or her alternate chosen method of infant feeding;

3. identify special or abnormal maternal or infant situations that may influence breastfeeding, and develop an appropriate plan;
4. use appropriate therapies to support effective breastfeeding;
5. facilitate the introduction of the new family member;
6. recognize postpartum complications, including postpartum depression, and take appropriate action, including consulting or referring when indicated;
7. prescribe, order and administer appropriate pharmacologic agents as necessary in the postpartum period in accordance with provincial/territorial regulations and standards;
8. conduct a six week postpartum assessment of the woman, including vaginal and speculum examination where appropriate;
9. counsel clients in decision-making and use of contraceptive methods;
10. provide appropriate referrals for ongoing care;
11. facilitate the closure of the midwife-woman relationship.

VI. CARE OF THE NEWBORN AND THE YOUNG INFANT

A. The entry level midwife should have the knowledge of:

1. anatomy and physiology of the newborn;
2. newborn assessment, including gestational age assessment;
3. growth and development of the healthy newborn;
4. the nutritional needs of the newborn including properties of breast milk and infant formula, and methods of infant feeding;
5. newborn screening and diagnostic testing;
6. abnormal conditions in the newborn;
7. prophylactic medications commonly administered to the newborn;
8. effects of prescriptive and non-prescriptive substances on the newborn, including those excreted through the breast milk;
9. environmental, biological and pharmacologic hazards to the newborn;
10. the physical and emotional needs of the newborn including appropriate safety considerations;
11. issues related to circumcision.

B. The entry level midwife should have the ability to:

1. perform a complete physical examination of the newborn;
2. provide ongoing newborn care and assessment of well-being and development;
3. recognize complications in the newborn and make appropriate referrals as necessary;
4. administer medications and immunizations to the newborn according to provincial/territorial regulations and standards;
5. perform a heel puncture to obtain blood samples;
6. provide information to parents regarding available public health and community resources, and make appropriate referrals for ongoing care.

VII. WELL WOMAN CARE, SEXUALITY AND GYNECOLOGY

A. The entry level midwife should have the knowledge of:

1. physiological and psychosocial components of human sexuality in general and during the childbearing cycle;
2. physiological and psychosocial aspects of human fertility;
3. normal reproductive health and signs and symptoms of pathology;
4. factors involved in women's responses to pregnancy, and resources for counseling and referral, including for women seeking termination.

B. The entry level midwife should have the ability to:

1. assess the woman's reproductive and sexual health;
2. provide well-woman care according to provincial/territorial regulations and standards;
3. inform and advise clients on issues of human sexuality, fertility and unplanned pregnancies, and make referral where appropriate;
4. support a woman seeking termination of pregnancy and make referrals when requested;
5. provide information on various methods of contraception.

VIII. PROFESSIONAL, INTER-PROFESSIONAL, LEGAL AND OTHER ASPECTS OF THE PROFESSION

A. The entry level midwife should have the knowledge of:

1. current issues in midwifery at local, provincial, national and international levels;
2. the general structures and principles of the Canadian health care system;
3. legislation and public health policies and procedures relevant to midwifery nationally and in the province/territory in which she practises;
4. the history and philosophy of the midwifery profession in Canada;
5. the structure and function of professional and regulatory midwifery organizations in Canada;
6. community standards of care and the roles and responsibilities of other health care providers and their scopes of practice in the province/territory in which she practises;
7. the process of teambuilding and engaging in professional and inter-professional partnerships;
8. legal requirements of midwifery practice, including those respecting privacy and freedom of information, informed consent and informed choice, recording and reporting, and provincial/territorial data collection requirements;
9. the code of ethic, regulations and standards for midwifery in the province/territory in which she practises.

B. The entry level midwife should have the ability to:

1. work in a collegial manner with other caregivers in a variety of settings;

2. communicate and collaborate effectively and professionally with midwifery colleagues, students and other caregivers;
3. practise in accordance with provincial/territorial codes of ethics and other ethical frameworks and standards guiding midwifery practice.

IX. PROFESSIONAL DEVELOPMENT

A. The entry level midwife should have knowledge of:

1. methods for assessing statistical evidence and critically appraising the research literature;
2. continuing education and quality assurance programs and requirements for the ongoing evaluation of midwifery practice;
3. midwifery practice management.

B. The entry level midwife should have the ability to:

1. engage in reflective practice;
2. share midwifery knowledge and participate in midwifery-related research;
3. recognize her personal and professional boundaries and limitations, practise appropriate self-care, and seek support when needed.

ADVANCED COMPETENCIES:

There are a number of advanced competencies that midwives in Canada may perform in certain jurisdictions and/or in certain circumstances, when provincial/territorial regulations and standards allow it. A few of the competencies that are considered "advanced" in one jurisdiction are considered "entry-level" in another. Currently there is no agreement on advanced competencies and this remains an area of difference between Canadian provinces and territories. There is, however, some initial discussion at a national level with regards to how advanced competencies may be recognized. It is expected that this discussion will continue and may result in a national statement regarding advanced competencies.

These advanced competencies include but are not limited to:

1. epidural monitoring;
2. application of scalp electrodes;
3. pharmacologic augmentation of labour;
4. induction of labour for post-dates pregnancy;
5. performing vacuum extraction;
6. first surgical assist at cesarean sections;
7. suturing of 3rd degree tears;
8. evacuation of the uterus;
9. fitting barrier methods of contraception;
10. prescribing contraceptives;
11. inserting umbilical vein catheters in the newborn;
12. providing well-baby care after six weeks postpartum and to healthy newborns in general;
13. providing well-woman care after six weeks postpartum and to healthy women in general.

APPENDIX M

Provincial/Territorial
Midwifery Regulations

Français

Midwifery Act, 1991

S.O. 1991, CHAPTER 31

Consolidation Period: From June 4, 2007 to the e-Laws currency date.

Last amendment: 2007, c. 10, Sched. B, s. 13.

Definitions

1. In this Act,

"College" means the College of Midwives of Ontario; ("Ordre")

"Health Professions Procedural Code" means the Health Professions Procedural Code set out in Schedule 2 to the *Regulated Health Professions Act, 1991*; ("Code des professions de la santé")

"member" means a member of the College; ("membre")

"profession" means the profession of midwifery; ("profession")

"this Act" includes the Health Professions Procedural Code. ("la présente loi") 1991, c. 31, s. 1.

Health Professions Procedural Code

2. (1) The Health Professions Procedural Code shall be deemed to be part of this Act. 1991, c. 31, s. 2 (1).

Terms in Code

(2) In the Health Professions Procedural Code as it applies in respect of this Act,

"College" means the College of Midwives of Ontario; ("ordre")

"health profession Act" means this Act; ("loi sur une profession de la santé")

"profession" means the profession of midwifery; ("profession")

"regulations" means the regulations under this Act. ("règlements") 1991, c. 31, s. 2 (2).

Definitions in Code

(3) Definitions in the Health Professions Procedural Code apply with necessary modifications to terms in this Act. 1991, c. 31, s. 2 (3).

Scope of practice

3. 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. 1991, c. 31, s. 3.

Authorized acts

4. In the course of engaging in the practice of midwifery, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

1. Managing labour and conducting spontaneous normal vaginal deliveries.
2. Performing episiotomies and amniotomies and repairing episiotomies and lacerations, not involving the anus, anal sphincter, rectum, urethra and periurethral area.
3. Administering, by injection or inhalation, a substance designated in the regulations.
4. Putting an instrument, hand or finger beyond the labia majora during pregnancy, labour and the post-partum period.
5. Taking blood samples from newborns by skin pricking or from women from veins or by skin pricking.
6. Inserting urinary catheters into women.
7. Prescribing drugs designated in the regulations. 1991,c. 31, s. 4.

College established

5. The College is established under the name College of Midwives of Ontario in English and Ordre des sages-femmes de l'Ontario in French. 1991, c. 31, s. 5.

Council

6. (1) The Council shall be composed of,

(a) at least seven and no more than eight persons who are members elected in accordance with the by-laws;

(b) at least five and no more than seven persons appointed by the Lieutenant Governor in Council who are not,

(i) members,

(ii) members of a College as defined in the *Regulated Health Professions Act, 1991*, or

(iii) members of a Council as defined in the *Regulated Health Professions Act, 1991*. 1991, c. 31, s. 6 (1); 1998, c. 18, Sched. G, s. 36 (1).

Who can vote in elections

(2) Subject to the by-laws, every member who practises or resides in Ontario and who is not in default of payment of the annual membership fee is entitled to vote in an election of members of the Council. 1991, c. 31, s. 6 (2); 1998, c. 18, Sched. G, s. 36 (2).

President and Vice-President

7. The Council shall have a President and Vice-President who shall be elected annually by the Council from among the Council's members. 1991, c. 31, s. 7.

Restricted titles

8. (1) No person other than a member shall use the title "midwife", a variation or abbreviation or an equivalent in another language. 1991, c. 31, s. 8 (1).

Representations of qualification, etc.

(2) No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a midwife or in a specialty of midwifery. 1991, c. 31, s. 8 (2).

Exception for aboriginal midwives

(3) An aboriginal person who provides traditional midwifery services may,

(a) use the title "aboriginal midwife", a variation or abbreviation or an equivalent in another language; and

(b) hold himself or herself out as a person who is qualified to practise in Ontario as an aboriginal midwife. 1991, c. 31, s. 8 (3).

Definition

(4) In this section,

"abbreviation" includes an abbreviation of a variation. 1991, c. 31, s. 8 (4).

Notice if suggestions referred to Advisory Council

9. (1) The Registrar shall give a notice to each member if the Minister refers to the Advisory Council, as defined in the *Regulated Health Professions Act, 1991*, a suggested,

(a) amendment to this Act;

(b) amendment to a regulation made by the Council; or

(c) regulation to be made by the Council. 1991, c. 31, s. 9 (1).

Requirements re notice

(2) A notice mentioned in subsection (1) shall set out the suggestion referred to the Advisory Council and the notice shall be given within thirty days after the Council of the College receives the Minister's notice of the suggestion. 1991, c. 31, s. 9 (2).

Offence

10. Every person who contravenes subsection 8 (1) or (2) is guilty of an offence and on conviction is liable to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence. 2007, c. 10, Sched. B, s. 13 (1).

Regulations

11. (1) Subject to the approval of the Lieutenant Governor in Council and with prior review by the Minister, the Council may make regulations,

(a) designating the substances that may be administered by injection or inhalation by members in the course of engaging in the practice of midwifery;

(b) designating the drugs that may be prescribed by members in the course of engaging in the practice of midwifery;

(c) specifying the drugs that a member may use in the course of engaging in the practice of midwifery. 2007, c. 10, Sched. B, s. 13 (2).

Individual drugs or categories

(2) A regulation made under clause (1) (b) or (c) may designate or specify individual drugs or categories of drugs. 2007, c. 10, Sched. B, s. 13 (2).

12., 13. REPEALED: 2007, c. 10, Sched. B, s. 13 (3).

14. OMITTED (PROVIDES FOR COMING INTO FORCE OF PROVISIONS OF THIS ACT). 1991, c. 31, s. 14.

15. OMITTED (ENACTS SHORT TITLE OF THIS ACT). 1991, c. 31, s. 15.

Français

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MIDWIVES REGULATION

Definitions

1. In this regulation

"aboriginal" means relating to the Indian, Inuit or Métis peoples of Canada;

"aboriginal midwifery" means

(a) traditional aboriginal midwifery practices such as the use and administration of traditional herbs and medicines and other cultural and spiritual practices,

(b) contemporary aboriginal midwifery practices which are based on, or originate in, traditional aboriginal midwifery practices, or

(c) a combination of traditional and contemporary aboriginal midwifery practices;

"reserve" means a reserve as defined in the *Indian Act.*

Designation

2. (1) Midwifery is designated as a health profession.

(2) The "College of Midwives of British Columbia" is the name of the college established under section 15 (1) of the *Health Professions Act* for midwifery.

Reserved title

3. No person other than a registrant may use the title "midwife".

Scope of practice

4. (1) Subject to the bylaws, registrants may

(a) assess, monitor, and care for women during normal pregnancy, labour, delivery and the postpartum period,

(b) counsel, support and advise women during pregnancy, labour, delivery and the postpartum period,

(c) manage spontaneous normal vaginal deliveries,

(d) care for, assess and monitor the healthy newborn, and

(e) provide advice and information regarding care for newborns and young infants and deliver contraceptive services during the 3 months following birth.

(2) Subject to the bylaws, aboriginal registrants may practise aboriginal midwifery.

Reserved acts

5. (1) Subject to section 14 of the *Health Professions Act*, no person other than a registrant may, for the purposes of midwifery,

(a) conduct internal examinations of women during pregnancy, labour, delivery and the postpartum period,

(b) manage spontaneous normal vaginal deliveries,

(c) perform episiotomies and amniotomies during established labour and repair episiotomies and simple lacerations,

(d) prescribe, order or administer drugs and substances specified in Schedule 1 to this regulation, and

(e) order, collect samples for, perform or interpret the results and reports of screening and diagnostic tests specified in Schedule 2 to this regulation.

(2) Subsection (1) does not apply on a reserve to an aboriginal person who practised aboriginal midwifery prior to the coming into force of this regulation.

Limitations on practice

6. (1) Registrants must

(a) advise clients to consult a medical practitioner for a medical examination during the first trimester of pregnancy,

(b) consult with a medical practitioner regarding any deviations from the normal course of pregnancy, labour, delivery and the postpartum period that indicate pathology and transfer responsibility when necessary,

(c) consult with a medical practitioner if the result or report of a test in item 4 of Schedule 2 is abnormal.

(1.1) A registrant may

(a) prescribe or administer a substance in item, 1 (2) of Schedule 1 only for intrapartum chemoprophylaxis for Group B strep,

(b) prescribe or administer a substance in item 1 (3) of Schedule 1 only for therapeutic rest in prodromal labour,

(c) order and administer a drug in item 2 of Schedule 1 only in emergency conditions and in consultation with a medical practitioner, and

(d) administer a drug in item 3 of Schedule 1 only after consulting with and on the order of a medical practitioner.

(2) and (3) Repealed

Patient relations program

7. The College of Midwives is designated for the purposes of section 16 (2) (f) of the *Health Professions Act*.

Section Spent

8. Spent.

Schedule 1 – Midwives Regulation
June 21, 2007

Schedule 1 - DRUGS AND SUBSTANCES

1. (1) A midwife may prescribe or administer the following substances:

Cephalexin
Chloroprocaine - 2%
Clindamycin
Clotrimazole
Diphenhydramine hydrochloride - IM
Domperidone
Doxylamine succinate-pyridoxine hydrochloride
Ergonovine maleate
Erythromycin ophthalmic ointment
Hepatitis B immune globulin
Hepatitis B vaccine
Hydrocortisone anorectal therapy compound
Intravenous fluids - normal saline, Ringer's Lactate, 5% dextrose in water
Lidocaine hydrochloride without epinephrine - 1%
Measles / Mumps / Rubella (MMR) Vaccine
Miconazole
Misoprostol (po or pr)
Mupirocin-clotrimizole-nystatin-betamethasone
Nystatin
Oxytocin - IV or IM injection
Phytonadione
PregVit Prenatal/Postpartum Vitamin-Mineral Supplement
Pre-mixed 50/50 nitrous oxide and oxygen
RhD Immune globulin
Therapeutic oxygen
Triamcinolone –neomycin sulphate- nystatin – gramicidin (Kenacomb)
Triple dye

(2) Subject to section 6 (1.1) (a) of the regulation, a midwife may prescribe or administer the following substances:

Ampicillin
Cefazolin
Penicillin G
Vancomycin

2. Subject to section 6 (1.1) (c) of the regulation, a midwife may order and administer the following drugs:

    Carboprost tromethamine
    Epinephrine hydrochloride
    Naloxone hydrochloride
    Nitroglycerin

3. Subject to section 6 (1.1) (d) of the regulation, a midwife may order and administer the following drugs:

    Acetominophen with codeine
    Antibiotics
    Antiemetic/sedative agents with narcotic analgesics
    Barbiturates
    Cervical ripening agents - in hospital only
    Sedatives
    Epidural analgesia (continuous infusion maintenance) - in hospital only
    Narcotic antagonists
    Narcotics - in hospital only
    Oxytocin intravenous infusion - in hospital only

4. A midwife may order, prescribe or administer any drug or substance that may lawfully be purchased or acquired without a prescription.

Schedule 2 – Midwives Regulation
October 18, 2007

Schedule 2 - SCREENING AND DIAGNOSTIC TESTS

1. A midwife may order, collect samples for and interpret the report of the following screening and diagnostic tests:

    (a) for a woman:

        (i) chemistry: blood glucose, urinalysis (routine and microscopic), serum ferritin, serum B12, serum thyroid stimulating hormone, free thyroxine, Maternal Serum Marker Screening;

        (ii) cytology: cervical smears (Pap smears);

        (iii) hematology: hemoglobin, hematocrit, white blood cell count with differential, red blood cell morphology, platelet count, sickle cell solubility, fetal blood screen, Kleihauer-Betke and Rosette;

        (iv) microbiology:

            (A) cervical and vaginal cultures and smears (including sensitivities where relevant) for Group B streptococcus, gonorrhoea, chlamydia, yeasts, trichomonas, and bacterial vaginosis;

            (B) urine for culture and sensitivities; swabs for culture and sensitivities (e.g. wounds, episiotomies);

            (C) wet preparation (for fungus, trichomonas, parasites);

            (D) viral swabs (e.g. herpes);

        (v) serology/immunology; blood group and type with antibody screen, repeat antibody testing, hepatitis, human immunodeficiency virus antibody, rubella antibody, toxoplasmosis antibody, syphilis serology, cytomegalo virus antibody, HSV antibodies IgG and IgM, parvovirus B19 serology including anti-B19 IgG and IgM, varicella-zoster serology IgG and IgM;

        (vi) pregnancy test (blood and urine);

(b) for a newborn:

(i) hemoglobin, hematocrit, white blood cell count with differential, blood type and Rh factor, neonatal metabolic screen, glucose, Coombs, and bilirubin;

(ii) microbiology samples: cord and eye, ear, and gastric fluid cultures.

2. A midwife may order, perform and interpret the results of the following screening and diagnostic tests:

(a) urine (dip stick analysis);

(b) pregnancy test (urine);

(c) blood glucose: adult and newborn (stix method);

(d) hemoglobin (finger prick method);

(e) ferning test (amniotic fluid);

(f) non-stress test;

(f.1) fetal fibronectin;

(g) external fetal monitoring.

3. A midwife may order and interpret the report of:

(a) an obstetrical ultrasound test, or

(b) an amniocentesis for advanced maternal age.

4. Subject to section 6 (1) (c) of the regulation, a midwife may order the following tests for a woman:

(a) 24 hour urine for protein;
(b) BUN;
(c) liver function;
(d) serum creatinine;
(e) serum electrolytes;
(f) serum uric acid.

Midwifery Regulation, Alta. Reg. 328/1994

(Consolidated up to 119/2003)

ALBERTA REGULATION 328/94

Health Disciplines Act

MIDWIFERY REGULATION

Table of Contents

Definitions

1 In this Regulation,

(a) "Act" means the *Health Disciplines Act*;

(b) "assessment" means the gathering of information about the health status of the client, analysis and synthesis of that data, and the making of a clinical judgment or diagnosis;

(c) "Association" means the Alberta Association of Midwives;

(d) "Board" means the Health Disciplines Board;

(e) "Committee" means the Midwifery Health Discipline Committee established under section 9(1) of the Act;

(f) "midwife" means a person who is registered pursuant to this Regulation;

(g) "primary health care provider" means a person who

(i) is directly accessible to clients without referral from another health professional,

(ii) is authorized to provide health services within a defined scope of practice without supervision by a member of another health profession,

(iii) co-ordinates health related services and makes referrals to other health professionals when appropriate, and

(iv) ensures continuity of care;

(h) "registrar" means the registrar of the designated health discipline of midwives.

AR 328/94 s1;251/2001

Eligibility for registration

2**(1)** For the purposes of section 22(a) of the Act, a person is eligible to be registered as a midwife if that person

(a) has satisfactorily completed a program of studies approved by the Board,

(b) has satisfactorily completed an examination approved by the Board,

(c) has

(i) within the 2 years immediately preceding the date of application, met the requirements of clause (a),

(ii) within the one year immediately preceding the date of application, satisfactorily completed a refresher program approved by the Board, or

(iii) maintained competence by actively engaging in the practice of midwifery in accordance with criteria established by the Committee,

(d) has completed and submitted to the registrar the forms prescribed by the Minister, and

(e) has paid the application fee and registration fee prescribed by the Minister.

(2) Notwithstanding subsection (1)(a), (b) and (c), a person is eligible to be registered as a midwife

(a) if the Committee is satisfied that the person has attained a level of competence equivalent to that required under subsection 1(a), (b) and (c) because of directly related training, examinations and practice, or

(b) if the person successfully completes any training or examinations, or consents to any terms, conditions or limitations on registration or practice, required by the Committee under section 23(5)(b) of the Act.

AR 328/94 s2;251/2001;27/2002

Temporary registration

3**(1)** Notwithstanding section 2, for the purposes of section 22(a) of the Act, a person is eligible to be registered as a midwife on a temporary basis if the Committee is satisfied, on the basis of generally accepted criteria, that temporary registration is appropriate.

(2) A person who is registered pursuant to subsection (1) may engage in the practice of midwifery under a type and level of supervision specified by the Committee and subject to any terms, conditions or limitations imposed by the Committee.

(3) Temporary registration may be granted for a maximum period of one year and may, on application and at the discretion of the Committee, be extended for not more than one additional period of not more than one year.

AR 328/94 s 3;251/2001

Renewal of registration

4**(1)** For the purposes of section 24(3)(a) and (b) of the Act, a midwife is eligible for an annual renewal of registration if the midwife has paid the renewal fee prescribed by the Minister and has

(a) within the 2 years immediately preceding the date of submission of the application for renewal of registration, met the requirements of section 2(1)(a),

(b) within the one year immediately preceding the date of submission of the application for renewal of registration, satisfactorily completed a refresher program approved by the Board, or

(c) maintained competence by actively engaging in the practice of midwifery in accordance with the criteria established by the Committee.

(2) For the purposes of section 24(1) of the Act, the date for submission of an application for renewal of registration is May 1.

(3) Notwithstanding subsection (1), a midwife is eligible for an annual renewal of registration

(a) if the Committee is satisfied that the midwife has maintained a level of competence equivalent to that required under subsection (1)(a), (b) or (c) because of directly related training or practice, or

(b) if the midwife successfully completes any training and examinations, or consents to any terms, conditions or limitations on registration or practice, required by the Committee under section 24(7) of the Act.

AR 328/94 s4;251/2001;27/2002

Training programs and examinations

5 For the purposes of section 23(5)(a) and 24(7)(a) of the Act, the training programs and examinations that the Committee may require are the following:

(a) a refresher program approved by the Board;

(b) the examination referred to in section 2(1)(b);

(c) all or part of a program of studies referred to in section 2(1)(a) as prescribed by the Committee or any other training the Committee considers appropriate.

AR 328/94 s5;251/2001

Register

6**(1)** The registrar shall enter in the register

(a) the name, mailing address, practice status and registration number of each midwife, and

(b) any terms, conditions or limitations imposed on a midwife's practice by the Committee under section 2, 3 or 4 of this Regulation or Part 4 of the Act.

(2) A midwife shall forthwith notify the registrar of any change in name, mailing address or practice status.

Use of title

7 A person registered pursuant to this Regulation may use the name "midwife".

Practice of midwifery

8 A midwife may

(a) provide counselling and education related to childbearing,

(b) carry out assessments necessary to confirm and monitor pregnancies,

(c) advise on and secure the further assessments necessary for the earliest possible identification of pregnancies at risk,

(d) identify the conditions in the woman, fetus or newborn that necessitate consultation with or referral to a physician or other health professional,

(e) care for the woman and monitor the condition of the fetus during labour,

(f) conduct spontaneous vaginal births,

(g) examine and care for the newborn in the immediate postpartum period,

(h) care for the woman in the postpartum period and advise her and her family on newborn and infant care and family planning,

(i) take emergency measures when necessary,

(j) perform, order or interpret screening and diagnostic tests in accordance with Schedule 1,

(k) perform episiotomies and amniotomies and repair episiotomies and lacerations not involving the anus, anal sphincter, rectum and urethra,

(l) prescribe and administer drugs in accordance with Schedule 2, and

(m) on the order of a physician relating to a particular client, administer any drugs by the route and in the dosage specified by the physician.

Autonomous practice and medical consultation

9**(1)** In respect of normal pregnancy, a midwife may, in accordance with the guidelines approved by the Board,

(a) engage in the practice of midwifery as a primary health care provider, and

(b) provide services in a variety of settings.

(2) If medical conditions exist or arise during the course of midwifery care that may require management by a physician, a midwife shall consult with a physician in accordance with the guidelines approved by the Board.

(3) If the result of the consultation under subsection (2) is a determination that management by a physician is required, the midwife shall transfer primary responsibility for care, or aspects of care, to a physician and may engage in the practice of midwifery in collaboration with the physician, to the extent agreed to by the client, physician and midwife.

Standards of conduct

10 A midwife shall

(a) execute all duties in accordance with generally accepted standards of practice and professional ethics and be guided at all times by the welfare, best interests and informed consent of the client,

(b) work within, be limited by and inform clients regarding

(i) the midwife's scope of practice and individual ability,

(ii) any terms, conditions or limitations on registration or practice imposed by the Committee, and

(iii) the practical limitations imposed by the environment or equipment at hand,

(c) maintain currency in knowledge and skill in the practice of midwifery and enhance knowledge and skill in accordance with new developments in procedures or equipment,

(d) work to encourage high standards of performance and research in the practice of midwifery,

(e) refer any incompetent, illegal or unethical professional conduct by colleagues or other health care personnel to the appropriate authorities,

(f) hold in confidence all client information unless the midwife is permitted by the client or required by the Act or any other enactment or by order of a court to disclose the information, and

(g) comply with government standards and reporting requirements.

Practice Review

11**(1)** A Practice Review Committee is established consisting of

(a) 3 midwives,

(b) 2 consumer representatives, and

(c) one member of the College of Physicians and Surgeons of Alberta

appointed by the Association, in accordance with the guidelines approved by the Board.

(2) The Practice Review Committee may, on its own initiative, and shall, at the request of the Board, conduct a review of the practice of a midwife in accordance with guidelines approved by the Board.

(3) After each review under subsection (2), the Practice Review Committee may provide advice and make recommendations to the midwife as to the practice of midwifery by that midwife.

(4) If, in the course of a review of the practice of a midwife,

(a) the Practice Review Committee discovers conduct or competence problems it believes warrant disciplinary action, or

(b) the midwife does not co-operate with the Practice Review Committee in carrying out the review,

the Practice Review Committee shall refer the matter to the Midwifery Committee and the referral shall be treated as a complaint under Part 4 of the Act.

(5) The Practice Review Committee may inquire into, report to and advise the Midwifery Committee in respect of:

(a) the assessment and development of educational, experiential and practice standards that are conditions precedent to registration or renewal of registration under this Regulation,

(b) the evaluation of desirable standards of competence of midwives generally, and

(c) the practice of midwifery generally.

Liability insurance

12 A midwife shall carry professional liability insurance with an insurer acceptable to the Board and in an amount that is at least the minimum level of coverage required by the Board.

Coming into force

13**(1)** This Regulation except for Schedule 2 comes into force on August 1, 1995.

(2) Schedule 2 comes into force on the coming into force of an order of the Lieutenant Governor in Council under section 1(1)(v) of the *Pharmaceutical Profession Act* that authorizes midwives to prescribe drugs.

Schedule 1

1 A midwife may order, collect samples for and interpret the report of the following screening and diagnostic tests:

(a) for a woman:

(i) chemistry: blood glucose;

(ii) cytology: cervical smears (Pap smears);

(iii) haematology: haemoglobin, haematocrit, white blood cell count, differential, platelet count, red blood cell morphology, sickle cell solubility, Kleihauer;

(iv) microbiology:

(A) cervical and vaginal cultures (including sensitivities where relevant) for group B streptococcus, gonorrhoea, chlamydia, yeasts, trichomonas, and gardenerella;

(B) urine for culture and sensitivities; swabs for culture and sensitivities (eg. wounds, episiotomies);

(C) viral swabs (herpes);

(v) serology/immunology: blood group and type with antibody screen, repeat antibody testing, hepatitis, human immunodeficiency virus antibody, rubella antibody, toxoplasmosis antibody, syphilis serology, cytomegalo virus antibody, maternal serum biochemical screening and varicella titre;

(vi) pregnancy tests (blood and urine);

(vii) urine: routine, microscopic urinalysis;

(b) for a newborn:

(i) haemoglobin, haematocrit, white blood cell count with differential, neonatal metabolic screen, glucose, direct coombs, direct antiglobulin test and bilirubin;

(ii) microbiology samples: cord and eye cultures;

(iii) serology/immunology: screen to evaluate possible congenital syphilis, rubella and herpes simplex; blood group and type with antibody screen.

2 A midwife may perform and interpret the results of the following screening and diagnostic tests:

(a) urine (dip stick urinalysis);

(b) pregnancy test (urine);

(c) blood glucose: adult and newborn (stix method).

3 A midwife may order and interpret the report of an ultra sound test: obstetrical for diagnostic purposes only.

4 A midwife may order and perform non-stress tests and interpret the results of non-stress tests.

AR 328/94 Sched.1;119/2003

Schedule 2

1 A midwife may prescribe and administer the following substances in accordance with the guidelines approved by the Board:

Antibiotics for prophylactic treatment of

Group B streptococcus and treatment of mastitis

Antifungal agents considered safe in pregnancy

and for newborns

Calcium gluconate

Carboprost

Dimenhydrinate

Diphenhydramine hydrochloride

Doxylamine succinate-pyridoxine hydrochloride

Entonox

Epinephrine hydrochloride

Ergometrine maleate

Erythromycin ophthalmic ointment

Hepatitis B Immunoglobulin

Hydralazine

Hydrocortisone

Intramuscular or intravenous oxytocin

Intravenous fluids

Lidocaine hydrochloride with or without epinephrine

Magnesium Sulphate

Naloxone

Phytonadione

Promethazine

RhD immune globulin

Therapeutic oxygen

2 A midwife may administer, prescribe or order any drug or substance that may lawfully be purchased or acquired without a prescription.

AR 328/94 Sched.2;82/98;119/2003

Midwifery Act, S.S. 1999, c. M-14.1

The
Midwifery Act

being

Chapter M-14.1 of The Statutes of Saskatchewan, 1999 (effective February 23, 2007 except for subsections 7(2) to (5), sections 8 to 10, sections 18 to 43, sections 47 and 49, not yet proclaimed).

NOTE:
This consolidation is not official. Amendments have been incorporated for convenience of reference and the original statutes and regulations should be consulted for all purposes of interpretation and application of the law. In order to preserve the integrity of the original statutes and regulations, errors that may have appeared are reproduced in this consolidation.

Table of Contents

CHAPTER M-14.1

An Act respecting Midwives

Short title

1 This Act may be cited as The Midwifery Act.

Interpretation

2 In this Act:

(a) "administrative bylaw" means a bylaw made for a purpose set out in subsection 14(1);

(b) "bylaws" means the valid and subsisting bylaws of the college;

(c) "college" means the Saskatchewan College of Midwives established pursuant to section 3;

(d) "council" means:

(i) the transitional council of the college established pursuant to section 51, for the period commencing on the day this Act comes into force and ending on the day the Lieutenant Governor in Council dissolves the transitional council; and

(ii) from the date the transitional council is dissolved, the council of the college as set out in section 7;

(e) "councillor" means a person who is a member of council;

(f) "court" means the Court of Queen's Bench;

(g) "member" means a member of the college who is in good standing;

(h) "minister" means the member of the Executive Council to whom for the time being the administration of this Act is assigned;

(i) "record" includes any information that is recorded or stored in any medium or by means of any device, including a computer or electronic media;

(j) "register" means the register kept pursuant to section 19;

(k) "registrar" means the registrar appointed pursuant to section 11;

(l) "regulatory bylaw" means a bylaw made for a purpose set out in subsection 14(2) or pursuant to subsection 16(3).

1999, c.M-14.1, s.2.

College

3 The Saskatchewan College of Midwives is established as a corporation.
1999, c.M-14.1, s.3.

Membership

4 The membership of the college consists of those persons who are admitted as members of the college pursuant to this Act and the bylaws.
1999, c.M-14.1, s.4.

Property

5(1) The college may acquire, hold, mortgage, lease, sell or dispose of any property.

(2) All fees, fines and penalties receivable or recoverable pursuant to this Act are the property of the college.

(3) The college may:

(a) invest its funds in investments in which trustees are authorized to invest pursuant to The Trustee Act; and

(b) sell or otherwise dispose of those investments and reinvest the proceeds in similar investments.

1999, c.M-14.1, s.5.

Meetings

6(1) An annual meeting of the college is to be held at the time and place that is determined by the council in accordance with the bylaws.

(2) A special meeting of the college for the transaction of the business that is specified in the resolution or demand is to be held:

(a) on resolution of the council; or

(b) on the demand, in writing, of the number of members specified in the bylaws.

(3) The procedure at an annual meeting or special meeting is to be determined by bylaw.

(4) The registrar shall send a notice of an annual meeting or special meeting to each member in the manner prescribed in the bylaws.
1999, c.M-14.1, s.6.

COUNCIL

Council

7(1) The council shall manage and regulate the affairs and business of the college.

(2 to 5) Not Yet Proclaimed.
1999, c.M-14.1, s.7.

8 Not Yet Proclaimed.

9 Not Yet Proclaimed.

10 Not Yet Proclaimed.

Officers and employees

11(1) The officers of the college are to be those that are:

(a) designated in the bylaws; and

(b) appointed or elected in accordance with the bylaws.

(2) The council shall appoint a registrar.

(3) The college may engage any employees that the council considers necessary to carry out the duties and functions of the college.

(4) Subject to this Act and the bylaws, the council shall determine the duties, responsibilities and remuneration of the officers and employees of the college.
1999, c.M-14.1, s.11.

Committees

12(1) The council may establish any committees that are provided for by the bylaws or that it considers necessary.

(2) The council shall appoint persons to any committees that are provided for by this Act or the bylaws or that it has established pursuant to subsection (1).

(3) Subject to this Act and the bylaws, the council, on any terms or conditions that it may determine, may delegate any of its powers or duties to a committee that is established pursuant to subsection (1) or that is provided for by this Act or the bylaws.

(4) The council shall not delegate the power to make bylaws.

(5) Subject to this Act and the bylaws, a committee may establish its own procedures.

1999, c.M-14.1, s.12.

BYLAWS

Procedures

13(1) The council, with the approval of two-thirds of the councillors, may make bylaws for any purpose set out in section 14.

(2) The registrar shall notify each member of each bylaw made pursuant to subsection (1) within 60 days after the bylaw is made.

(3) Failure to comply with subsection (2) does not invalidate a bylaw.

(4) No regulatory bylaw made by the council comes into force until it is:

(a) approved by the minister pursuant to section 15; and

(b) published in the Gazette.

(5) An administrative bylaw comes into force on the date specified in the bylaw, which may not be prior to the date it is made.

(6) If an administrative bylaw does not specify the date on which it is to become effective, the administrative bylaw becomes effective on the day it is passed by council.

1999, c.M-14.1, s.13.

Bylaws

14(1) Subject to this Act, administrative bylaws may be made pursuant to section 13 for the following purposes:

(a) prescribing the seal of the college;

(b) providing for the execution of documents by the college;

(c) respecting the banking and financial dealings of the college;

(d) fixing the fiscal year of the college and providing for the audit of the accounts and transactions of the college;

(e) respecting the management of the property of the college;

(f) prescribing the number and terms of office of elected councillors;

(g) prescribing the officers of the college and governing the procedure for the appointment or election of those officers;

(h) prescribing the duties of councillors, and officers and employees of the college;

(i) prescribing the remuneration and reimbursement for expenses for elected councillors and committee members;

(j) governing the procedures for the election of elected councillors;

(k) prescribing the organization, powers and procedures of the council and regulating the council in the performance of its duties;

(l) respecting the holding and procedures of meetings of the council and annual and special meetings of the college;

(m) prescribing the amount of registration, licensing and other fees payable to the college, the times of payment and penalties for late payment;

(n) providing for the receipt, management and investment of contributions, donations or bequests;

(o) respecting joint participation by the college with any educational institution or any person, group, association, organization or body corporate inside or outside Saskatchewan that has goals or objectives similar to those of the college;

(p) establishing any committees that the council considers necessary, determining the duties of committees and prescribing the manner of election,

appointment or removal of committee members;
(q) establishing and governing scholarships, bursaries and prizes;
(r) prescribing any other thing that is necessary for the effective administration of the college.

(2) Subject to this Act, regulatory bylaws may be made pursuant to section 13 for the following purposes:
(a) prescribing the qualifications, standards and tests of competency for:
(i) the registration of persons or any category of persons as members;
(ii) the issuing of licences;
(b) prescribing qualifications, standards and tests of competency for determining whether a member may be licensed to perform an authorized practice pursuant to section 23;
(c) prescribing:
(i) the procedures governing registration of persons or any category of persons as members;
(ii) the procedures governing the issuing of licences;
(iii) the terms and conditions of licences;
(d) setting standards of professional conduct, competency and proficiency of members;
(e) providing for a code of ethics for members;
(f) setting standards regarding the manner and method of practice of members;
(g) prescribing procedures for:
(i) the review, investigation and disposition by the professional conduct committee of complaints alleging that a member is guilty of professional misconduct or professional incompetence;
(ii) hearings by the discipline committee of complaints alleging that a member is guilty of professional misconduct or professional incompetence;
(iii) reviews pursuant to subsection 21(4);
(h) establishing categories of membership in the college and prescribing the rights and privileges of each category;
(i) prescribing the circumstances under which members are required to attend re-entry education programs and courses and approving programs and courses for that purpose;
(j) governing the approval of education and competency assessment programs for the purposes of registration pursuant to this Act and prescribing terms and conditions for initial or continued approval of those programs;
(k) setting standards for continuing education and the participation of members in continuing education;

(l) governing the reinstatement of a member who has been expelled;
(m) governing examinations to be held for the purposes of section 20;
(n) setting requirements for maintenance of membership;
(o) regulating advertising by members;
(p) prescribing the number of members required to demand a special meeting of the college;
(q) governing persons who practise under restricted licences issued pursuant to subsection 20(2);
(r) prescribing the minimum amount of liability protection that members are required to obtain;
(s) prescribing the minimum amount of liability protection that the college may obtain on behalf of each member;
(t) prescribing the form, content and maintenance of the register and the information to be provided by members for the purpose of the register;
(u) respecting the reporting and publication of decisions and reports of the council and committees;
(v) respecting the types and service of notices that may be served electronically;
(w) establishing programs for the assessment of the competency of members;
(x) defining activities that constitute a conflict of interest and prohibiting

the participation of members in those activities;
(y) prescribing any other matters considered necessary for the better carrying out of this Act.

1999, c.M-14.1, s.14.

Filing of bylaws

15(1) The college shall file with the minister two copies, certified by the registrar to be true copies, of:

(a) all regulatory bylaws; and

(b) any amendment to a regulatory bylaw together with two certified copies of the regulatory bylaw to which the amendment relates.

(2) Where the minister does not advise the college, in writing, within 90 days of receiving copies of the regulatory bylaw or amendment that the minister approves the regulatory bylaw or amendment, the regulatory bylaw or amendment is deemed not to be approved.

(3) Where the minister approves a regulatory bylaw or an amendment to a regulatory bylaw, the minister shall file with the Department of Justice two copies, certified by the registrar to be true copies, of the regulatory bylaw or amendment.

(4) Where an amendment to a regulatory bylaw is filed pursuant to subsection (3), the minister shall file two copies, certified by the registrar to be true copies, of the regulatory bylaw with the amendment.

(5) Within 30 days after administrative bylaws or amendments to administrative bylaws are made, the council shall file with the Department of Justice two copies, certified by the registrar to be true copies, of all administrative bylaws and all amendments made to those bylaws.

(6) Where an amendment to an administrative bylaw is filed pursuant to subsection (5), the council shall also file two copies, certified by the registrar to be true copies, of the administrative bylaw with the amendment.

(7) Where an administrative bylaw or an amendment to an administrative bylaw is not filed within the time required by subsection (5), the administrative bylaw or amendment to the administrative bylaw is deemed to be revoked on the expiration of the 30 days mentioned in subsection (5).

1999, c.M-14.1, s.15.

Ministerial bylaws

16(1) The minister may request the council to amend or repeal a regulatory bylaw or to make a new regulatory bylaw if the minister is satisfied that it is necessary or advisable.

(2) Where the minister makes a request pursuant to subsection (1), the council shall be provided with the reasons for the amendment and, if the minister considers it appropriate, a draft of the amendment.

(3) If the council does not comply with a request pursuant to subsection (1) within 90 days after the date of the request, the minister may amend or revoke the existing regulatory bylaw or make the new regulatory bylaw in accordance with that request.

(4) A regulatory bylaw made pursuant to this section or an amendment or revocation of a regulatory bylaw pursuant to this section comes into force when it is published in the Gazette.

(5) Where the minister makes, amends or revokes a regulatory bylaw, the minister shall file with the Department of Justice two copies of the regulatory bylaw, amendment or revocation.

(6) Where an amendment to or a revocation of a regulatory bylaw is filed pursuant to subsection (5), the minister shall file two copies of the regulatory bylaw with the amendment or revocation.

1999, c.M-14.1, s.16.

Regulations

17 Following consultations with the council by the minister, the Lieutenant

Governor in Council may make regulations:

(a) respecting drugs that a member may prescribe, dispense or administer and any conditions or restrictions on the prescribing, dispensing or administering of those drugs;

(b) respecting diagnostic tests that a member may order, perform or interpret and any conditions or restrictions on the ordering, performing or interpreting of those tests;

(c) respecting invasive procedures that a member may perform and any conditions or restrictions on the performance of those procedures;

(d) authorizing the council to make regulatory bylaws:

(i) respecting drugs that members may prescribe, dispense or administer;

(ii) respecting diagnostic tests that members may order, perform or interpret; and

(iii) respecting invasive procedures that members may perform;

(e) prescribing a date for the purposes of subsection 20(4).

1999, c.M-14.1, s.17.

18 to 43 Not Yet Proclaimed.

Review by Legislative Assembly

44(1) One copy of every bylaw and amendment filed with the Department of Justice pursuant to section 15 is to be laid before the Legislative Assembly by the Minister of Justice in accordance with The Tabling of Documents Act, 1991.

(2) Where any bylaw or amendment laid before the Legislative Assembly is found by the Assembly to be beyond the powers delegated by the Legislature or in any way prejudicial to the public interest, that bylaw or amendment ceases to have any effect and is deemed to have been revoked.

1999, c.M-14.1, s.44.

Record of revocation and notification

45(1) Where it appears from any Votes and Proceedings of the Legislative Assembly that any bylaw or amendment has ceased to have effect, the Clerk of the Legislative Assembly shall immediately:

(a) forward two copies of the Votes and Proceedings to the Deputy Minister of Justice; and

(b) advise him or her that the copies are forwarded pursuant to this subsection.

(2) On receipt of the copies mentioned in subsection (1), the Deputy Minister of Justice shall immediately:

(a) file one of the copies with the bylaw or amendment to which it relates;

(b) forward the other copy to the college; and

(c) advise the college that the copy is forwarded pursuant to this subsection.

1999, c.M-14.1, s.45.

Liability protection

46(1) The college may enter into a contract of insurance under which members or any category of members are insured with respect to professional liability claims.

(2) The college is deemed to be an agent for the members or any category of members for the purpose of entering into a contract of insurance pursuant to this section.

1999, c.M-14.1, s.46.

47 Not Yet Proclaimed.

Annual report

48 The college shall file an annual report with the minister in the form, with the contents and in the time prescribed by the minister.

1999, c.M-14.1, s.48.

49 Not Yet Proclaimed.

Service of notices, etc.

50(1) Unless otherwise provided for in this Act or the bylaws, any notice or other document that is required to be served pursuant to this Act may be served by:

(a) personal service made:

(i) in the case of an individual, on that individual;
(ii) in the case of a partnership, on any partner; or
(iii) in the case of a corporation, on any officer or director;

(b) registered mail addressed to the last business or residential address of the person to be served known to the registrar.

(2) A notice or document sent by registered mail is deemed to have been served on the seventh day following the date of its mailing, unless the person to whom it was mailed establishes that, through no fault of that person, the person did not receive the notice or document or received it at a later date.

(3) If it is for any reason impractical to effect service of any documents as set out in subsection (1), the court may, on an ex parte application, make an order for substitutional service.

(4) Service of a document in accordance with the terms of an order mentioned in subsection (3) is deemed to be proper service.

1999, c.M-14.1, s.50.

TRANSITIONAL AND COMING INTO FORCE

Transitional council

51(1) The Lieutenant Governor in Council shall appoint a transitional council after consultations by the minister with the following associations:

(a) the Midwives Association of Saskatchewan;

(b) the College of Physicians and Surgeons of the Province of Saskatchewan;

(c) the Saskatchewan Medical Association;

(d) The Saskatchewan Registered Nurses' Association;

(e) the Saskatchewan Health-Care Association, commonly known as the Saskatchewan Association of Health Organizations.

(2) The transitional council consists of not more than 13 persons.

(3) The transitional council must include at least two, but not more than five, persons chosen by the minister from a list of not less than five persons who are recommended by the Midwives Association of Saskatchewan.

(4) The term of office of councillors appointed pursuant to this section is not to exceed three years.

(5) A councillor appointed pursuant to this section holds office until that person's successor is appointed and is eligible for reappointment.

(6) The Lieutenant Governor in Council may designate a chairperson from among the members of the transitional council.

(7) At least one member of the transitional council is to be a member of the discipline committee.

(8) The absence or inability to act as a member of the discipline committee by a member of the transitional council mentioned in subsection (7) or the failure to designate a member pursuant to subsection (7) does not impair the power of the other members of the discipline committee to act.

(9) A member of the transitional council may resign by giving written notice of his or her resignation to the minister.

(10) In addition to making bylaws for any of the purposes set out in section 14, the transitional council shall pass bylaws pursuant to clauses 14(1)(f), (g), (h), (i), (j) and (k) and shall, on or before a date to be set by the Lieutenant Governor in Council conduct an election pursuant to those bylaws to elect members of council pursuant to subsection 7(2).

(11) The minister shall remunerate and reimburse for expenses the members of the transitional council appointed pursuant to this section at the rate determined by the Lieutenant Governor in Council.

1999, c.M-14.1, s.51.

Coming into force

52 This Act comes into force on proclamation.

1999, c.M-14.1, s.52.

REGINA, SASKATCHEWAN
Printed by the authority of
THE QUEEN'S PRINTER

Midwifery Act, C.C.S.M. c. M125

C.C.S.M. c. M125

The Midwifery Act

(Assented to June 28, 1997)

HER MAJESTY, by and with the advice and consent of the Legislative Assembly of Manitoba, enacts as follows:

PART 1

DEFINITIONS

Definitions

1 In this Act,

"by-laws" means the by-laws of the college made under section 51; (« règlements administratifs »)

"college" means the College of Midwives of Manitoba; (« Ordre »)

"council" means the council of the college; (« Conseil »)

"court" means the Court of Queen's Bench; (« tribunal »)

"midwife" means a person registered as a midwife under this Act; (« sage-femme »)

"minister" means the member of the Executive Council charged by the Lieutenant Governor in Council with the administration of this Act; (« ministre »)

"public representative" means a person who is not and never has been registered under this Act and who is not a member of a health profession regulated by an Act of the Legislature for which the minister has statutory responsibility; (« représentant du public »)

"register" means a register under section 10; (« registre »)

"registrar" means the registrar of the college appointed under subsection 8(4); (« registraire »)

"regulations" means the regulations made under section 50; (« règlements »)

"student" means a person registered as a student under section 16. (« étudiant »)

PART 2

PRACTICE OF MIDWIFERY

Practice of midwifery

2(1) The practice of midwifery means 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 vaginal deliveries.

Included practices

2(2) In the course of engaging in the practice of midwifery, a midwife may

(a) order and receive reports of screening and diagnostic tests designated in the regulations;

(b) prescribe and administer drugs designated in the regulations; and

(c) perform minor surgical and invasive procedures designated in the regulations.

Midwife as primary health care provider

2(3) A midwife may, in accordance with this Act and the regulations, engage in the practice of midwifery as a primary health care provider who

(a) is directly accessible to clients without referral from a member of another health profession;

(b) is authorized to provide health services within the practice of midwifery without being supervised by a member of another health profession; and

(c) consults with other health professionals, including physicians, if medical conditions exist or arise during pregnancy that may require management outside the scope of the practice of midwifery.

Exclusive right to practice midwifery

3(1) Subject to subsection (2), no person other than a midwife may engage in the practice of midwifery.

Application to other persons

3(2) Nothing in this Act prevents a person from performing any action described in section 2

(a) in an emergency; or

(b) under the authority of another Act of the Legislature.

Representation as a midwife

4(1) No person except a midwife shall

(a) represent or hold out, expressly or by implication, that he or she is a midwife or is entitled to engage in the practice of midwifery; or

(b) use any sign, display, title or advertisement implying that the person is a midwife.

Use of titles

4(2) No person except a midwife shall use the title "midwife", a variation or abbreviation of that title, or an equivalent in another language.

PART 3

COLLEGE OF MIDWIVES OF MANITOBA

College established

5(1) The College of Midwives of Manitoba is established as a body corporate.

Powers

5(2) The college has the capacity and, subject to this Act, the rights, powers and privileges of a natural person.

Membership

5(3) The membership of the college consists of the persons whose names are on the register and who have paid the fees provided for in the by-laws.

Meetings

5(4) A general meeting of the college shall be held at least once a year and special general meetings of the college shall be held when the council considers it advisable.

Notice of meetings

5(5) Notice of the time and place of each meeting referred to in subsection (4) shall be given in accordance with the by-laws.

Qualification to vote

5(6) Every member who is a registered midwife is entitled to vote at a meeting of the college.

Public meetings

6 The college shall

(a) permit members of the public to attend meetings of the college and the council, except where it considers that a private meeting is necessary in order to consider matters of a confidential nature or of a personal nature concerning an individual;

(b) make its by-laws available to the public; and

(c) hold an annual public meeting to explain the role of the college and to invite public comment.

Council established

7(1) There is hereby established a governing body of the college called the council.

Council to manage affairs

7(2) The council shall

(a) manage and conduct the business and affairs of the college; and

(b) exercise the rights, powers and privileges of the college in the name and on behalf of the college.

Composition of council

8(1) The council shall consist of at least six persons of whom at least

(a) two are public representatives;

(b) three are elected from the members of the college in accordance with the by-laws; and

(c) one is a member of the standing committee referred to in clause (5)(b).

Officers

8(2) The members of the council shall elect from among themselves the officers of the college specified in the by-laws in the manner and for the term specified in the by-laws.

Remuneration

8(3) The members of the council shall be paid such remuneration and expenses as the council may determine.

Registrar and staff

8(4) The council shall appoint a registrar and may appoint any other officers, practice auditors, investigators or staff that it considers necessary to perform the work of the college.

Committees

8(5) The council shall establish

(a) a standing committee for the purpose of recruiting and selecting public representatives to serve on the council and committees of the college;

(b) a standing committee to advise the college on issues related to midwifery care to aboriginal women; and

(c) any other committee that the council considers necessary.

Council to convene meetings

9 On receiving a written request signed by at least 5% of the members of the college entitled to vote, the council shall convene a special general meeting for the purpose specified in the request after giving notice of the time and place of the meeting in accordance with the by-laws.

PART 4

REGISTRATION

Registers

10(1) The registrar shall, subject to the direction of the council, maintain the following registers:

(a) a register of practising midwives;

(b) a register of students; and

(c) any other registers that are provided for in the regulations.

Register of practising midwives

10(2) The register of practising midwives shall contain

(a) every midwife's name, business address and business telephone number;

(b) the conditions imposed on every certificate of registration;

(c) a notation of every revocation and suspension of a certificate of registration;

(d) the result of every disciplinary proceeding; and

(e) information that the regulations specify as information to be kept in the register.

Access to information

10(3) A person may obtain, during normal business hours, the following information contained in the register of practising midwives:

(a) the information described in clauses (2)(a) and (b);

(b) the information described in clause (2)(c) relating to a suspension that is in effect;

(c) the results of every disciplinary proceeding completed within six years before the register was prepared or last updated

(i) in which a midwife's certificate of registration was revoked or suspended or had conditions imposed on it, or

(ii) in which a midwife was required to pay a fine or attend to be censured; and

(d) information designated as public in the regulations.

Board of assessors

11 The council shall, in accordance with the by-laws, appoint a board of assessors to consider and decide on applications for registration under section 12.

Registration of midwives

12(1) The board of assessors shall approve an application for registration as a midwife if the applicant

(a) meets the competency requirements approved by the council;

(b) establishes that his or her name has not been removed for cause from the register of persons authorized to engage in the practice of midwifery in Canada or elsewhere;

(c) establishes that he or she has not been suspended as a result of professional misconduct by a regulatory authority governing the practice of midwifery in Canada or elsewhere;

(d) pays the fees provided for in the by-laws; and

(e) meets any other requirements set out in the regulations.

Conditions

12(2) An approval may be made subject to any conditions that the board of assessors considers advisable.

Entry in register

12(3) The registrar shall enter in the register of practising midwives the name of a person whose application for registration is approved by the board of assessors.

Certificate of registration

12(4) On entering the name of a person in the register of midwives, the registrar shall issue a certificate of registration to the person.

Registration if emergency

12.1(1) Despite anything in this Act or the regulations, the board of assessors may waive any requirements for registration under this Act and the regulations to allow a person who is authorized to practise midwifery in another jurisdiction in Canada or the United States to practise midwifery in the province during an emergency, if the minister gives the board of assessors written notice that

(a) a public health emergency exists in all or part of the province; and

(b) he or she has determined, after consulting with public health officials and any other persons that the minister considers advisable, that the services of a midwife from outside the province are required to assist in dealing with the emergency.

Emergency need not be declared

12.1(2) The board of assessors may exercise its authority under subsection (1) even if no emergency has been declared under an enactment of Manitoba or Canada.

Certificate of registration

12.1(3) If necessary to carry out the intent of this section, the board of assessors may authorize the registrar to issue a certificate of registration to a person allowed to practise under subsection (1), on such terms and conditions as the council may determine.

S.M. 2005, c. 39, s. 28.

Application for registration not approved

13 If the board of assessors does not approve an application for registration or approves an application subject to conditions, it shall give notice to the applicant in writing, with reasons for its decision, and shall advise the applicant of the right to appeal the decision of the board of assessors to the council.

Appeal to council

14(1) A person whose application for registration as a midwife is not approved by the board of assessors or whose application is approved subject to conditions may, by notice in writing within 30 days after receiving a notice of refusal, appeal the decision of the board of assessors to the council, specifying the reasons for the appeal.

Hearing

14(2) On receiving a notice of appeal under this section, the council shall schedule an appeal to be held within 90 days after receiving the notice of appeal by the council.

Notification of hearing

14(3) An applicant who appeals a decision of the board of assessors under this section

(a) shall be given notice in writing by the council of the date, place and time of the appeal; and

(b) is entitled to appear with counsel and make representations to the council at the appeal.

Participation by board of assessors

14(4) A member of the board of assessors who is also a member of the council may participate in the appeal but shall not vote on a decision under this section.

Decision by council

14(5) The council shall decide the appeal within 90 days after the hearing and may make any decision the board of assessors could have made.

Notice of decision of appeal

14(6) Within 30 days after deciding the appeal, the council shall give the applicant written notice of its decision.

Appeal to court

15(1) A person whose application for registration as a midwife is refused by the council or whose application is approved subject to conditions may appeal the decision to the court by filing a notice of appeal within 30 days after the date on which the applicant is notified of the refusal or conditions.

Powers of court on appeal

15(2) The court on hearing an appeal may

(a) make any decision that in its opinion should have been made; or

(b) refer the matter back to the council for further consideration in accordance with any direction of the court.

Registration of students

16(1) The registrar shall approve an application for registration as a student if the applicant

(a) is a student engaged in a midwifery education program approved by the college;

(b) pays the fee provided for in the by-laws; and

(c) meets any other requirements set out in the regulations.

Appeal from refusal to register

16(2) A person whose application for registration as a student is refused under subsection (1) may appeal the refusal to the council, in which case section 14 applies with necessary modifications.

PART 5

ENFORCEMENT OF STANDARDS

OF PRACTICE

Definitions

17 In this Part,

"conduct" includes an act or omission; (« conduite »)

"investigated person" means a midwife or a former midwife in respect of whose conduct an investigation is conducted or a hearing is held under this Part. (« personne visée par l'enquête »)

COMPLAINTS COMMITTEE

Complaints committee

18 The council shall, in accordance with the by-laws, appoint a complaints committee consisting of

(a) one member of the council who is a midwife;

(b) one member of the council who is a public representative; and

(c) one member of the college who is not a member of the council.

Complaints

19(1) Any person may make a complaint in writing to the registrar about the conduct of a midwife, and the complaint shall be dealt with in accordance with this Part.

Complaints against former midwives

19(2) If, after a midwife's registration is cancelled or not renewed under this Act,

(a) a complaint is made about the former midwife; and

(b) the complaint relates to conduct occurring before the cancellation or non-renewal occurred;

the complaint may, notwithstanding the cancellation or non-renewal, be dealt with within five years from the date of the cancellation or non-renewal as if the former midwife's registration was still in effect.

Referral to complaints committee

20 The registrar shall refer to the complaints committee

(a) a complaint made under section 19;

(b) any other matter that the registrar considers advisable.

Investigation

21(1) On referral of a matter to the complaints committee, the complaints committee may direct that an investigation into the conduct of a midwife be held and may appoint an investigator to conduct the investigation.

Records and information

21(2) An investigator appointed under subsection (1) may require the investigated person

(a) to produce to the investigator any records in the possession of or under the control of the investigated person; and

(b) to attend at the investigation to be interviewed.

Failure to produce records

21(3) The college may apply to the court for an order

(a) directing the investigated person to produce to the investigator any records in his or her possession or under his or her control, if it is shown that the investigated person failed to produce them when required by the investigator; or

(b) directing any person to produce to the investigator any records that are or may be relevant to the complaint being investigated.

Investigation of other matters

21(4) The investigator may investigate any other matter related to the professional conduct or the skill in practice of the investigated person that arises in the course of the investigation.

Report to complaints committee

21(5) On concluding the preliminary investigation, the investigator shall report his or her findings to the complaints committee.

DECISION OF COMPLAINTS COMMITTEE

Decision of complaints committee

22(1) The complaints committee may, after review or preliminary investigation,

(a) direct that the matter be referred, in whole or in part, to the inquiry committee;

(b) direct that the matter not be referred to the inquiry committee;

(c) accept the voluntary surrender of the midwife's registration;

(d) censure the midwife if

(i) the committee has met with the midwife and the midwife has agreed to accept the censure, and

(ii) the committee has determined that no action is to be taken against the midwife other than the censure;

(e) refer the matter to mediation if the complaints committee determines that the complaint is strictly a matter of concern to the complainant and the investigated person and both parties agree to mediation;

(f) enter into an agreement with the midwife that provides for one or more of the following:

(i) assessing the midwife's capacity or fitness to practise midwifery,

(ii) counselling or treatment of the midwife,

(iii) monitoring or supervision of the midwife's practice of midwifery,

(iv) the midwife's completion of a specified course of studies by way of remedial training,

(v) placing conditions on the midwife's right to practise midwifery.

Matter not resolved by mediation

22(2) If a matter referred for mediation under clause (1)(e) cannot be resolved, it shall be referred back to the complaints committee who may make any other decision under subsection (1) that it considers appropriate.

Decision served on investigated person and complainant

22(3) The complaints committee shall serve on the investigated person and the complainant a notice setting out its decision and the reasons for the decision.

Hearing not required

22(4) Except as required by clause (1)(d), the complaints committee is not required to hold a hearing or give any person an opportunity to appear or to make formal submissions before making a decision under this section.

Conditions on right to practise

23(1) If the complaints committee enters into an agreement with a midwife for conditions on the midwife's right to practise midwifery under subclause 22(1)(f)(v), those conditions may include the conditions referred to in section 26.

Costs

23(2) The complaints committee may order the midwife to pay all or part of the costs incurred by the college in monitoring compliance with conditions imposed on a midwife's right to practice midwifery under an agreement entered into under subclause 22(1)(f)(v).

CENSURE

Censure: personal appearance

24(1) The complaints committee may require a midwife who is censured under clause 22(1)(d) to appear personally before the committee to be censured.

Publication of censure

24(2) The complaints committee may publish the fact that a midwife has been censured, and publication may include the midwife's name and a description of the circumstances that led to the censure.

Order for costs

24(3) If the complaints committee censures a midwife, it may also order the midwife to pay all or part of the costs of the investigation.

VOLUNTARY SURRENDER OF REGISTRATION

Voluntary surrender of registration

25(1) If the complaints committee accepts a voluntary surrender of a midwife's registration under clause 22(1)(c), it may direct the midwife to do one or more of the following to the satisfaction of any person or committee that the complaints committee may determine, before the midwife's right to practise midwifery may be reinstated:

(a) obtain counselling or treatment;

(b) complete a specified course of studies;

(c) obtain supervised experience.

Order for costs

25(2) The complaints committee may direct the midwife to pay any costs incurred by the college in monitoring compliance with a direction given under subsection (1) and to pay all or part of the costs of the investigation up to the time that the voluntary surrender takes effect.

Conditions on re-instatement

26 A voluntary surrender remains in effect until the complaints committee is satisfied that the conduct or complaint that was the subject of the investigation has been resolved, at which time the committee may impose conditions on the midwife's entitlement to practice midwifery, including conditions that the midwife do one or more of the following:

(a) limit his or her practice;

(b) practise under supervision;

(c) not engage in sole practice;

(d) permit periodic audits of his or her practice;

(e) permit periodic audits of records;

(f) report to the complaints committee or the registrar on specific matters;

(g) comply with any other conditions that the committee considers appropriate in the circumstances;

and may order the midwife to pay all or any part of the costs incurred by the college in monitoring compliance with those conditions.

APPEAL BY COMPLAINANT

Appeal by complainant to council

27(1) When the complaints committee makes a decision under clause 22(1)(b),(c) or (f), the complainant may, by notice in writing to the registrar mailed within 30 days after the date of notification of the complaints committee decision made under subsection 22(2), appeal the decision to the council.

Power on appeal

27(2) On an appeal under subsection (1), the council shall do one or more of the following:

(a) make any decision that in its opinion ought to have been made by the complaints committee;

(b) quash, vary or confirm the decision of the complaints committee;

(c) refer the matter back to the complaints committee for further consideration in accordance with any direction that the council may make.

Notification of decision

27(3) The council shall give notice to the investigated person and the complainant in writing of its decision and the reasons for its decision.

CANCELLATION OF REGISTRATION PENDING DECISION

Cancellation pending decision

28(1) Notwithstanding anything in this Act, the complaints committee may, when there is a question that the investigated person's conduct exposes or is likely to expose the public to serious risk, direct the registrar to cancel the investigated person's certificate of registration or place conditions on his or her practice of midwifery pending the outcome of proceedings under this Part.

Notice of cancellation or conditions

28(2) On receiving a direction under subsection (1), the registrar shall promptly serve a notice of the cancellation or the conditions of practice on the midwife.

Application for stay

29 The investigated person may, by filing an application with the court and serving a copy on the registrar, apply for an order of the court staying a decision of the complaints committee to cancel the investigated person's certificate of registration or to place conditions on his or her practice under section 28 pending the outcome of proceedings under this Part.

MISCELLANEOUS

Referral to inquiry committee

30 Notwithstanding any other action it may have taken, with the exception of a censure, the complaints committee may at any time refer the conduct or complaint that was the subject of the preliminary investigation to the inquiry committee.

Disclosure of information to authorities

31 Notwithstanding any other provision of this Act, the complaints committee may disclose to a law enforcement authority any information respecting possible criminal activity on the part of a midwife that is obtained during an investigation into that midwife's conduct.

INQUIRY COMMITTEE

Inquiry committee

32(1) There shall be an inquiry committee consisting of not less than five persons appointed by the council in accordance with this section.

Membership

32(2) The inquiry committee shall consist of at least

(a) one person who is a midwife and a member of the council who is to be the chair;

(b) two persons who are members of the college but not members of the council; and

(c) two persons who are public representatives.

Exclusion from committee

32(3) No person who has taken part in the review or investigation of what is to be the subject matter of the inquiry shall be a member of the inquiry committee.

Effect of member being unable to continue

32(4) If a hearing has begun and a member of the inquiry committee is unable to continue as a member, the committee may complete the hearing if at least three members remain, one of whom is a public representative.

Procedure

33 Subject to the approval of the council, the inquiry committee shall determine its own practice and procedure.

HEARING

Hearing by inquiry committee

34(1) On referral of a matter to the inquiry committee, the inquiry committee shall hold a hearing.

Date of hearing

34(2) The hearing before the inquiry committee shall commence within 120 days after the date on which the matter is referred.

Notice of hearing

34(3) At least 30 days before the date of the hearing, the registrar shall serve on the investigated person and the complainant a notice of hearing stating the date, time and place

at which the inquiry committee will hold a hearing and identifying in general terms the complaint or matter in respect of which the hearing will be held.

Public notice of hearing

34(4) The registrar may issue a public notice of the hearing in a manner that the registrar considers appropriate, but the notice must not include the name of the investigated person.

Right to appear and be represented

35(1) The college and the investigated person may appear and be represented by counsel at a hearing before the inquiry committee, and the committee may have counsel to assist it.

Examination of documentary evidence

35(2) An investigated person shall be given an opportunity to examine before the hearing any written or documentary evidence that will be produced and any report the contents of which will be given in evidence at the hearing.

Adjournments

35(3) The chairperson of the inquiry committee may adjourn a hearing from time to time.

Investigation of other matters

35(4) The inquiry committee may investigate and hear any other matter concerning the conduct of an investigated person that arises in the course of its proceedings, but in that event the committee shall declare its intention to investigate the further matter and shall permit the investigated person sufficient opportunity to prepare a response.

Hearings open to public

36(1) A hearing shall be open to the public unless the inquiry committee is satisfied that

(a) matters involving public security may be disclosed;

(b) financial or personal or other matters may be disclosed at the hearing that are of such a nature that the desirability of avoiding public disclosure of those matters in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public;

(c) a person involved in a criminal proceeding or a civil suit or proceeding may be prejudiced; or

(d) the safety of a person may be jeopardized.

Exclusion of public

36(2) If the inquiry committee is satisfied that the hearing is required to be closed, it may make an order that the public be excluded from the hearing or any part of it and it may make other orders it considers necessary to prevent the public disclosure of matters disclosed at the hearing, including orders banning the publication or broadcasting of those matters.

Public information may be disclosed

36(3) No order shall be made under subsection (2) that prevents the publication of anything that is contained in the register and available to the public.

Exclusion of public during certain motions

36(4) The inquiry committee may make an order that the public be excluded from the part of a hearing dealing with a motion for an order under subsection (2).

Orders with respect to matters in submissions

36(5) The inquiry committee may make any order necessary to prevent the public disclosure of matters disclosed in the submissions relating to any motion described in subsection (2), including prohibiting the publication or broadcasting of those matters.

Reasons for excluding public to be available

36(6) The inquiry committee shall ensure that any order it makes under this section and its reasons are available to the public in writing.

Reconsidering of order to exclude public, etc.

36(7) The inquiry committee may reconsider an order made under subsection (2) at the request of any person or on its own motion.

Evidence

37(1) At a hearing of the inquiry committee, the oral evidence of witnesses shall be taken on oath or affirmation and the parties shall have the right to cross-examine witnesses and call evidence in defence and reply.

Power to administer oaths and affirmations

37(2) For the purpose of an investigation or hearing under this Act, the registrar and the chairperson of the inquiry committee have the power to administer oaths and affirmations.

Recording of evidence

37(3) The oral evidence given at a hearing of the inquiry committee shall be recorded.

Witnesses

38 Any person, other than the investigated person, who in the opinion of the inquiry committee has knowledge of the complaint or matter being heard is a compellable witness in any proceeding before the inquiry committee.

Notice to attend and produce records

39(1) The attendance of witnesses before the inquiry committee and the production of records may be enforced by a notice issued by the registrar requiring the witness to attend and stating the date, time and place at which the witness is to attend and the records, if any, that the witness is required to produce.

Registrar shall provide notices

39(2) On the written request of the investigated person or the person's counsel or agent, the registrar shall provide any notices that the person requires for the attendance of witnesses or the production of records.

Witness fees

39(3) A witness, other than the investigated person, who has been served with a notice to attend or a notice for production under this section is entitled to be paid the same fees in the same manner as a witness in an action in the court.

Failure to attend or give evidence

40 Proceedings for civil contempt of court may be brought against a witness

(a) who fails to attend before the inquiry committee in compliance with a notice to attend;

(b) who fails to produce any records in compliance with a notice to produce them; or

(c) who refuses to be sworn or to affirm or to answer any question he or she is directed to answer by the inquiry committee.

Hearing in absence of investigated person

41 The inquiry committee, on proof of service on the investigated person of the notice of hearing, may

(a) proceed with the hearing in the absence of the investigated person or the person's agent; and

(b) act, decide or report on the matter being heard in the same way as if the investigated person were in attendance.

DECISION OF INQUIRY COMMITTEE

Findings of committee

42 If, at the conclusion of a hearing, the inquiry committee finds that the investigated person

(a) is guilty of professional misconduct;

(b) has contravened this Act, the regulations, the by-laws or the code of ethics of the college;

(c) has been found guilty of an offence that is relevant to the midwife's suitability to practise;

(d) has displayed a lack of knowledge of or lack of skill or judgment in the practice of midwifery;

(e) has demonstrated an incapacity or unfitness to practise midwifery; or

(f) is found to be suffering from an ailment that might, if the midwife continues to practise, constitute a danger to the public;

it shall deal with the investigated person in accordance with this Act.

Orders of inquiry committee

43(1) If the inquiry committee makes any of the findings described in section 42, the committee may make one or more of the following orders:

(a) reprimand the investigated person;

(b) cancel the certificate of registration of the investigated person for a stated period;

(c) cancel the certificate of registration of the investigated person until

(i) the investigated person has completed a specified course of studies or supervised practical experience, or

(ii) the committee is satisfied as to the competence of the investigated person to practise midwifery;

(d) accept in place of the cancellation of the certificate of registration, the investigated person's undertaking to limit his or her practice;

(e) impose conditions on the investigated person's entitlement to practise midwifery, including conditions that he or she

(i) practise under supervision,

(ii) permit periodic inspections of his or her practice by a person authorized by the committee to carry out inspections,

(iii) permit periodic audits of records,

(iv) report to the committee on specified matters,

(v) not engage in sole practice;

(f) require the investigated person to satisfy the committee of his or her competence to practise midwifery;

(g) require the investigated person to satisfy the committee that a disability or addiction can be or has been overcome, and cancel the certificate of registration of the investigated person until the committee is so satisfied;

(h) require the investigated person to take counselling;

(i) direct the investigated person to waive, reduce or repay money paid to the investigated person that, in the opinion of the committee, was unjustified for any reason; and

(j) cancel the certificate of registration held by the investigated person.

Committee may consider censure

43(2) To assist the inquiry committee in making an order under this section, the committee may be advised of any censure or order previously issued to the investigated person and the circumstances under which it was issued.

Ancillary orders

43(3) The inquiry committee may make any ancillary order that is appropriate or required in connection with an order mentioned in subsection (1) or may make any other order that it considers appropriate in the circumstances, including an order that

(a) a further or new investigation be held into any matter; or

(b) the inquiry committee be convened to hear a complaint without a preliminary investigation.

Contravention of order

43(4) If the inquiry committee is satisfied that an investigated person has contravened an order made under subsection (1), it may, without a further hearing, cancel the certificate of registration held by the investigated person.

Costs and fines

44(1) The inquiry committee may, in addition to or instead of dealing with the conduct of an investigated person in accordance with section 43, order that the investigated person pay to the college

(a) all or part of the costs of the investigation, hearing and appeal;

(b) a fine not exceeding $10,000.; or

(c) both the costs under clause (a) and the fine under clause (b);

within the time set by the order.

Nature of costs

44(2) The costs referred to in subsection (1) may include, but are not limited to,

(a) all disbursements incurred by the college, including

(i) fees and expenses for experts, investigators and auditors whose reports or attendances were reasonably necessary for the investigation or hearing,

(ii) travel costs and reasonable expenses of any witnesses required to appear at the hearing,

(iii) fees for retaining a reporter and preparing transcripts of proceedings,

(iv) costs of service of documents, long distance telephone and facsimile charges, courier delivery charges and similar miscellaneous expenses;

(b) payments made to members of the inquiry committee or the complaints committee; and

(c) costs incurred by the college in providing counsel for the college and the inquiry committee, whether or not counsel is employed by the college.

Failure to pay costs and fines by time ordered

44(3) If the investigated person is ordered to pay a fine or costs or both under subsection (1) and fails to pay within the time ordered, the registrar may immediately cancel his or her certificate of registration until the fine or costs are paid.

Filing of order

44(4) The college may file an order under subsection (1) in the court, and on the order being filed it may be enforced in the same manner as a judgment of the court.

Written decision

45(1) The inquiry committee shall, within 90 days following the completion of a hearing, make a written decision on the matter consisting of the reasons for its decision and a statement of any order made by it.

Decision forwarded to registrar

45(2) The inquiry committee shall forward to the registrar

(a) the decision; and

(b) the record of the proceedings, consisting of all evidence presented before it, including all exhibits and documents.

Service of decision

45(3) The registrar shall, on receiving the decision and record, serve a copy on the investigated person and the complainant.

Copies of transcript

45(4) The investigated person may examine the record of the proceedings before the inquiry committee, and is entitled to receive, on payment of the cost of providing it, a transcript of the oral evidence given before the committee.

Publication of decision

46 Notwithstanding that any proceeding or part of a proceeding under this Part may have been held in private, the college may, after the expiration of any appeal period, publish the name of an investigated person in respect of whom an order is made under section 43 or 44 and the general circumstances relevant to the findings.

APPEAL TO COURT OF APPEAL

Appeal to Court of Appeal

47(1) An investigated person in respect of whom a finding or order is made by the inquiry committee under section 42, 43 or 44 may appeal the finding or order to The Court of Appeal.

Commencement of appeal

47(2) An appeal shall be commenced

(a) by filing a notice of appeal; and

(b) by giving a copy of the notice of appeal to the registrar;

within 30 days after the date on which the decision of the inquiry committee is served on the investigated person.

Appeal on the record

47(3) An appeal shall be founded on the record of the hearing before the inquiry committee and the decision of the inquiry committee.

Powers of Court on appeal

48 The Court of Appeal on hearing the appeal may

(a) make any finding or order that in its opinion ought to have been made;

(b) quash, vary or confirm the decision of the inquiry committee or any part of it; or

(c) refer the matter back to the inquiry committee for further consideration in accordance with any direction of the court.

Stay pending appeal

49 The decision and any order of the inquiry committee remains in effect pending an appeal unless the Court of Appeal, on application, stays the decision and any order pending the appeal.

PART 6

REGULATIONS, BY-LAWS

AND CODE OF ETHICS

Regulations made by the council

50(1) The council may make regulations

(a) respecting standards for the practice of midwifery;

(b) for the purpose of clause 2(2)(a), designating screening and diagnostic tests that a midwife may order or about which a midwife may receive reports;

(c) for the purpose of clause 2(2)(b), designating drugs that a midwife may prescribe and administer;

(d) for the purpose of clause 2(2)(c),designating minor surgical and invasive procedures that a midwife may perform;

(e) establishing requirements to be met by applicants for registration as midwives and students;

(f) requiring midwives to carry professional liability insurance and governing the coverage required to be carried;

(g) establishing a process for assessing the experience and knowledge of applicants for registration as midwives;

(h) respecting the establishment and operation of committees under subsection 8(5);

(i) respecting the establishment, content and maintenance of registers under section 10 and, for the purpose of clause 10(3)(d), designating information contained in a register that may be made public;

(j) governing the publication of a notice of the cancellation of a certificate of registration or of any other decision under Part 5 in a form and manner determined by the council;

(k) respecting the conditions under which the name of a person whose certificate of registration has been cancelled may be reinstated in a register and the conditions under which a certificate of registration may be reissued;

(l) establishing requirements for continuing education and training;

(m) prescribing the records to be kept by midwives and the length of time they must be kept.

Approval of regulations

50(2) A regulation made under subsection (1) does not come into force until it is approved by

(a) a majority of members of the college voting in accordance with the by-laws; and

(b) the Lieutenant Governor in Council.

By-laws

51(1) The council may make by-laws

(a) for the government of the college and the management and conduct of its affairs;

(b) respecting the calling and conduct of meetings of the college and the council;

(c) respecting the nomination, election and number of council members and officers of the college, the filling of vacancies on the council and on any committee or board established by the council, and the appointment of *ex officio* members of the council and of any committee or board established by the council, and prescribing the term of office and the duties and functions of those members, officers and *ex officio* members;

(d) providing for the procedures for the election of midwives to the council;

(e) providing for the division of the province into districts and prescribing the number of council members to be elected from each district;

(f) governing the number of members that constitutes a quorum at meetings of the college and the council;

(g) governing the operation, proceedings and quorum of the complaints committee and the inquiry committee, the appointment of acting members and *ex officio* members and the procedures for filling vacancies, and prescribing the terms of office, duties and functions of *ex officio* members;

(h) setting remuneration, fees and expenses payable to members of the council or of committees or boards established under this Act, the regulations or the by-laws for attending to the business of the college;

(i) prescribing the fees payable by midwifes and by applicants for registration or the manner of determining such fees;

(j) authorizing the council to prescribe the form of a certificate of registration and any other form or document that may be required for the purposes of this Act, the regulations or the by-laws;

(k) respecting the holding of votes by mail or any other method on any matter relating to the college;

(l) governing the establishment, operation and proceedings of committees or boards, the appointment and revocation of members and acting members of those committees or boards and the procedures for filling vacancies on those committees or boards;

(m) providing for the appointment and remuneration of officers and other employees of the college and prescribing their duties and functions;

(n) respecting the payment of sums of money or the providing of other assistance to other midwifery associations;

(o) providing for the term of office of the registrar and the appointment of an individual as an acting registrar who has all of the powers, duties and functions of the registrar under this Act and the regulations when the registrar is absent or unable to act or when there is a vacancy in the office of registrar;

(p) respecting the procedures for the approval of regulations by midwifes.

Amendments and repeal of by-laws

51(2) After notice is given in accordance with the by-laws, a by-law under subsection (1) may be amended or repealed by a majority of the members of the college

(a) present and voting at a general meeting; or

(b) voting in a mail vote conducted in accordance with the by-laws.

Code of ethics

52 The college may, by resolution passed at an annual general meeting, adopt a code of ethics governing the conduct of midwives and students.

PART 7

GENERAL PROVISIONS

Appointment of practice auditors

53(1) The council may appoint one or more practice auditors for the purposes of this Act.

Audit of a midwifery practice

53(2) A practice auditor may review the operation of a midwifery practice and shall report his or her findings to the registrar on the conclusion of each audit.

Entry of premises and inspection of records

54(1) For the purpose of enforcing and administering this Act and the regulations, a practice auditor may at any reasonable time, and when requested, upon presentation of an identification card issued by the council,

(a) without a warrant, enter the office of a midwife and make such inspections as may be reasonably required to determine compliance with this Act and the regulations;

(b) require the production by the midwife of any record that the practice auditor reasonably considers necessary for the purpose of enforcing this Act and the regulations;

(c) inspect and, upon giving a receipt, remove records or things relevant to the inspection for the purpose of making copies or extracts; and

(d) remove substances and things for examination or test purposes upon giving a receipt.

Admissibility of copies

54(2) A copy of a record made under clause (1)(c) and certified to be a true copy by the practice auditor is, in the absence of evidence to the contrary, admissible in evidence in any proceeding or prosecution as proof of the original record and its contents.

Entry with order

54(3) When a justice is satisfied by information under oath that there are reasonable grounds for believing that it is necessary for a practice auditor to enter a building, vehicle or other place for the enforcement of this Act or the regulations and

(a) a reasonable, unsuccessful effort to effect entry without the use of force has been made; or

(b) there are reasonable grounds for believing that entry would be denied without a warrant;

the justice may at any time, and if necessary upon application without notice, issue an order authorizing the practice auditor and such other persons as may be named in the order, with such peace officers as are required to assist, to enter the building or other place and to take such action as a practice auditor may take under subsection (1).

Obstruction of practice auditor

54(4) No person shall obstruct a practice auditor or withhold from a practice auditor or conceal or destroy any records, documents, substances or things relevant to an audit.

Service of documents

55(1) A notice, order or other document under this Act or the regulations is sufficiently given or served if it is

(a) delivered personally; or

(b) sent by registered mail, or by another service that provides the sender with proof of delivery, to the intended recipient at that person's last address appearing on the records of the college.

Deemed receipt

55(2) A notice, order or other document sent by registered mail is deemed to be given or served five days after the day it was sent.

Registrar's certificate

56 A certificate purporting to be signed by the registrar and stating that a named person was or was not, on a specified day or during a specified period,

(a) a midwife of the college; or

(b) an officer, investigator or a practice auditor of the college or a member of the council or of a committee or board established under this Act, the regulations or the by-laws;

is, in the absence of evidence to the contrary, admissible in evidence in all courts and tribunals as proof of the facts stated in it without proof of the registrar's appointment or signature.

Proof of conviction

57 For the purpose of proceedings under this Act, a certified copy under the seal of the court or signed by the convicting judge or the Clerk of The Provincial Court, of the conviction of a person for any crime or offence under the *Criminal Code* (Canada) or under any other Act or regulation is conclusive evidence that the person has committed the crime or offence stated, unless it is shown that the conviction has been quashed or set aside.

Offence

58(1) A person who contravenes a provision of this Act or the regulations, other than section 60.1 of this Act, is guilty of an offence and is liable on summary conviction

(a) for a first offence, to a fine of not more than $5,000.; and

(b) for a subsequent offence, to a fine of not more than $15,000.

Offence

58(1.1) A person who contravenes section 60.1 is guilty of an offence and is liable, on summary conviction, to a fine of not more than $50,000.

Limitation on prosecution

58(2) A prosecution under this section may be commenced within two years after the commission of the alleged offence, but not afterwards.

Prosecution of offence

58(3) Any person may be a prosecutor or complainant in the prosecution of an offence under this Act, and the government may pay to the prosecutor a portion of any fine recovered, in an amount that it considers appropriate, toward the costs of the prosecution.

Stay of proceedings

58(4) When the college is the prosecutor of an offence under this Act, it may apply for a stay of proceedings in the prosecution, and the court shall grant the stay.

S.M. 1998, c. 32, s. 6.

Protection from liability

59 No action lies against the college, the council, the registrar, a person conducting a preliminary investigation, a practice auditor, a member of a committee or board established under this Act or the regulations or the by-laws, or any officer or person acting on the instructions of any of them for anything done in good faith in the performance or intended exercise of any power under this Act, the regulations or the by-laws or for any neglect or default in the performance or exercise in good faith of such a duty or power.

Injunction

60 The court, on application by the council, may grant an injunction enjoining any person from doing any act that contravenes Part 2 notwithstanding any penalty that may be provided by this Act in respect of that contravention.

Confidentiality of information

60.1 Subject to section 60.2, every person employed, appointed or retained for the purpose of administering this Act, and every member of the council or a committee of the council, shall preserve secrecy about all information that comes to his or her knowledge in the course of his or her duties, and shall not communicate any information to any other person, except

(a) to the extent the information is available to the public, or is required to be disclosed, under this Act;

(b) in connection with the administration of this Act, including, but not limited to, the registration of members, complaints about members, allegations of members' incapacity, unfitness, incompetence or acts of professional misconduct, or the governing of the profession;

(c) to a body that governs the practice of a health profession pursuant to an Act of the Legislature, to the extent the information is required for that body to carry out its mandate under the Act;

(d) to a body that governs the practice of midwifery in a jurisdiction other than Manitoba; or

(e) as may be required for the administration of *The Health Services Insurance Act* or *The Prescription Drugs Cost Assistance Act*.

S.M. 1998, c. 32, s. 6; S.M. 2005, c. 39, s. 29.

Registrar to collect information

60.2(1) In addition to any other information maintained in administering this Act, the registrar must collect and record each member's

(a) date of birth;

(b) sex; and

(c) education or training, as required for registration and renewal of registration.

Member to provide information

60.2(2) A member must provide the registrar with the information required under subsection (1), in the form and at the time set by the registrar.

Minister may require information

60.2(3) The minister may request in writing that the registrar provide information on members — including personal information — contained in the register or collected under subsection (1), to establish and maintain an electronic registry of health service providers to be used for the following purposes:

(a) to validate the identity of a provider seeking access to a patient's personal health information maintained in electronic form;

(b) to administer programs respecting payment for professional services under *The Health Services Insurance Act*;

(c) to generate information — in non-identifying form — for statistical purposes.

Registrar to provide information to minister

60.2(4) The registrar must provide the minister with the information — including personal information — requested under subsection (3), in the form and at the time set by the minister after consulting with the registrar.

Minister may disclose information

60.2(5) Despite any other provision of this Act or any provision of another Act or a regulation, the minister may

(a) disclose — in non-identifying form — information provided under subsection (4) to any entity authorized to receive it under subsection (6); and

(b) impose conditions respecting the use, retention and further disclosure of the information.

An entity must comply with any conditions imposed by the minister.

Authorized entities

60.2(6) The following entities are authorized to receive information — in non-identifying form — under subsection (5):

(a) a regional health authority established or continued under *The Regional Health Authorities Act*;

(b) Regional Health Authorities of Manitoba, Inc.;

(c) CancerCare Manitoba;

(d) The Manitoba Centre for Health Policy;

(e) a government or organization with which the Government of Manitoba has entered into an agreement to share information for the purposes stated in subsection (3).

S.M. 2005, c. 39, s. 30.

PART 8

TRANSITIONAL, CONSEQUENTIAL AND

COMING INTO FORCE

Transitional council of the college

61(1) The Lieutenant Governor in Council may appoint a transitional council.

Powers of transitional council

61(2) After this Act receives royal assent but before it comes into force, the transitional council and its employees and committees may do anything that is necessary or advisable for the coming into force of this Act and may perform any activities that the council and its employees and committees could do under this Act if it were in force.

Registration in transitional period

61(3) Without limiting the generality of subsection (2), the transitional council may appoint a registrar, and the registrar and the transitional council's committees may accept and process applications for the issue of certificates of registration and may charge application fees and issue certificates of registration.

Powers of minister

61(4) The minister may

(a) review the transitional council's activities and require the transitional council to provide reports and information;

(b) require the transitional council to make, amend or revoke a regulation under this Act;

(c) require the transitional council to do anything that, in the opinion of the minister, is necessary or advisable to carry out the intent of this Act.

Transitional council to comply with minister's request

61(5) If the minister requires the transitional council to do anything under subsection (4), the transitional council shall, within the time and in the manner specified by the minister, comply with the requirement and submit a report to the minister.

Lieutenant Governor in Council regulations

61(6) If the minister requires the transitional council to make, amend or revoke a regulation under clause 4(b) and the transitional council does not do so within 60 days, the Lieutenant Governor in Council may make, amend or revoke the regulation.

Authority

61(7) Subsection (6) does not give the Lieutenant Governor in Council authority to do anything that the transitional council does not have the authority to do.

Transition after Act in force

62 After this Act comes into force, the transitional council shall be the council if it is constituted in accordance with subsection 8(1) or, if it is not, it shall be deemed to be the council until a new council is constituted in accordance with subsection 8(1).

63 to 65

NOTE: These sections contained consequential amendments to other Acts, which are now included in those Acts.

C.C.S.M. reference

66 This Act may be cited as *The Midwifery Act* and referred to as chapter M125 of the *Continuing Consolidation of the Statutes of Manitoba.*

Coming into force

67(1) This Act, except section 61, comes into force on a day fixed by proclamation.

Coming into force: section 61

67(2) Section 61 comes into force on the day this Act receives royal assent.

NOTE: S.M. 1997, c. 9, except section 61, was proclaimed in force June 12, 2000.

Midwives Act, R.S.Q. c. S-0.1

R.S.Q., chapter S-0.1

Midwives Act

The Minister of Justice is entrusted with the application of this Act. Order in Council 121-2005 dated 18 February 2005, (2005) 137 G.O. 2 (French), 874.

DIVISION I

ORDRE DES SAGES-FEMMES DU QUÉBEC

Professional order.

1. All the persons qualified to practise the profession of midwifery in Québec constitute a professional order called "Ordre professionnel des sages-femmes du Québec" or "Ordre des sages-femmes du Québec".

1999, c. 24, s. 1.

Professional Code.

2. Subject to this Act, the Order and its members shall be governed by the Professional Code (chapter C-26).

1999, c. 24, s. 2.

Head office.

3. The head office of the Order shall be within the territory of Ville de Montréal or at any other place in Québec determined by regulation of the Bureau pursuant to paragraph f of section 93 of the Professional Code (chapter C-26).

1999, c. 24, s. 3; 2000, c. 56, s. 219.

DIVISION II

BUREAU

Bureau.

4. The Order shall be governed by a Bureau constituted as provided in the Professional Code (chapter C-26).

1999, c. 24, s. 4.

Regulations.

5. In addition to the regulations and by-laws the Bureau is required to adopt in accordance with the Professional Code (chapter C-26), the Bureau shall, by regulation,

1) determine standards relating to the form and content of the verbal and written prescriptions made by a midwife ;

2) determine the standards of practice and the conditions for engaging in the practice of midwifery that must be complied with for conducting home deliveries ;

3) determine the cases presenting a risk for a woman or her child during pregnancy, labour, delivery and the first six weeks of the postnatal period that requires, as a consequence, a consultation by a physician or the transfer of clinical responsibility to a physician, and the conditions under which the consultation or transfer is to be effected.

Provisions applicable.

Sections 95.2 and 95.3 of the Professional Code apply to a regulation made pursuant to subparagraph 1 of the first paragraph.

1999, c. 24, s. 5; 2000, c. 13, s. 95.

DIVISION III

PRACTICE OF MIDWIFERY

Midwifery.

6. Any act the purpose of which is to provide the professional care and services required by a woman during normal pregnancy, labour and delivery and to provide a woman and her child with the professional care and services required during the first six weeks of a normal postnatal period constitutes the practice of midwifery. The professional care and services concerned consist in

1) monitoring and assessing a woman and her child during pregnancy, labour, delivery and the first six weeks of the postnatal period, and include the provision of preventive care and the detection of any abnormal conditions in the woman or child ;

2) conducting spontaneous deliveries ;

3) performing an amniotomy, performing and repairing an episiotomy and repairing a first or second degree perineal tear or laceration.

Emergency procedures.

In addition, in an emergency, while awaiting the required medical intervention or in the absence of medical intervention, applying suction, conducting a breech delivery, performing manual placental extraction followed by digital exploration of the uterus or performing resuscitation procedures on the woman or newborn also constitutes the practice of midwifery.

1999, c. 24, s. 6.

Counselling.

7. The practice of midwifery by a midwife also includes the provision of

1) counselling and information on parenting, family planning, contraception, preparation for delivery and breastfeeding, the usual care to be provided to a child up to the age of one year, in particular as regards diet, hygiene and accident prevention, and on the resources available in the community ; and

2) counselling and information to the public on perinatal health care.

1999, c. 24, s. 7.

Medication.

8. For the purpose of providing the professional care and services referred to in section 6, a midwife may prescribe or administer a drug designated on the list established by a regulation made under the first paragraph of section 9, according to such conditions as may be fixed in the regulation.

Examinations.

For the same purpose, a midwife may prescribe, conduct or interpret any examination or analysis designated on the list established by a regulation made under the second paragraph of section 9, according to such conditions as may be fixed in the regulation.

1999, c. 24, s. 8.

List of drugs.

9. The Office des professions du Québec shall, after consultation with the Conseil du médicament, the Ordre des sages-femmes du Québec, the Collège des médecins du Québec and the Ordre des pharmaciens du Québec, establish, by regulation, a list of the drugs that may be prescribed or administered by a midwife pursuant to the first paragraph of section 8 and determine, if necessary, the conditions according to which the drugs may be prescribed or administered.

List of examinations.

The Office shall also, after consultation with the Ordre des sages-femmes du Québec and the Collège des médecins du Québec, establish, by regulation, a list of the examinations and analyses that may be prescribed, conducted or interpreted by a midwife pursuant to the second paragraph of section 8 and determine, if necessary, the conditions according to which the examinations and analyses may be prescribed, conducted or interpreted.

1999, c. 24, s. 9; 2002, c. 27, s. 41.

Name.

10. Midwifery may not be practised under a name other than that of the practising midwife.

Firm name.

However, midwives may practise under a firm name which may be the name of one, several or all of the partners. The name of any partner who has ceased to practise may be included in the firm name for a period not exceeding three years from the date on which the partner ceased to practise, provided the name of the partner was included in the firm name at the time the partner ceased to practise.

1999, c. 24, s. 10.

Prohibition.

11. Midwives shall not, in their professional practice, hold themselves out otherwise than as midwives.

1999, c. 24, s. 11.

DIVISION IV

ILLEGAL PRACTICE

Exclusivity.

12. Subject to the rights and privileges granted by law to other professionals, no person may perform an act described in section 6 unless the person is a midwife.

Nurses.

In particular, section 6 shall not be construed as prohibiting nurses from providing a woman and her child with the nursing care required during pregnancy, labour and delivery and the postnatal period.

Exceptions.

The provisions of the first paragraph do not apply to an act performed by a person acting in accordance with

1) a regulation made under paragraph h of section 94 of the Professional Code (chapter C-26);

2) an agreement between the Government and a Native nation represented by the band councils of all the communities forming the Native nation, a Native community represented by its band council or by its council in the case of a Northern village, a group of communities so represented or any other Native group, allowing a Native person who is not a member of the Order to perform acts described in section 6 in the territory defined in the agreement, in accordance with the conditions fixed therein and to the extent that the terms of the agreement are observed.

1999, c. 24, s. 12.

Penalties.

13. Every person who contravenes section 12 is liable, for each offence, to the penalties prescribed in section 188 of the Professional Code (chapter C-26).

1999, c. 24, s. 13.

DIVISION V

AMENDING PROVISIONS

HEALTH INSURANCE ACT

14. (Amendment integrated into c. A-29, s. 3).

1999, c. 24, s. 14.

ACT RESPECTING PRESCRIPTION DRUG INSURANCE

15. (Amendment integrated into c. A-29.01, s. 8).

1999, c. 24, s. 15.

PROFESSIONAL CODE

16. (Amendment integrated into c. C-26, s. 31).

1999, c. 24, s. 16.

17. (Amendment integrated into c. C-26, s. 32).

1999, c. 24, s. 17.

18. (Amendment integrated into c. C-26, Schedule I).

1999, c. 24, s. 18.

MEDICAL ACT

19. (Amendment integrated into c. M-9, s. 19).

1999, c. 24, s. 19.

20. (Amendment integrated into c. M-9, s. 43).

1999, c. 24, s. 20.

ACT RESPECTING LABOUR STANDARDS

21. (Amendment integrated into c. N-1.1, s. 81.3).

1999, c. 24, s. 21.

22. (Amendment integrated into c. N-1.1, s. 81.6).

1999, c. 24, s. 22.

ACT RESPECTING INCOME SECURITY

23. (Amendment integrated into c. S-3.1.1, s. 14).

1999, c. 24, s. 23.

24. (Amendment integrated into c. S-3.1.1, s. 16).

1999, c. 24, s. 24.

ACT RESPECTING HEALTH SERVICES AND SOCIAL SERVICES

25. (Amendment integrated into c. S-4.2, s. 34.1).

1999, c. 24, s. 25.

26. (Amendment integrated into c. S-4.2, s. 41).

1999, c. 24, s. 26.

27. (Amendment integrated into c. S-4.2, s. 131).

1999, c. 24, s. 27.

28. (Amendment integrated into c. S-4.2, s. 151).

1999, c. 24, s. 28.

29. (Amendment integrated into c. S-4.2, s. 159).

1999, c. 24, s. 29.

30. (Amendment integrated into c. S-4.2, s. 173).

1999, c. 24, s. 30.

31. (Amendment integrated into c. S-4.2, ss. 208.1-208.3).

1999, c. 24, s. 31.

32. (Amendment integrated into c. S-4.2, ss. 225.1-225.6).

1999, c. 24, s. 32.

33. (Amendment integrated into c. S-4.2, s. 226).

1999, c. 24, s. 33.

34. (Amendment integrated into c. S-4.2, s. 236).

1999, c. 24, s. 34.

35. (Amendment integrated into c. S-4.2, ss. 259.2-259.11).

1999, c. 24, s. 35.

36. (Amendment integrated into c. S-4.2, s. 347).

1999, c. 24, s. 36.

37. (Amendment integrated into c. S-4.2, s. 398.1).

1999, c. 24, s. 37.

38. (Amendment integrated into c. S-4.2, ss. 432.1-432.3).

1999, c. 24, s. 38.

39. (Amendment integrated into c. S-4.2, s. 505).

1999, c. 24, s. 39.

40. (Amendment integrated into c. S-4.2, s. 506.2).

1999, c. 24, s. 40.

41. (Amendment integrated into c. S-4.2, s. 530.24).

1999, c. 24, s. 41.

42. (Amendment integrated into c. S-4.2, s. 530.62).

1999, c. 24, s. 42.

43. (Amendment integrated into c. S-4.2, s. 530.78.1).

1999, c. 24, s. 43.

ACT RESPECTING HEALTH SERVICES AND SOCIAL SERVICES FOR CREE NATIVE PERSONS

44. (Amendment integrated into c. S-5, ss. 63.1-63.2).

1999, c. 24, s. 44.

ACT RESPECTING ADMINISTRATIVE JUSTICE

45. (Amendment integrated into c. J-3, Schedule I).

1999, c. 24, s. 45.

ACT RESPECTING INCOME SUPPORT, EMPLOYMENT ASSISTANCE AND SOCIAL SOLIDARITY

46. (Amendment integrated into c. S-32.001, s. 24).

1999, c. 24, s. 46.

47. (Amendment integrated into c. S-32.001, s. 28).

1999, c. 24, s. 47.

DIVISION VI

TRANSITIONAL AND FINAL PROVISIONS

First Bureau.

48. Notwithstanding section 4 of this Act, the first Bureau shall be composed of the following persons :

1) six directors appointed by the Office des professions du Québec and chosen from among the persons who, on 30 June 1999, are certified to practise within the framework of pilot projects in accordance with the Act respecting the practice of midwifery within the framework of pilot projects (chapter P-16.1) ; the directors are deemed to be elected directors ;

2) two directors appointed by the Office des professions du Québec in accordance with the first paragraph of section 78 of the Professional Code (chapter C-26);

3) a chair elected by the directors referred to in paragraph 1 from among their number by secret ballot ; the chair is deemed to be elected in the manner provided in subparagraph b of the first paragraph of section 64 of the Professional Code.

1999, c. 24, s. 48.

Presumption.

49. For the purposes of section 75 of the Professional Code (chapter C-26), the territory of Québec constitutes a single region until the date of the coming into force of a regulation made under section 65 of that Code.

1999, c. 24, s. 49.

Directors' term.

50. The term of the directors of the first Bureau is four years, beginning on their appointment.

1999, c. 24, s. 50.

Vacancy.

51. Any vacancy in the office of a director deemed elected shall be filled for the unexpired portion of the term by a new director appointed by the Office des professions du Québec from among the persons referred to in paragraph 1 of section 48, if the vacancy occurs before 24 September 1999, or from among the members of the Order, if the vacancy occurs after that date.

1999, c. 24, s. 51.

Midwifery permit.

52. Every person who, on 30 June 1999, is the holder of a qualification certificate for the practice of midwifery within the framework of pilot projects issued by the committee on admission to the practice of midwifery, in accordance with the Act respecting the practice of midwifery within the framework of pilot projects (chapter P-16.1), also becomes the holder of a permit for the practice of midwifery issued by the Bureau.

Restricted permit.

Every person who, on that date and in accordance with that Act, is deemed to be certified to practise within the framework of the perinatal care project under the responsibility of the Centre de santé Inuulitsivik also becomes the holder of a restricted permit issued by the Bureau. Under the permit, the person shall be allowed to practise midwifery only in a centre operated by the institution administering the project.

1999, c. 24, s. 52.

Midwifery permit.

53. A candidate declared eligible by the committee on admission to the practice of midwifery but who has not, on 30 June 1999, satisfied all the conditions imposed by the committee to obtain a qualification certificate for the practice of midwifery within the framework of pilot projects, becomes the holder of a permit issued by the Bureau upon satisfying those conditions.

1999, c. 24, s. 53.

Midwifery permit.

54. A person whose qualification certificate for the practice of midwifery within the framework of pilot projects has on 30 June 1999 been suspended by the committee on admission to the practice of midwifery becomes the holder of a permit issued by the Bureau upon satisfying the conditions imposed by the committee for the lifting of the suspension.

1999, c. 24, s. 54.

Roll of Order.

55. The persons referred to in section 52 and the persons who obtain a permit upon satisfying the conditions referred to in section 53 or 54 shall be entered on the roll of the Order if they meet the requirements of section 63 of this Act and the other conditions for entry on the roll set out in section 46 of the Professional Code (chapter C-26).

Applicability of provisions.

However, Divisions IV, VI, VII and VIII of Chapter IV and section 192 of the Professional Code do not apply before 24 September 1999.

1999, c. 24, s. 55.

Suspension.

56. Where a midwife holds a permit and is on the roll of the Order at the time the committee on admission to the practice of midwifery decides to suspend the midwife's qualification certificate, the midwife's name is struck from the roll by the Bureau and cannot be re-entered until the conditions imposed by the committee are satisfied.

Revocation.

The Bureau shall revoke a permit issued to a person whose qualification certificate for the practice of midwifery within the framework of pilot projects is revoked by the committee on admission to the practice of midwifery.

1999, c. 24, s. 56.

Provisions applicable.

57. The provisions of the Regulation respecting the general standards of competence and training for midwives within the framework of pilot projects, made pursuant to the third paragraph of section 23 of the Act respecting the practice of midwifery within the framework of pilot projects (chapter P-16.1) and approved by Order in Council 1193-92 (1992, G.O. 2, p. 4343), apply until the coming into force of the regulation to be made by the Government pursuant to the first paragraph of section 184 of the Professional Code (chapter C-26) for the purpose of determining the diplomas which give access to the permit concerned.

1999, c. 24, s. 57.

Provisions applicable.

58. The provisions of the Regulation respecting obstetrical and neonatal risks made pursuant to the third paragraph of section 23 of the Act respecting the practice of midwifery within the framework of pilot projects (chapter P-16.1) and approved by Order in Council 413-93 (1993, G.O. 2, p. 2009), apply until the coming into force of the regulation to be made by the Bureau pursuant to subparagraph 3 of the first paragraph of section 5 of this Act.

1999, c. 24, s. 58.

Authorization to prescribe.

59. Until the coming into force of the regulations to be made by the Office des professions du Québec in accordance with section 9, midwives are authorized to prescribe or administer the same drugs and to prescribe, conduct or interpret the same examinations and analyses as in the case of pilot projects.

1999, c. 24, s. 59.

Code of ethics.

60. The provisions of the code of ethics for midwives, adopted by the Regroupement Les sages-femmes du Québec on 4 December 1997, apply until the coming into force of the regulation to be made by the Bureau pursuant to section 87 of the Professional Code (chapter C-26).

1999, c. 24, s. 60.

Home deliveries.

61. Midwives may not conduct home deliveries before the coming into force of the regulation to be made by the Bureau pursuant to subparagraph 2 of the first paragraph of section 5.

1999, c. 24, s. 61.

Annual assessment.

62. Notwithstanding the provisions of the second paragraph of section 86 of the Professional Code (chapter C-26), the resolution to be adopted by the Bureau for the purpose of fixing the first annual assessment need not be approved by a majority of the members of the Order in order to come into force.

1999, c. 24, s. 62.

Security required.

63. Until the coming into force of the regulation to be made by the Bureau pursuant to paragraph d of section 93 of the Professional Code (chapter C-26), the security to be furnished in accordance with paragraph 3 of section 46 of the Professional Code must be at least equivalent to the security required within the framework of pilot projects.

1999, c. 24, s. 63.

Records, registers and documents.

64. The records, registers and documents kept by the committee on admission to the practice of midwifery and relating to the persons who have applied for admission, in accordance with subparagraph 2 of the first paragraph of section 23 of the Act respecting the practice of midwifery within the framework of pilot projects (chapter P-16.1), become the records, registers and documents of the Order.

1999, c. 24, s. 64.

Discipline committee.

65. The chair of the committee on discipline of the Collège des médecins du Québec shall act as chair of the committee on discipline of the Order until replaced or reappointed in accordance with section 117 of the Professional Code (chapter C-26).

1999, c. 24, s. 65.

Designated institution.

66. An institution which, pursuant to the Act respecting the practice of midwifery within the framework of pilot projects (chapter P-16.1), is responsible for a pilot project on 24 September 1999 is deemed to be an institution designated by the regional board under the fourth paragraph of section 347 of the Act respecting health services and social services (chapter S-4.2).

1999, c. 24, s. 66.

Contract.

67. The midwives employed under a contract by an institution responsible for a pilot project pursuant to section 9 of the Act respecting the practice of midwifery within the framework of pilot projects (chapter P-16.1), and who hold a position on 24 September 1999 shall continue to practise under that contract until 31 March 2000 or any later date determined by the Government.

Service contract.

By the latter date, the midwives must have entered into a service contract in conformity with the provisions of sections 259.2 and 259.5 of the Act respecting health services and social services (chapter S-4.2) and have furnished proof of compliance with section 259.9 of that Act.

1999, c. 24, s. 67.

Midwifery services coordinator.

68. Every public institution referred to in section 66 must ensure that the midwifery services coordinator and the council of midwives, if any, are able to exercise their functions on 31 March 2000 or any later date determined by the Government. Until that date, the multidisciplinary board established for the institution under section 11 of the Act respecting the practice of midwifery within the framework of pilot projects (chapter P-16.1) shall exercise their functions.

Transfer of records.

On the date mentioned in the first paragraph, the records and other documents of the multidisciplinary board shall be transferred to the midwifery services coordinator, to the council of midwives or, where section 225.2 of the Act respecting health services and social services (chapter S-4.2) applies, to the council of physicians, dentists and pharmacists, according to their respective requirements.

1999, c. 24, s. 68.

Rules of care.

69. The rules of care established by the multidisciplinary board under subparagraph 1 of the first paragraph of section 16 of the Act respecting the practice of midwifery within the framework of pilot projects (chapter P-16.1) shall continue to apply until new rules of care established under paragraph 2 of section 208.2 of the Act respecting health services and social services (chapter S-4.2) come into force.

1999, c. 24, s. 69.

Exception.

70. The board of directors of a public institution not governed by section 66 that wishes to enter into a service contract with a midwife pursuant to section 259.2 of the Act respecting health services and social services (chapter S-4.2) is not required to obtain the recommendations referred to in the second paragraph of that section 259.2 before the midwifery services coordinator is appointed by the institution in accordance with section 208.1 of the Act respecting health services and social services.

1999, c. 24, s. 70.

Advisory council.

71. An advisory council is hereby instituted within the Order for a term of four years, which may be renewed by the Government.

1999, c. 24, s. 71.

Mandate.

72. The mandate of the advisory council is to advise and make recommendations to the Bureau concerning the draft regulations of the Order, before their adoption by the Order, and concerning any other matter pertaining to the practice of midwifery which the Bureau considers expedient to submit to the advisory council.

Recommendations.

The advisory council shall also, through the agency of the Bureau, advise and make recommendations to the Minister responsible for the administration of legislation respecting the professions or to the Office des professions du Québec concerning any matter they consider expedient to submit to the advisory council in relation to the practice of midwifery.

1999, c. 24, s. 72.

Members.

73. The advisory council shall be composed of the following six members appointed by the Government and chosen by reason of their knowledge of and experience with the professional system or their professional expertise in the fields related to the practice of midwifery :

1) one midwife, after consultation with the Bureau ;

2) two physicians, after consultation with the Collège des médecins du Québec ;

3) one nurse, after consultation with the Ordre des infirmières et infirmiers du Québec ;

4) one pharmacist, after consultation with the Ordre des pharmaciens du Québec ;

5) one representative of the public, after consultation with interested groups.

Consultants.

The advisory council may consult any person whose particular expertise is required and any person representing a body concerned with the practice of midwifery and authorize them to participate in its meetings.

1999, c. 24, s. 73.

By-laws.

74. The advisory council may, by by-law, adopt rules governing the conduct of its affairs.

1999, c. 24, s. 74.

Particular positions.

75. The advice and recommendations submitted by the advisory council must, if necessary, contain explanations on the particular position of each member.

Transmission.

The advice and recommendations are filed with the Bureau which shall transmit them to the Office des professions du Québec or, as the case may be, to the Minister responsible for the administration of legislation respecting the professions.

1999, c. 24, s. 75.

Administrative support.

76. The secretary of the Order shall provide the required administrative support to the advisory council, see to the preparation and conservation of its minutes, advice and recommendations and convene its meetings when requested.

Operating costs.

The Order shall defray the operating costs of the advisory council, including the travel and lodging expenses of its members and the flat-rate fees determined by resolution of the Bureau that are granted to them.

1999, c. 24, s. 76.

Report.

77. Not later than six months before the expiry of the term of the first Bureau and after consultation with the bodies concerned, the Office des professions du Québec shall report to

the Minister responsible for the administration of legislation respecting the professions on the functioning of the Order, the efficiency of its human and financial resources and the advisability of renewing the term of the advisory council.

1999, c. 24, s. 77.

Fund.

78. To enable the Order to fulfil all the obligations imposed on it by this Act and the Professional Code (chapter C-26) for the protection of the public during its first eight years of activity, a fund is hereby established consisting of the balance remaining on the amounts reserved for the financing of pilot projects.

Transfer of sum.

The fund, to be managed by the Office des professions du Québec, shall transfer each year to the Order a sum calculated on a regressive averaging basis.

Costs.

The costs incurred for the management of the fund shall be paid out of the interest it produces.

Financial statements.

The annual report of the Order must contain a note to its financial statements detailing the use of the sum transferred pursuant to the second paragraph.

1999, c. 24, s. 78.

Report.

79. Not later than six months before the expiry of the eight years of financial assistance granted to the Order in accordance with section 78, the Office des professions du Québec shall report to the Minister responsible for the administration of legislation respecting the professions on the Order's ability to fulfil the duties imposed on it by this Act and the Professional Code (chapter C-26).

1999, c. 24, s. 79.

Tabling.

80. The reports referred to in sections 77 and 79 shall be tabled in the National Assembly by the Minister responsible for the administration of legislation respecting the professions within 30 days after receiving them or, if the Assembly is not sitting, within 30 days after resumption.

1999, c. 24, s. 80.

Interpretation.

81. Unless the context indicates a different meaning, the provisions of any regulation or other document referring to the practice of midwifery within the framework of pilot projects shall be interpreted to refer to the practice of the midwifery profession pursuant to this Act.

1999, c. 24, s. 81.

82. (Omitted).

1999, c. 24, s. 82.

REPEAL SCHEDULE

In accordance with section 9 of the Act respecting the consolidation of the statutes and regulations (chapter R-3), chapter 24 of the statutes of 1999, in force on 1 April 2000, is repealed, except section 82, effective from the coming into force of chapter S-0.1 of the Revised Statutes.

MIDWIFERY PROFESSION GENERAL REGULATIONS, N.W.T. Reg. 002-2005

MIDWIFERY PROFESSION ACT

MIDWIFERY PROFESSION GENERAL REGULATIONS

R-002-2005

In force January 29, 2005

INCLUDING AMENDMENTS MADE BY

R-046-2005

LOI SUR LA PROFESSION DE SAGE-FEMME

RÈGLEMENT GÉNÉRAL SUR LA PROFESSION DE SAGE-FEMME

R-002-2005

En vigueur le 29 janvier 2005

MODIFIÉ PAR

R-046-2005

This consolidation is not an official statement of the law. It is an office consolidation prepared by Legislation Division, Department of Justice, for convenience of reference only. The authoritative text of regulations can be ascertained from the *Revised Regulations of the Northwest Territories, 1990* and the monthly publication of Part II of the *Northwest Territories Gazette*.

La présente codification administrative ne constitue pas le texte officiel de la loi; elle n'est établie qu'à titre documentaire par les Affaires législatives du ministère de la Justice. Seuls les règlements contenus dans les *Règlements révisés des Territoires du Nord-Ouest (1990)* et dans les parutions mensuelles de la Partie II de la *Gazette des Territoires du Nord-Ouest* ont force de loi.

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MIDWIFERY PROFESSION GENERAL REGULATIONS

R-046-2005,s.2.

The Commissioner, on the recommendation of the Minister, under section 52 of the *Midwifery Profession Act* and every enabling power, makes the *Midwifery Profession Application and Registration Regulations*.

1. In this regulation, "unrestricted", in respect of a person's registration or the registration for which he or she is eligible as a midwife in a province, means that the registration

(a) is not or would not be limited to a temporary period of time that is less than the period for full registration; and

(b) permits or would permit the person to exercise the entire scope of practice of midwifery

(i) without any conditions or restrictions imposed on the person's practice,

(ii) without a requirement for supervision of the person's practice, and

(iii) without a requirement that the person complete additional training or examination prior to entitlement to exercise the entire scope of practice.

2. (1) An applicant must be entitled to work in Canada to be qualified to be a registered midwife.

(2) An applicant is only qualified to be a registered midwife if

(a) his or her registration as a midwife in a province is unrestricted; or

(b) he or she is eligible for unrestricted

RÈGLEMENT GÉNÉRAL SUR LA PROFESSION DE SAGE-FEMME

R-046-2005, art. 2.

Le commissaire, sur la recommandation du ministre, en vertu de l'article 52 de la *Loi sur la profession de sage-femme* et de tout pouvoir habilitant, prend le *Règlement sur la demande d'inscription et l'inscription à titre de sage-femme*.

1. Dans le présent règlement et dans le cadre de l'inscription d'une personne ou de l'admissibilité d'une personne à une inscription à titre de sage-femme dans une province, «sans restriction» s'entend au sens d'une inscription qui, à la fois :

a) n'est pas ou ne serait pas assujettie à des restrictions limitant la durée de l'inscription à une période moindre qu'une inscription complète;

b) accorde ou accorderait à la personne le droit d'exercer pleinement la profession de sage-femme :

(i) sans que ce droit d'exercice soit assujetti à une restriction ou une condition,

(ii) sans que ce droit d'exercice soit assujetti à une supervision,

(iii) sans que ce droit d'exercice soit assujetti à une formation supplémentaire ou à un examen écrit.

2. (1) La personne qui présente une demande doit être autorisée à travailler au Canada pour obtenir le titre de sage-femme autorisée.

(2) La personne qui présente une demande peut obtenir le titre de sage-femme autorisée si :

a) soit elle est dûment inscrite, sans restriction, à titre de sage-femme dans une province;

registration as a midwife in a province.

3. (1) On application to be registered as a registered midwife under subsection 8(1) of the Act, an applicant shall provide the Registrar with a completed application form and other supporting material, including the following:

(a) information satisfactory to the Registrar confirming the identity of the applicant;

(b) a mailing address and telephone number for the applicant;

(c) a photograph of the applicant clearly showing his or her face, taken within six months of the application;

(d) proof that the applicant is entitled to work in Canada;

(e) information on the languages written and spoken by the applicant;

(f) information about

(i) any plans for employment as a registered midwife in the Northwest Territories, including the name, address and telephone number of the prospective employer and the planned date of commencement, or

(ii) any plans to practice as a registered midwife in the Northwest Territories, including the address of, and telephone number for, the planned location of practice and the planned date of commencement;

(g) a resume including all employment history relevant to the practice of midwifery and other health care or professional employment or practice;

(h) proof that the applicant is registered and in good standing as a midwife in a province and that the registration is unrestricted, or proof that the applicant

b) soit elle est admissible à être inscrite, sans restriction, à titre de sage-femme dans une province.

3. (1) Lorsqu'une personne présente une demande d'inscription à titre de sage-femme en application du paragraphe 8(1) de la Loi, elle doit fournir au registraire un formulaire de demande rempli ainsi que la documentation pertinente, notamment :

a) les renseignements que le registraire juge satisfaisants pour confirmer l'identité de la personne qui présente la demande;

b) l'adresse postale et le numéro de téléphone de la personne qui présente la demande;

c) une photographie, prise dans les six mois précédants la demande, qui montre clairement le visage de la personne qui présente la demande;

d) une preuve que la personne qui présente la demande est autorisée à travailler au Canada;

e) des renseignements relatifs aux langues parlées et écrites par la personne qui présente la demande;

f) des renseignements relatifs à, selon le cas :

(i) tout projet d'emploi à titre de sage-femme autorisée aux Territoires du Nord-Ouest de la personne qui présente la demande, notamment le nom, l'adresse et le numéro de téléphone de l'employeur éventuel, ainsi que la date d'entrée en fonction prévue,

(ii) tout projet d'exercice de la profession de sage-femme autorisée aux Territoires du Nord-Ouest de la personne qui présente la demande, notamment l'adresse et le numéro de téléphone du lieu d'exercice prévu, ainsi que la date d'entrée en fonction prévue;

is eligible for unrestricted registration as a midwife in a province;

(i) a copy of the applicant's degree, diploma or certificate in respect of midwifery or documentation proving a determination that the applicant has achieved equivalencies to a degree, diploma or certificate in respect of midwifery, that

(i) entitle the applicant to be registered as a midwife in a province, or

(ii) make the applicant eligible to be registered as a midwife in a province;

(j) information about each current and previous registration or licensing of the applicant as a midwife, or as a practitioner in any other health care field, in the Northwest Territories or in any other jurisdiction, including dates of registration, class of registration, periods of active practice, any restrictions in respect of practice, any periods of suspension or cancellation, and any revocations;

(k) information about each application by the applicant for registration or licensing as a midwife, or as a practitioner in any other health care field, that has been refused in the Northwest Territories or any other jurisdiction;

(l) information about each finding against the applicant of unprofessional conduct as a midwife or as a practitioner in any health care field in the Northwest Territories or any other jurisdiction, including a finding of professional misconduct, incompetence to practice, incapacity to practice, or lack of fitness to practice;

(m) information about any allegation, complaint or proceeding against the applicant in respect of unprofessional conduct as a midwife or as a practitioner in any health care field in the Northwest Territories or any other jurisdiction,

g) le curriculum vitae de la personne qui présente la demande, notamment son expérience professionnelle antérieure pertinente à l'exercice de la profession de sage-femme, ainsi que toute expérience dans le domaine des soins de la santé ou à titre de membre d'une profession libérale pour son propre compte ou pour le compte d'autrui;

h) la preuve que la personne qui présente la demande est dûment inscrite à titre de sage-femme dans une province et que son inscription est sans restriction, ou la preuve que la personne qui présente la demande est admissible à une inscription sans restriction à titre de sage-femme dans une province;

i) une copie du diplôme ou du certificat portant sur la profession de sage-femme de la personne qui présente la demande, ou une preuve écrite d'une décision à l'effet que la personne qui présente la demande a obtenu une équivalence du diplôme ou du certificat portant sur la profession de sage-femme, qui lui donne le droit :

(i) d'être inscrite à titre de sage-femme dans une province,

(ii) d'être admissible à une inscription à titre de sage-femme dans une province;

j) des renseignements relatifs à chaque inscription et à chaque permis d'exercer, à titre de sage-femme ou à titre de professionnel de la santé aux Territoires du Nord-Ouest ou dans toute autre juridiction, passé ou présentement en vigueur, de la personne qui présente la demande, notamment les dates d'inscription, les catégories d'inscription, les périodes d'exercice, toute restriction afférente à l'exercice, toute période de suspension ou d'annulation et toute révocation;

k) des renseignements relatifs à chaque demande d'inscription ou à chaque demande de permis d'exercer à titre de sage-femme ou à titre de professionnel de la santé, faite par la personne qui

including an allegation, a complaint or a proceeding in respect of professional misconduct, incompetence to practice, incapacity to practice, or lack of fitness to practice;

(n) information about any professional liability insurance claim made in respect of the applicant's practice as a midwife or as a practitioner in any health care field in the Northwest Territories or any other jurisdiction;

(o) information about a settlement or judgment in any civil law suit that relates to the applicant's practice as a midwife or as a practitioner in any health care field in the Northwest Territories or any other jurisdiction;

(p) information about any coroner's inquest or verdict that relates to the applicant's practice as a midwife or as a practitioner in any health care field in the Northwest Territories or any other jurisdiction;

(q) information about any conviction of the applicant for an offence under the *Food and Drugs Act* (Canada), the *Controlled Drugs and Substances Act* (Canada), or any other law in any jurisdiction that may be relevant to the practice of a registered midwife;

(r) information about any physical, mental or medical condition of the applicant that may affect the ability of the applicant to practice as a registered midwife;

(s) information about any treatment of the applicant for an addiction that may affect the ability of the applicant to practice as a registered midwife;

(t) a statement by the applicant authorizing the Registrar, or a person designated by the Registrar, to make enquiries of any person, government or body with regard to the information provided by the applicant in the application form and in other supporting material, and authorizing any person to whom enquiries are made to provide any

présente la demande, qui a été refusée aux Territoires du Nord-Ouest ou dans toute autre juridiction;

l) des renseignements relatifs à chaque conclusion de manquement aux devoirs de la profession de sage-femme ou des professionnels de la santé aux Territoires du Nord-Ouest ou toute autre juridiction, de la personne qui présente la demande, en raison notamment d'une faute professionnelle, d'une incompétence à exercer la profession, d'une incapacité à exercer la profession ou d'un manque d'aptitude à exercer la profession;

m) des renseignements relatifs à toute allégation, plainte ou poursuite contre la personne qui présente la demande relativement à sa conduite à titre de sage-femme ou de professionnel de la santé aux Territoires du Nord-Ouest ou toute autre juridiction, en raison notamment d'une faute professionnelle, d'une incompétence à exercer la profession, d'une incapacité à exercer la profession ou d'un manque d'aptitude à exercer la profession;

n) des renseignements relatifs à toute demande d'indemnisation au titre d'une assurance responsabilité, faite contre la personne qui présente la demande, en relation avec son exercice à titre de sage-femme ou à titre de professionnel de la santé aux Territoires du Nord-Ouest ou toute autre juridiction;

o) des renseignements relatifs à un règlement conclu ou une décision rendue dans le cadre d'une poursuite en responsabilité, contre la personne qui présente la demande, en relation avec son exercice à titre de sage-femme ou à titre de professionnel de la santé aux Territoires du Nord-Ouest ou toute autre juridiction;

p) des renseignements relatifs à toute enquête ou verdict du coroner en relation avec l'exercice à titre de sage-femme ou à titre de professionnel de la santé de la personne qui présente la demande aux Territoires du Nord-Ouest

information requested;

(u) a statutory declaration by the applicant attesting to the truth of the information provided by the applicant in the application form and in other supporting material;

(v) an undertaking that the applicant, upon registration, will carry professional liability insurance with an insurer acceptable to the Minister in an amount that is at least the minimum level of coverage required by the Minister.

(2) In addition to the requirements under subsection (1), three references in respect of the

ou toute autre juridiction;

q) des renseignements relatifs à une déclaration de culpabilité, de la personne qui présente la demande, à l'égard d'une infraction à la *Loi sur les aliments et drogues* (Canada), la *Loi réglementant certaines drogues et autres substances* (Canada), ou à toute autre loi d'une autre juridiction qui peut être pertinente à l'exercice de la profession de sage-femme autorisée;

r) des renseignements relatifs à l'état physique, mental ou pathologique de la personne qui présente la demande qui pourraient avoir un effet sur sa capacité d'exercer la profession de sage-femme autorisée;

s) des renseignements relatifs à tout traitement de la toxicomanie suivi par la personne qui présente la demande qui pourraient avoir un effet sur sa capacité d'exercer la profession de sage-femme autorisée;

t) une déclaration de la personne qui présente la demande autorisant le registraire, ou la personne qu'il désigne, à s'enquérir auprès de toute personne, tout gouvernement ou tout organisme des renseignements fournis dans le formulaire de demande et dans la documentation pertinente, et autorisant toute personne consultée dans le cadre de cette recherche à fournir les renseignements demandés;

u) une déclaration solenelle de la personne qui présente la demande attestant de la véracité des renseignements fournis dans le formulaire de demande et dans la documentation pertinente;

v) un engagement, qu'une fois inscrite, la personne qui présente la demande contractera auprès d'un assureur approuvé par le ministre, une assurance responsabilité pour un montant au moins équivalent à celui de la couverture minimale exigée par le ministre.

(2) En plus des exigences du paragraphe (1), la personne qui présente la demande doit fournir au

applicant must be sent directly to the Registrar from people not related to the applicant.

(3) One of the references, referred to in subsection (2), must be from a person who the applicant has known in a professional capacity.

(4) The references referred to in subsection (2) must be in a form approved by the Registrar.

4. Before commencing employment or practice, the registered midwife shall provide the Registrar with proof that the registered midwife carries professional liability insurance with an insurer acceptable to the Minister in an amount that is at least the minimum level of coverage required by the Minister.

5. (1) A registered midwife shall provide to the Registrar, for entry in the Midwifery Register, information in respect of

(a) the registered midwife's employer and place of employment, or the registered midwife's practice and place of practice;

(b) the registered midwife's business address and business telephone number;

(c) any change in the registered midwife's employer, place of employment, practice, place of practice, business address or business telephone number; and

(d) any change in status in respect of the registered midwife's registration or licensing in a province or territory.

d) tout changement dans son statut d'inscription ou d'admissibilité à une inscription dans une province ou un territoire. (2) A registered midwife shall provide the Registrar with the information referred to in paragraphs 5(a) and (b) within two weeks of obtaining employment or commencing practice unless he or she provided the information in his or her application.

(3) A registered midwife shall provide the Registrar with the information referred to in paragraphs 5(c) and (d) within two weeks of the change.

registraire trois références sans lien de parenté avec elle.

(3) Une des références mentionnées au paragraphe (2) doit être une référence professionnelle.

(4) Les références mentionnées au paragraphe (2) doivent être rédigées selon la forme approuvée par le registraire.

4. Avant de commencer son emploi ou l'exercice de sa profession, la sage-femme autorisée doit fournir au registraire une preuve qu'elle contracte auprès d'un assureur approuvé par le ministre, une assurance responsabilité pour un montant au moins équivalent à celui de la couverture minimale exigée par le ministre.

5. (1) Pour être inscrite au registre des sages-femmes, une sage-femme autorisée doit fournir au registraire des renseignements relatifs à :

a) son employeur et son lieu d'emploi ou son exercice de la profession et son lieu d'exercice de la profession;

b) son adresse professionnelle et son numéro de téléphone au travail;

c) tout changement d'employeur, de lieu d'emploi, dans son exercice de la profession, de lieu d'exercice de la profession, d'adresse professionnelle ou de numéro de téléphone au travail;

(2) Dans les deux semaines de l'obtention d'un emploi ou du début d'exercice de la profession de la sage-femme autorisée, celle-ci doit fournir au registraire les renseignements mentionnés aux alinéas 5a) et b), à moins qu'elle ait déjà fourni ces renseignements dans le cadre de sa demande.

(3) Dans les deux semaines du changement de statut de la sage-femme autorisée, celle-ci doit fournir au registraire les renseignements mentionnés aux alinéas 5c) et d).

(4) In addition to the information set out in subsection (1), the Registrar shall enter in the Midwifery Register the information provided by the registered midwife in respect of

(a) the registered midwife's degree, diploma or certificate in respect of midwifery, or information in respect of the determination that the registered midwife has achieved equivalencies to a degree, diploma or certificate in respect of midwifery;

(b) the province where the registered midwife was registered at the time of his or her application under subsection 8(1) of the Act, if he or she qualified to be registered in the Northwest Territories on the basis of that registration;

(c) the province where the registered midwife was eligible for registration at the time of his or her application under subsection 8(1) of the Act, if he or she qualified to be registered in the Northwest Territories on the basis of that eligibility; and

(d) each current and previous registration or licensing of the registered midwife in a province or territory.

5.1. A registered midwife is only eligible for an annual renewal of his or her certificate of registration if he or she holds valid certification in

(a) adult and infant cardiopulmonary resuscitation from a program that complies with guidelines set by the Heart and Stroke Foundation of Canada or other guidelines satisfactory to the Minister; and

(b) neonatal resuscitation, including intubation, from a program that complies with nationally recognized guidelines in respect of neonatal resuscitation, or other guidelines satisfactory to the Minister.

R-046-2005,s.3.

(4) En plus des renseignements mentionnés au paragraphe (1), le registraire inscrit au registre des sages-femmes les renseignements fournis par la sage-femme relativement à :

a) son diplôme ou son certificat portant sur la profession de sage-femme ou la décision qui a été prise attestant que la sage-femme autorisée a obtenu une équivalence du diplôme ou du certificat portant sur la profession de sage-femme;

b) la province où la sage-femme autorisée était inscrite au moment de sa demande d'inscription en vertu du paragraphe 8(1) de la Loi, si cette inscription lui a permis d'être inscrite aux Territoires du Nord-Ouest;

c) la province où la sage-femme autorisée était admissible à une inscription au moment de sa demande d'inscription en vertu du paragraphe 8(1) de la Loi, si cette admissibilité lui a permis d'être inscrite aux Territoires du Nord-Ouest;

d) chaque inscription et chaque permis d'exercer dans une province ou un territoire de la sage-femme autorisée.

5.1. Une sage-femme autorisée est admissible pour un renouvellement annuel de son certificat d'inscription si elle est titulaire d'une attestation en règle en matière de :

a) réanimation cardio-pulmonaire des adultes et des enfants émanant d'un programme qui est conforme aux normes établies par la Fondation des maladies du coeur du Canada ou d'autres normes que le ministre juge satisfaisantes;

b) réanimation néonatale, notamment l'intubation, émanant d'un programme qui est conforme aux normes nationales en matière de réanimation néonatale ou d'autres normes que le ministre juge satisfaisantes. R-046-2005, art. 3.

6. (1) On application for the renewal of a certificate of registration as a registered midwife under subsection 11(2) of the Act, the registered midwife shall provide the Registrar with a completed application form in respect of renewal and other supporting material, including the following:

(a) information satisfactory to the Registrar confirming the identity of the registered midwife;

(b) a mailing address for the registered midwife;

(c) information in respect of the registered midwife's employer and place of employment, or the registered midwife's practice and place of practice;

(d) the registered midwife's business address and business telephone number;

(e) proof that the registered midwife

(i) is registered and in good standing as a midwife in a province and that the registration is unrestricted, or

(ii) has satisfactorily completed the continuing competency program for registered midwives adopted under section 8;

(e.1) proof that the registered midwife holds the certifications required under section 5.1;

(f) proof that the registered midwife carries professional liability insurance with an insurer acceptable to the Minister in an amount that is at least the minimum level of coverage required by the Minister;

(g) information about each finding against the registered midwife of unprofessional conduct, including professional misconduct, incompetence to practice, incapacity to practice, or lack of fitness to practice as a midwife or as a practitioner in any health care field in the Northwest Territories or any other

6. (1) Lorsqu'une personne présente une demande de renouvellement du certificat d'inscription d'une sage-femme autorisée en application du paragraphe 11(2) de la Loi, elle doit fournir au registraire un formulaire de demande de renouvellement rempli ainsi que la documentation pertinente, notamment :

a) les renseignements que le registraire juge satisfaisants pour confirmer l'identité de la sage-femme autorisée;

b) l'adresse postale de la sage-femme autorisée;

c) des renseignements relatifs à l'employeur et au lieu d'emploi de la sage-femme autorisée ou son exercice de la profession et son lieu d'exercice de la profession;

d) l'adresse professionnelle et le numéro de téléphone au travail de la sage-femme autorisée;

e) une preuve que la sage-femme autorisée :

(i) est dûment inscrite à titre de sage-femme dans une province et que son inscription est sans restriction,

(ii) a terminé avec succès le programme de formation professionnelle continue pour les sages-femmes autorisées adopté en vertu de l'article 8;

e.1) une preuve que la sage-femme autorisée est titulaire des attestations exigées en vertu de l'article 5.1;

f) une preuve que la sage-femme autorisée contracte auprès d'un assureur approuvé par le ministre, une assurance responsabilité pour un montant au moins équivalent à celui de la couverture minimale exigée par le ministre;

g) des renseignements relatifs à chaque conclusion de manquement aux devoirs de la profession de sage-femme ou de professionnel de la santé aux Territoires du Nord-Ouest ou toute autre juridiction,

jurisdiction;

(h) information about any allegation, complaint or proceeding against the registered midwife in relation to conduct, including professional misconduct, incompetence to practice, incapacity to practice, or lack of fitness to practice as a midwife or as a practitioner in any health care field in the Northwest Territories or any other jurisdiction;

(i) information about any professional liability insurance claim made in respect of the registered midwife's practice as a midwife or as a practitioner in any health care field in the Northwest Territories or any other jurisdiction;

(j) information about a settlement or judgment in any civil law suit that relates to the registered midwife's practice as a midwife or as a practitioner in any health care field in the Northwest Territories or any other jurisdiction;

(k) information about any coroner's inquest or verdict that relates to the registered midwife's practice as a midwife or as a practitioner in any health care field in the Northwest Territories or any other jurisdiction;

(l) information about any conviction of the registered midwife for an offence under the *Food and Drugs Act* (Canada), the *Controlled Drugs and Substances Act* (Canada), or any other law in any jurisdiction that may be relevant to the practice of a registered midwife;

(m) information about any physical, mental or medical condition of the registered midwife that may affect his or her ability to practice as a registered midwife;

(n) information about any treatment of the registered midwife for an addiction that may affect his or her ability to practice as a registered midwife;

(o) a statement by the registered midwife

de la sage-femme autorisée, en raison notamment d'une faute professionnelle, d'une incompétence à exercer la profession, d'une incapacité à exercer la profession ou d'un manque d'aptitude à exercer la profession;

h) des renseignements relatifs à toute allégation, plainte ou poursuite contre la sage-femme autorisée relativement à sa conduite à titre de sage-femme ou de professionnel de la santé aux Territoires du Nord-Ouest ou toute autre juridiction, en raison notamment d'une faute professionnelle, d'une incompétence à exercer la profession, d'une incapacité à exercer la profession ou d'un manque d'aptitude à exercer la profession;

i) des renseignements relatifs à toute demande d'indemnisation au titre d'une assurance responsabilité, faite contre la sage-femme autorisée, en relation avec son exercice à titre de sage-femme ou à titre de professionnel de la santé aux Territoires du Nord-Ouest ou toute autre juridiction;

j) des renseignements relatifs à un règlement conclu ou une décision rendue dans le cadre d'une poursuite en responsabilité, contre la sage-femme autorisée, en relation avec son exercice à titre de sage-femme ou à titre de professionnel de la santé aux Territoires du Nord-Ouest ou toute autre juridiction;

k) des renseignements relatifs à toute enquête ou verdict du coroner en relation avec l'exercice à titre de sage-femme ou à titre de professionnel de la santé de la sage-femme autorisée aux Territoires du Nord-Ouest ou toute autre juridiction;

l) des renseignements relatifs à une déclaration de culpabilité, de la sage-femme autorisée, à l'égard d'une infraction à la *Loi sur les aliments et drogues* (Canada), la *Loi réglementant certaines drogues et autres substances* (Canada), ou à toute autre loi d'une autre juridiction qui peut être pertinente à l'exercice de la profession de sage-

authorizing the Registrar, or a person designated by the Registrar, to make enquiries of any person, government or body, with regard to the information provided by the registered midwife in the application form and in other supporting material, and authorizing any person to whom enquiries are made to provide any information requested;

(p) a statutory declaration by the registered midwife attesting to the truth of the information provided by the registered midwife in the application form and in other supporting material.

femme autorisée;

m) des renseignements relatifs à l'état physique, mental ou pathologique de la sage-femme autorisée qui pourraient avoir un effet sur sa capacité d'exercer la profession de sage-femme autorisée;

n) des renseignements relatifs à tout traitement de la toxicomanie suivi par la sage-femme autorisée qui pourraient avoir un effet sur sa capacité d'exercer la profession de sage-femme autorisée;

o) une déclaration de la personne qui présente la demande autorisant le registraire, ou la personne qu'il désigne, à s'enquérir auprès de toute personne, tout gouvernement ou tout organisme des renseignements fournis dans le formulaire de demande et dans la documentation pertinente;

p) une déclaration solenelle de la sage-femme autorisée attestant de la véracité des renseignements fournis dans le formulaire de demande et dans la documentation pertinente.

(2) On application for reinstatement of a person's registration as a registered midwife under subsection 11(5) of the Act, the person shall provide the Registrar with a completed application form in respect of renewal, referred to in subsection (1), and the other supporting material referred to in subsection (1).

R-046-2005,s.4.

(2) Lorsqu'une personne présente une demande de rétablissement de l'inscription d'une sage-femme autorisée en application du paragraphe 11(5) de la Loi, elle doit fournir au registraire un formulaire rempli de demande de renouvellement mentionné au paragraphe (1) ainsi que la documentation pertinente mentionnée au paragraphe (1). R-046-2005, art. 4.

7. (1) The fee prescribed under subsection 8(1) of the Act for registration of an applicant as a registered midwife is $150.

(2) The fee prescribed under subsection 11(2) and paragraph 11(5)(b) of the Act for renewal of a certificate of registration for a registered midwife is $150.

(3) The fee prescribed under paragraph 11(5)(b) of the Act for reinstatement of a person's registration as a registered midwife is $150.

(4) A person to whom section 12 of the Act

7. (1) Les cotisations pour l'inscription d'une sage-femme autorisée visées au paragraphe 8(1) de la Loi sont de 150 $.

(2) Les cotisations pour le renouvellement d'un certificat d'inscription d'une sage-femme autorisée visées au paragraphe 11(2) et à l'alinéa 11(5)b) de la Loi sont de 150 $.

(3) Les cotisations pour le rétablissement de l'inscription d'une personne à titre de sage-femme autorisée visées à l'alinéa 11(5)b) de la Loi sont de 150 $.

(4) Une personne visée à l'article 12 de la Loi doit payer les cotisations suivantes pour obtenir le

applies shall pay the following fees for reinstatement:

(a) the fee set out in subsection (2) for renewal, if the period of suspension includes the date when the person's certificate of registration as a registered midwife would have expired; and

(b) the fee set out in subsection (3) for reinstatement.

8. The *Continuing Competency Program For Registered Midwives In the NWT*, established by the Midwives Association of the Northwest Territories and Nunavut, January 31, 2005, is adopted.

R-046-2005,s.5.

9. The *Code of Conduct for Registered Midwives in the NWT*, established by the Midwives Association of the Northwest Territories and Nunavut, January 31, 2005, is adopted. R-046-2005,s.5.

10. The practice of registered midwives shall conform with standards for the practice of registered midwives approved by the Minister. R-046-2005,s.5.

rétablissement de son inscription :

a) d'une part, les cotisations fixées au paragraphe (2) pour le renouvellement du certificat d'inscription, si la période de suspension inclut la date à laquelle le certificat d'inscription de la personne se serait expiré;

b) d'autre part, les cotisations fixées au paragraphe (3) pour le rétablissement de l'inscription.

8. Le *Continuing Competency Program For Registered Midwives In the NWT*, établi par l'Association des sages-femmes des Territoires du Nord-Ouest et du Nunavut le 31 janvier 2005, est adopté. R-046-2005, art. 5.

9. Le *Code of Conduct for Registered Midwives in the NWT*, établi par l'Association des sages-femmes des Territoires du Nord-Ouest et du Nunavut le 31 janvier 2005, est adopté. R-046-2005, art. 5.

10. L'exercice de la profession de sage-femme autorisée doit être conforme aux normes qui s'appliquent à l'exercice de la profession de sage-femme autorisée approuvées par le ministre.

R-046-2005, art. 5.

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MIDWIFERY PROFESSION ACT, S.N.W.T. 2003, c. 21

MIDWIFERY PROFESSION ACT

S.N.W.T. 2003,c.21

In force January 29, 2005;

SI-001-2005

LOI SUR LA PROFESSION DE SAGE-FEMME

L.T.N.-O. 2003, ch. 21

En vigueur le 29 janvier 2005;

TR-001-2005

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ENTRÉE EN VIGUEUR

Entrée en vigueur

MIDWIFERY PROFESSION ACT

The Commissioner of the Northwest Territories, by and with the advice and consent of the Legislative Assembly, enacts as follows:

INTERPRETATION

Definitions **1.** In this Act,

"Complaints Officer" means the Complaints Officer appointed under subsection 15(1); (*préposé aux plaintes*)

"Deputy Complaints Officer" means the Deputy Complaints Officer appointed under subsection 15(1) and any additional Deputy Complaints Officer appointed under subsection 15(2); (*Deputy*

LOI SUR LA PROFESSION DE SAGE-FEMME

Le commissaire des Territoires du Nord-Ouest, sur l'avis et avec le consentement de l'Assemblée législative, édicte :

DÉFINITIONS

1. Les définitions qui suivent s'appliquent à la présente loi. Définitions

«adjoint du préposé aux plaintes» L'adjoint du préposé aux plaintes nommé en application du paragraphe 15(1) et les adjoints du préposé aux plaintes nommés en application du paragraphe 15(2). (*Deputy Complaints Officer)*

«Cadre d'exercice de la profession de sage-

Complaints Officer)

"health care professional" means a health care professional as defined in section 13 of the *Evidence Act*; (*professionnel de la santé*)

"Midwifery Practice Framework" means the framework established or adopted under section 5; (*Cadre d'exercice de la profession de sage-femme*)

"Midwifery Register" means the Midwifery Register referred to in subsection 7(1); (*registre des sages-femmes*)

"registered midwife" means a person who is registered in the Midwifery Register under subsection 8(1); (*sage-femme autorisée*)

"Registrar" means the Registrar appointed under section 6. (*registraire*)

femme» Le Cadre d'exercice établit ou adopté en vertu de l'article 5. (*Midwifery Practice Framework*)

«préposé aux plaintes» Le préposé aux plaintes nommé en application du paragraphe 15(1). (*Complaints Officer*)

«professionnel de la santé» Un professionnel de la santé, tel que défini à l'article 13 de la *Loi sur la preuve*. (h*ealth care professional*)

«registraire» Le registraire nommé en application de l'article 6. (*Registrar*)

«registre des sages-femmes» Le registre des sages-femmes visé au paragraphe 7(1). (*Midwifery Register*)

«sage-femme autorisée» Personne inscrite au registre des sages-femmes en application du paragraphe 8(1). (*registered midwife*)

PART 1

PRACTICE OF REGISTERED MIDWIVES

PARTIE 1

EXERCICE DE LA PROFESSION DE SAGE-FEMME

Registered Midwives

Sages-femmes autorisées

Practice of registered midwives

2. (1) A registered midwife is entitled to apply midwifery knowledge, skills and judgment

(a) to provide counselling and education related to childbearing;

2. (1) La sage-femme autorisée a le droit de mettre en application des connaissances, des techniques et de porter un jugement clinique :

a) afin de donner des conseils et de faire de l'éducation en matière de

Exercice de la profession de sage-femme

(b) to carry out assessments necessary to confirm and monitor pregnancies;

(c) to advise on and secure the further assessments necessary for the earliest possible identification of pregnancies at risk;

(d) to identify the conditions in the woman, fetus or newborn that necessitate consultation with or referral to a medical practitioner or other health care professional;

(e) to care for the woman and monitor the condition of the fetus during labour;

(f) to conduct spontaneous vaginal births;

(g) to examine and care for the newborn in the immediate postpartum period;

(h) to care for the woman in the postpartum period and advise her and her family on newborn and infant care and family planning;

(i) to take emergency measures when necessary;

(j) to perform, order or interpret prescribed screening and diagnostic tests;

(k) to perform episiotomies and amniotomies and repair episiotomies and lacerations not involving the anus, anal sphincter, rectum and urethra;

(l) to prescribe and administer drugs authorized in the Midwifery Practice

maternité;

b) afin de confirmer et surveiller les grossesses;

c) afin de déceler, le plus tôt possible, les grossesses à risques;

d) afin d'identifier chez la patiente, le fœtus ou le nouveau-né, les troubles médicaux qui nécessitent l'intervention d'un médecin ou d'un autre professionnel de la santé;

e) afin de dispenser des soins à la patiente et surveiller l'évolution du fœtus pendant la période des contractions;

f) afin de pratiquer des accouchements spontanés par voie vaginale;

g) afin d'examiner et de dispenser des soins postnatals au nouveau-né;

h) afin de dispenser des soins à la patiente pendant la période postnatale et conseiller la patiente et sa famille sur les soins à apporter au nouveau-né et sur le planning familial;

i) afin de prendre des mesures d'urgence au besoin;

j) afin de pratiquer, ordonner et interpréter les tests de dépistage et de diagnostic appropriés;

k) afin de pratiquer des épisiotomies et des amnioscopies, coudre les épisiotomies et les lacérations qui ne touchent pas l'anus, le sphincter anal, le rectum et

Framework; and

(m) on the order of a medical practitioner relating to a particular client, to administer any drugs by the route and in the dosage specified by the medical practitioner.

l'urètre;

l) afin de prescrire et d'administrer les médicaments autorisés dans le Cadre d'exercice de la profession de sage-femme;

m) afin d'administrer à une patiente, sur ordonnance d'un médecin, des médicaments par la voie et selon le dosage spécifiés par le médecin.

Limitation

(2) The entitlement in subsection (1) is subject to the regulations and the Midwifery Practice Framework.

(2) Le droit conféré par le paragraphe (1) est assujetti aux règlements et au Cadre d'exercice de la profession de sage-femme.

Restriction

Use of title

(3) A registered midwife may use the title "Registered Midwife" or a variation or an equivalent in another language of the title, and may use after his or her name a designation that is an abbreviation of the title, variation or equivalent. S.N.W.T. 2006,c.24,s.49.

(3) A registered midwife may use the title "Registered Midwife" or a variation or an equivalent in another language of the title, and may use after his or her name a designation that is an abbreviation of the title, variation or equivalent. L.T.N.-O. 2006, ch. 24, art. 49.

Utilisation du titre

3. Deleted in Standing Committee, September 18, 2003.

3. Supprimé par le comité permanent le

18 septembre 2003.

Primary health care provider

4. A registered midwife may, in accordance with this Act, the regulations and the Midwifery Practice Framework, engage in the practice of registered midwives as a primary health care provider who

4. Une sage-femme autorisée peut, conformément à la présente loi, aux règlements et au Cadre d'exercice de la profession de sage-femme, exercer sa profession à titre de fournisseur de soins de santé primaires et :

Fournisseur de soins de santé primaires

(a) is directly accessible to clients without referral from a member of another health profession;

a) recevoir des clientes sans qu'elles ne lui soient dirigées par des membres d'autres professions de la santé;

(b) is authorized to provide the services of a registered midwife without being supervised by a member of another health profession;

b) dispenser des soins dans le cadre de sa profession sans la supervision de membres d'autres professions de la santé;

and

(c) consults with medical practitioners or other health care professionals if medical conditions exist or arise that may require management outside the scope of the practice of registered midwives.

c) consulter des médecins ou d'autres professionnels de la santé, s'il existe ou s'il survient des troubles médicaux nécessitant l'intervention de personnes n'exerçant pas la profession de sage-femme autorisée.

Midwifery Practice Framework

Cadre d'exercice de la profession de sage-femme

Establishment of framework

5. (1) The Minister, on the recommendation of the Executive Council, may establish a framework respecting the practice of registered midwives.

5. (1) Le ministre, sur la recommandation du Conseil exécutif, peut établir un Cadre d'exercice de la profession de sage-femme.

Établissement du Cadre d'exercice

Adoption of framework

(2) Where a framework respecting the practice of midwifery has been established by an association, person or body of persons in a province or another territory and is available in written form, the Minister, on the recommendation of the Executive Council, may adopt the framework or the framework as amended from time to time, and upon adoption the framework is in force in respect of registered midwives either in whole or in part or with such variations as may be specified in the instrument adopting the framework.

(2) Si un Cadre d'exercice de la profession de sage-femme est établi par une association, une personne ou un groupe de personnes dans une province ou un autre territoire et peut être obtenu sous forme écrite, le ministre, sur la recommandation du Conseil exécutif, peut adopter le Cadre d'exercice ou la version modifiée de celui-ci, auquel cas ce Cadre d'exercice s'applique dès son adoption aux sages-femmes autorisées, en tout ou en partie ou avec les modifications que peut préciser le texte qui l'adopte.

Adoption d'un Cadre d'exercice

PART 2

REGISTRATION

PARTIE 2

INSCRIPTION

Registrar

Registraire

Appointment

6. The Minister shall appoint a Registrar.

6. Le ministre nomme un registraire.

Nomination

Midwifery Register

Registre des sages-femmes

Midwifery

7. (1) The Registrar shall maintain a record called the Midwifery

7. (1) Le registraire tient un registre intitulé le Registre des sages-

Registre des

Register

Register, in which shall be entered

(a) the name, business address and business telephone number of every registered midwife;

(b) a notation of every suspension and reinstatement of a registered midwife's registration and certificate of registration and cancellation of a registered midwife's certificate of registration;

(c) a notation of every imposition, and every revocation of an imposition, of limitations, terms or conditions on the registered midwife's entitlement to practice;

(d) a notation of every decision or order made under Part 3 by a Board of Inquiry or the Supreme Court, including every deemed order under subsection 22(4), in respect of each registered midwife who is subject to the decision or order; and

(e) any other information that is prescribed pertaining to registered midwives.

Inspection of Midwifery Register

(2) Any person is entitled to inspect the Midwifery Register at any reasonable time.

sages-femmes

femmes, dans lequel sont inscrits :

a) le nom des sages-femmes autorisées, leur adresse professionnelle et leur numéro de téléphone au travail;

b) une inscription relative à chaque suspension et réinscription d'une sage-femme autorisée ou de son certificat d'inscription, et de chaque annulation d'un certificat d'inscription;

c) une inscription de chaque restriction et de chaque révocation de restrictions ou conditions, imposées au droit d'exercice d'une sage-femme autorisée;

d) une inscription de chaque décision ou ordonnance rendue sous le régime de la partie 3 par une commission d'enquête ou la Cour suprême, y compris les ordonnances rendues sous le régime du paragraphe 22(4) et ce, pour chaque sage-femme autorisée qui fait l'objet de la décision ou de l'ordonnance;

e) les renseignements relatifs aux sages-femmes, prévus par règlement.

Consultation des registres

(2) Le registre des sages-femmes peut être consulté par quiconque à un moment convenable.

Registration

Registration of registered midwives

8. (1) On application and payment of the prescribed fee, the Registrar shall, if satisfied that the applicant meets the qualifications set out in subsection (2),

(a) register the applicant in the Midwifery Register as a registered midwife; and

(b) issue a certificate of registration to the applicant.

Qualifications

(2) An applicant is qualified to be a registered midwife if the applicant

(a) is of good character, is competent and fit to engage in the practice of registered midwives and has a satisfactory professional reputation;

(b) is registered and in good standing as a midwife in a province or is eligible to be registered as a midwife in a province; and

(c) meets any other requirements that are prescribed.

Refusal to register

9. Where an application for registration as a registered midwife is refused under subsection 8(1), the Registrar shall provide the applicant with a written notice of and reasons for the refusal.

Appeal to Supreme Court

10. (1) A person whose application for registration as a registered midwife is refused may, within 30 days after receiving written notice of and reasons for the refusal, appeal the refusal to the Supreme Court by filing a notice of appeal with the Supreme Court and serving it on the Registrar.

Order of

(2) If, on hearing an appeal under subsection (1), the Supreme

Inscription

Inscription des sages-femmes autorisées

8. (1) Si une personne qui a payé les cotisations fixées par règlement lui présente une demande, et s'il est convaincu que cette personne remplit les conditions énoncées au paragraphe (2), le registraire :

a) l'inscrit au registre des sages-femmes à titre de sage-femme autorisée;

b) lui délivre un certificat d'inscription.

Conditions

(2) Peut être inscrite à titre de sage-femme autorisée, la personne qui, à la fois :

a) est de bonnes moeurs, a les compétences voulues et est apte à exercer la profession de sage-femme, et jouit d'une bonne réputation sur le plan professionnel;

b) est dûment inscrite à titre de sage-femme dans une province ou est éligible à être inscrite comme sage-femme dans une province;

c) répond à toute autre exigence prescrite par règlement.

Refus d'inscription

9. Si une demande d'inscription à titre de sage-femme autorisée est refusée sous le régime du paragraphe 8(1), le registraire fait parvenir à l'auteur de la demande un avis écrit motivé du refus.

Appel à la Cour suprême

10. (1) La personne dont la demande d'inscription à titre de sage-femme autorisée est refusée peut, dans les 30 jours suivant la réception de l'avis écrit et motivé du refus, interjeter appel du refus en déposant un avis d'appel auprès de la Cour suprême et en le signifiant au registraire.

Ordonnance

(2) Si elle conclut, après avoir instruit l'appel en application du

Supreme Court

Court finds that the refusal to register is unreasonable, the Supreme Court may

paragraphe (1), que le refus d'inscription est déraisonnable, la Cour suprême peut, par ordonnance :

de la Cour suprême

(a) make an order requiring the Registrar to register the person as a registered midwife and issue a certificate of registration to the person; or

a) enjoindre au registraire d'inscrire la personne à titre de sage-femme autorisée et de lui délivrer un certificat d'inscription;

(b) make any further order that is warranted in the circumstances.

b) prendre toute autre mesure justifiée dans les circonstances.

Costs

(3) The Supreme Court, on hearing an appeal under subsection (1), may make any order as to costs that it considers appropriate.

(3) La Cour suprême peut, après avoir instruit l'appel en vertu du paragraphe (1), rendre toute ordonnance qu'elle estime indiquée quant aux frais.

Frais

Order is final

(4) An order made under subsection (2) is final and conclusive and shall be acted upon without delay by the Registrar.

(4) L'ordonnance de la Cour suprême rendue en vertu du paragraphe (2) est définitive et sans appel, et le registraire doit l'exécuter sans délai.

Ordonnance

Annual Renewal of Certificate

Renouvellement annuel du certificat

Duration of certificate

11. (1) A certificate of registration of a registered midwife expires on December 31 next following the date of issue or renewal.

11. (1) Le certificat d'inscription d'une sage-femme autorisée est valide jusqu'au 31 décembre suivant la date de sa délivrance ou de son renouvellement.

Durée de validité du

certificatRenewal of certificate

(2) On application made before the expiry of a certificate of registration under subsection (1) and payment of the prescribed fee for renewal, the Registrar shall, if satisfied that the registered midwife is eligible under subsection (3), renew the certificate of registration of the registered midwife.

(2) Sur demande présentée en conformité avec le paragraphe (1) pendant la période de validité du certificat et sur paiement des cotisations prescrites par règlement, le registraire renouvelle le certificat d'inscription d'une sage-femme autorisée s'il est d'avis que la sage-femme a les qualités requises en vertu du paragraphe (3).

Renouvellement du certificat

Eligibility for renewal of certificate

(3) A registered midwife is eligible for an annual renewal of his or her certificate of registration if he or she

(3) Le certificat d'une sage-femme autorisée peut être renouvelé annuellement si, à la fois elle :

Conditions de renouvellement du certificat

(a) is registered and in good standing as a midwife in a province or has satisfactorily completed the continuing competence

a) est dûment inscrite à titre de sage-femme dans une province ou a complété de façon satisfaisante le programme de maintien des compétences pour les sages-

program for registered midwives established or adopted by the regulations; and

(b) meets any other requirements that are prescribed.

femmes autorisées, établit ou adopté par règlement;

b) répond à toute autre exigence prescrite par règlement.

Removal from Midwifery Register

(4) A person who fails to renew his or her certificate of registration shall be removed from the Midwifery Register.

(4) Le nom de toute personne qui omet de renouveler son certificat d'inscription est radié du registre des sages-femmes.

Radiation du registre des sages-femmes

Reinstatement

(5) If a person has been removed from the Midwifery Register under subsection (4), the Registrar may reinstate the person's registration and issue a certificate of registration to the person on

(a) application to reinstate the person's registration, if the application is made within 60 days after removal from the Midwifery Register under subsection (4); and

(b) payment of the prescribed fee for reinstatement and the prescribed fee for renewal.

(5) Le registraire peut rétablir l'inscription de toute personne dont le nom a été radié du registre des sages-femmes en application du paragraphe (4) et lui délivrer un certificat d'inscription sur :

a) demande de rétablissement de l'inscription présentée dans les 60 jours suivant la date de la radiation en application du paragraphe (4);

(b) paiement des cotisations et des droits prescrits par règlement pour le renouvellement et pour le rétablissement.

Rétablissement de l'inscription

Reinstatement following suspension

12. Where a registered midwife has been suspended under section 32 or 35, the Registrar shall, on payment of any fees required under the regulations, reinstate the person in the Midwifery Register

(a) where the suspension is for a stated period, on the expiry of that period; and

(b) where terms and conditions for reinstatement were set by a Board of Inquiry or a court, on being notified by the

12. Si une sage-femme autorisée suspendue en vertu de l'article 32 ou 35 paie les cotisations fixées par règlement, le registraire la réinscrit au registre des sages-femmes :

a) dans le cas où la personne a été suspendue pour une période déterminée, à la fin de cette période;

b) dans le cas où des conditions de réinscription ont été fixées par une commission d'enquête ou par un tribunal, dès qu'il est avisé par le préposé aux plaintes que

Réinscription au registre après une suspension

Complaints Officer that the terms and conditions have been met.

ces conditions ont été remplies.

Professional Liability Insurance

Assurance responsabilité

Professional liability insurance

13. A registered midwife shall carry professional liability insurance with an insurer acceptable to the Minister and in an amount that is at least the minimum level of coverage required by the Minister.

13. Une sage-femme autorisée doit contracter auprès d'un assureur approuvé par le ministre, une assurance responsabilité pour un montant au moins équivalent à celui de la couverture minimale exigée par le ministre.

Assurance responsabilité

PART 3

REVIEW OF CONDUCT

Interpretation

Definitions

14. (1) In this Part,

"complainant" means

(a) a person who files a complaint under subsection 19(1),

(b) the Complaints Officer, where he or she files a complaint under subsection 19(4) or refers further allegations to a Board of Inquiry under subsection 26(2), or

(c) the Deputy Complaints Officer referred to in paragraph 16(1)(b), where he or she refers further allegations to a Board of Inquiry under subsection 26(2); (*plaignant*)

"member of the public" means a person resident in the Northwest Territories who is not and never has been registered under this Act and who is not a member of a health profession regulated by an enactment of a province or territory; (*membre du public*)

"registered midwife" includes a former registered midwife. *(sage-femme autorisée)*

PARTIE 3

EXAMEN DE LA CONDUITE

Définitions

Définitions

14. (1) Les définitions qui suivent s'appliquent à la présente partie.

«membre du public» Un résident des Territoires du Nord-Ouest qui n'est pas et n'a jamais été inscrit sous le régime de la présente loi et qui n'est pas membre d'une profession de la santé régie par un texte d'une province ou d'un territoire. (*member of the public*)

«plaignant» S'entend :

a) de la personne qui dépose une plainte en vertu du paragraphe 19(1);

b) du préposé aux plaintes, lorsqu'il dépose une plainte en vertu du paragraphe 19(4) ou lorsque qu'il renvoie des allégations supplémentaires à une commission d'enquête en vertu du paragraphe 26(2);

c) de l'adjoint du préposé aux plaintes mentionné à l'alinéa 16 (1)b) lorsqu'il renvoie des allégations supplémentaires à une commission d'enquête en vertu du paragraphe 26 (2). (*complainant)*

«sage-femme autorisée» Y est assimilée la personne qui a déjà été une sage-femme autorisée.

(registered midwife)

Reference to complaint

(2) For the purposes of sections 18, 22 and 27 to 34, a reference to a complaint includes a reference to allegations referred to a Board of Inquiry under subsection 26(2).

Mention de la plainte

(2) Pour l'application des articles 18, 22 et 27 à 34, toute mention d'une plainte vaut mention des allégations renvoyées à une commission d'enquête en vertu du paragraphe 26(2).

Complaints Officer

Préposé aux plaintes

Appointments

15. (1) The Minister shall appoint a Complaints Officer and a Deputy Complaints Officer.

Nomination

15. (1) Le ministre nomme un préposé aux plaintes et un adjoint du préposé aux plaintes.

Additional appointments

(2) The Minister may appoint one or more additional Deputy Complaints Officers.

Nominations supplémentaires

(2) Le ministre peut nommer un ou plusieurs adjoints du préposé aux plaintes.

Complaints Officer as complainant

16. (1) Where the Complaints Officer is a complainant,

(a) he or she shall not perform or exercise the duties and powers of the Complaints Officer in respect of that complaint or any other complaint specified by the Minister under paragraph (b); and

(b) the Deputy Complaints Officer shall perform and exercise the duties and powers of the Complaints Officer in respect of that complaint, and if the Minister considers it appropriate in the circumstances, any other complaint specified by the Minister.

Préposé aux plaintes comme plaignant

16. (1) Le préposé aux plaintes qui agit comme plaignant:

a) ne doit pas exécuter ou exercer les fonctions et pouvoirs du préposé aux plaintes à l'égard de cette plainte ou de toute autre plainte spécifiée par le ministre en application de l'alinéa b);

b) l'adjoint du préposé aux plaintes exécute et exerce les attributions du préposé aux plaintes à l'égard de cette plainte, et de toute autre plainte que le ministre juge appropriée dans les circonstances.

plaignantDeputy Complaints Officer as complainant

(2) Where the Deputy Complaints Officer referred to in paragraph (1)(b) is a complainant,

(a) he or she shall not

(i) perform or exercise the duties and powers of the Complaints Officer in respect of that complaint or any other complaint specified by the Minister under

Adjoint du préposé aux plaintes comme plaignant

(2) L'adjoint du préposé aux plaintes mentionné à l'alinéa (1) b) qui agit comme plaignant :

a) ne doit pas :

(i) exécuter ou exercer les attributions du préposé aux plaintes à l'égard de cette plainte ou de toute autre plainte spécifiée par le ministre en application du sous-

subparagraph (b)(i), or

(ii) perform the duty of the Deputy Complaints Officer under subsection 26(3); and

(b) another Deputy Complaints Officer shall

(i) perform and exercise the duties and powers of the Complaints Officer in respect of that complaint, and if the Minister considers it appropriate in the circumstances, any other complaint specified by the Minister, and

(ii) perform the duty of the Deputy Complaints Officer under subsection 26(3).

alinéa b)(i),

(ii) exercer les fonctions de l'adjoint du préposé aux plaintes en vertu du paragraphe 26 (3);

b) un autre adjoint au préposé aux plaintes :

(i) exécute ou exerce les attributions du préposé aux plaintes à l'égard de cette plainte, et de toute autre plainte que le ministre juge appropriée dans les circonstances,

(ii) exerce les fonctions de l'adjoint du préposé aux plaintes en vertu du paragraphe 26 (3).

References to "Complaints Officer"

(3) Where the Complaints Officer or the Deputy Complaints Officer referred to in paragraph (1)(b) is a complainant, a reference to "Complaints Officer" in this Act shall be read as a reference to the Deputy Complaints Officer referred to in paragraph (1)(b) or (2)(b), as the case may be, except in the definition "Complaints Officer" in section 1, paragraph (b) of the definition "complainant" in subsection 14(1), section 15, this section and subsections 19(1), (4) and (5).

(3) Lorsque le préposé aux plaintes ou l'adjoint du préposé aux plaintes visé à l'alinéa (1)b), agit comme plaignant, une mention dans cette loi au «préposé aux plaintes» vaut mention de l'adjoint du préposé aux plaintes visé aux alinéas (1)b) ou (2)b), selon le cas, à l'exception de la définition de «préposé aux plaintes» à l'article 1, de l'alinéa b) de la définition de «plaignant» au paragraphe 14(1), à l'article 15, au présent article et aux paragraphes 19(1), (4) et (5).

Mention du préposé aux plaintes

Unprofessional Conduct

Manquement aux devoirs de la profession

Unprofessional conduct

17. (1) An act or omission of a registered midwife constitutes unprofessional conduct if a Board of Inquiry finds that the registered midwife

(a) engaged in conduct that

(i)

17. (1) Un acte ou une omission attribuable à une sage-femme autorisée constitue un manquement aux devoirs de la profession si une commission d'enquête conclut que la sage-femme autorisée :

a) a eu une conduite qui, selon le cas :

Manquement aux devoirs de

demonstrates a lack of knowledge, skill or judgment in the practice of registered midwives,

(ii) is detrimental to the best interests of the public,

(iii) harms the standing of the midwifery profession,

(iv) contravenes this Act or the regulations, or

(v) is prescribed as unprofessional conduct; or

(b) provided services of a registered midwife when his or her capacity to provide those services, in accordance with accepted standards, was impaired by a disability or a condition, including an addiction or an illness.

(i) indique un manque de connaissances, de technique ou de jugement dans l'exercice de la profession de sage-femme,

(ii) est préjudiciable à l'intérêt du public,

(iii) nuit à l'image de la profession de sage-femme,

(iv) contrevient à la présente loi ou aux règlements,

(v) constitue, selon les règlements, un manquement aux devoirs de la profession;

b) a fourni des services de sage-femme autorisée alors que sa capacité de le faire, selon les normes établies, était affaiblie par un handicap ou une affection, y compris une dépendance ou une maladie.

la professionExamples of unprofessional conduct

(2) Examples of unprofessional conduct include:

(a) practice that fails to meet accepted standards;

(b) the abandonment of a patient in danger without first ensuring that the patient has obtained alternative medical or nursing services or services of another registered midwife;

(c) verbal or physical abuse of a patient;

(d) irresponsible

(2) Sont assimilés à des manquements aux devoirs de la profession :

Exemples de manquements aux devoirs de la profession

a) le fait d'exercer la profession d'une manière qui ne satisfait pas aux normes requises;

b) le fait d'abandonner un malade en danger sans s'assurer au préalable que celui-ci ait obtenu d'autres services médicaux ou des soins infirmiers ou les services d'une autre sage-femme autorisée;

c) le fait

disclosure of confidential information about a patient;

(e) providing false or misleading information respecting birth, death, notice of disease, state of health, vaccination, course of treatment or any other matter relating to life or health;

(f) the impersonation of another registered midwife or health care professional;

(g) obtaining registration or employment through misrepresentation or fraud;

(h) the failure, or refusal, without reasonable cause, to respond to an inquiry, or to comply with a demand for the production of documents, records or other materials made by an investigator under subsection 24(1);

(i) a conviction for a criminal offence, the nature of which could affect the practice of registered midwives.

d'infliger des mauvais traitements verbaux ou physiques à une patiente;

d) le fait de divulguer de façon irresponsable des renseignements confidentiels au sujet d'une patiente;

e) le fait de fournir de renseignements faux ou trompeurs sur la naissance, la mort, la présence d'une maladie, l'état de santé, la vaccination, le traitement suivi ou sur tout autre sujet relatif à la vie ou à la santé;

f) le fait de se faire passer pour une autre sage-femme autorisée ou pour un autre professionnel de la santé;

g) le fait d'obtenir une inscription ou un emploi à l'aide de fausses déclarations ou d'une manière frauduleuse;

h) le fait d'omettre ou de refuser, sans raison valable, de répondre à une demande de renseignements ou de se conformer à une demande formelle de production d'éléments matériels, y compris des documents ou des dossiers, faite par un enquêteur en vertu du paragraphe 24(1);

i) le fait d'être déclaré coupable d'une infraction criminelle dont la nature pourrait nuire à l'exercice de la profession de sage-femme.

Complaints

Plaintes

Timely

18. Complaints shall be dealt with under this Part in a timely

18. Les plaintes déposées en conformité avec la présente partie,

Règlement

resolution

manner.

doivent être traitées en temps utile.

des plaintes en temps utile

Complaints

19. (1) A person who wishes to make a complaint that an act or omission of a registered midwife constitutes unprofessional conduct may file a complaint with the Complaints Officer.

19. (1) Toute personne peut déposer auprès du préposé aux plaintes une plainte à l'effet qu'une sage-femme autorisée s'est rendue coupable de manquement aux devoirs de la profession.

Plaintes

Continuing jurisdiction

(2) A complaint respecting the conduct of a registered midwife who is no longer registered in the Midwifery Register, may be dealt with under this Part if it is filed under subsection (1) within two years after the day on which the registered midwife ceased to be registered.

(2) Toute plainte concernant la conduite d'une sage-femme autorisée qui n'est plus inscrite au registre des sages-femmes peut être traitée en conformité avec la présente partie, pour autant qu'elle soit déposée en application du paragraphe (1) dans les deux ans suivant le jour où la sage-femme autorisée a cessé d'être inscrite.

Compétence se prolongeant dans le temps

Form of complaint

(3) A complaint filed under subsection (1) must be in writing and must include the name of and a mailing address for the complainant.

(3) La plainte déposée en vertu du paragraphe (1) est présentée sous forme écrite et indique le nom ainsi que l'adresse postale du plaignant.

Forme de

la plainteComplaint initiated by Complaints Officer

(4) In the absence of a complaint under subsection (1), if the Complaints Officer has evidence that the conduct of a registered midwife is likely to pose a significant risk to the health or safety of the public, the Complaints Officer shall file a written complaint with the Deputy Complaints Officer referred to in paragraph 16(1)(b).

(4) Si aucune plainte n'a été déposée sous le régime du paragraphe (1) et s'il possède la preuve que la conduite d'une sage-femme autorisée pourrait vraisemblablement représenter un risque sérieux pour la santé ou la sécurité du public, le préposé aux plaintes dépose une plainte écrite auprès de l'adjoint du préposé aux plaintes mentionné à l'alinéa 16(1)b).

Dépôt d'une plainte par le préposé aux plaintes

Service of complaint

(5) On receiving a complaint filed under subsection (1) or (4), the Complaints Officer or the Deputy Complaints Officer, if the Complaints Officer filed the complaint, shall cause the registered midwife who is the subject of the complaint to be served with written notice of the complaint and with information about the substance of the complaint.

(5) Lorsqu'il reçoit une plainte déposée en vertu des paragraphes (1) ou (4), le préposé aux plaintes, ou l'adjoint du préposé aux plaintes, si le préposé aux plaintes est celui qui a déposé la plainte, fait signifier à la sage-femme autorisée qui en fait l'objet un avis écrit de la plainte ainsi que des renseignements quant à la teneur de celle-ci.

Signification de la plainte

Review and inquiry

20. (1) The Complaints Officer shall review and inquire into a complaint to the extent that he or she determines is warranted for the purposes of this section and section 22.

20. (1) Le préposé aux plaintes examine la plainte et enquête sur celle-ci dans la mesure où il l'estime justifié pour l'application du présent article et de l'article 22.

Examen et enquête

Dismissal of complaint

(2) The Complaints Officer may dismiss a complaint if he or she finds that

(a) the allegations made in the complaint do not pertain to conduct that is regulated under this Act or the regulations; or

(b) the complaint is frivolous or vexatious.

(2) Le préposé aux plaintes peut rejeter la plainte s'il conclut, selon le cas :

a) que les allégations que contient la plainte ne concernent pas une conduite régie par la présente loi ou par les règlements;

b) qu'elle est frivole ou vexatoire.

Rejet de la plainte

Service of dismissal

(3) On dismissing a complaint under this section, the Complaints Officer shall cause the complainant and the registered midwife who is the subject of the complaint to be served with written notice of and reasons for the dismissal.

(3) S'il rejette la plainte en application du présent paragraphe, le préposé aux plaintes fait signifier au plaignant et à la sage-femme autorisée qui en fait l'objet un avis écrit motivé du rejet.

Signification du rejet

Suspension

21. (1) Where the conduct of a registered midwife is being reviewed under this Part, the Complaints Officer may

(a) suspend the registered midwife's registration and certificate, if the Complaints Officer determines that a suspension is necessary to protect the health or safety of the public; or

(b) impose any limitations, terms or conditions on the registered midwife's entitlement to practice that the Complaints Officer determines is necessary to protect the health or safety of the public.

21. (1) Si la conduite d'une sage-femme autorisée est examinée sous le régime de la présente partie, le préposé aux plaintes peut :

a) soit suspendre l'inscription et le certificat de la sage-femme autorisée, s'il estime que cette mesure est nécessaire pour la protection de la santé ou la sécurité du public;

b) soit imposer les restrictions ou les conditions relativement au droit d'exercer de la sage-femme autorisée, qu'il estime nécessaires pour la protection de la santé ou la sécurité du public.

Suspension

Service of suspension

(2) Where the Complaints Officer imposes a suspension under paragraph (1)(a), or imposes limitations, terms or conditions on a registered midwife's entitlement to practice under paragraph (1)(b), the Complaints Officer shall

(a) cause the

(2) S'il impose une suspension en application de l'alinéa (1)a), ou des restrictions ou conditions relativement au droit d'exercer de la sage-femme autorisée en application de l'alinéa (1)b), le préposé aux plaintes doit :

a) faire signifier à la sage-femme autorisée un avis

Signification d'un avis de suspension

registered midwife to be served with written notice of and reasons for the suspension or the imposition of limitations, terms or conditions; and

(b) cause the Registrar to be served with written notice of the suspension or the imposition of limitations, terms or conditions.

écrit motivé de la mesure prise;

b) faire signifier au registraire un avis écrit motivé de la mesure prise.

Effective date of suspension

(3) A suspension under paragraph (1)(a) or the imposition of limitations, terms or conditions under paragraph (1)(b),

(a) is not effective until written notice of and reasons for the suspension, or the imposition of limitations, terms or conditions, is served on the registered midwife who is the subject of the complaint; and

(b) is only effective until

(i) the complaint is settled and the settlement is approved under section 22,

(ii) the complaint is dismissed under subsection 25(1), or

(iii) a decision is rendered in respect of the complaint under sections 32 to 34.

(3) La mesure visée à l'alinéa (1)a) ou b) :

Prise d'effet de la suspension

a) ne prend pas effet avant qu'un avis écrit motivé soit signifié à la sage-femme autorisée qui fait l'objet de la plainte;

b) ne s'applique pas jusqu'à ce que la plainte, selon le cas :

(i) soit réglée et que le règlement soit approuvé en vertu de l'article 22,

(ii) soit rejetée en vertu du paragraphe 25(1),

(iii) fasse l'objet d'une décision en vertu des articles 32 à 34.

Revocation of suspension

(4) A suspension under paragraph (1)(a) or the imposition of limitations, terms or conditions under paragraph (1)(b) shall be revoked if the Complaints Officer determines that it is no longer necessary to protect the health or safety of the public.

(4) La mesure visée à l'alinéa (1)a) ou b) est révoquée si le préposé aux plaintes détermine qu'elle n'est plus nécessaire pour la protection de la santé ou de la sécurité du public.

Révocation de la suspension

Reinstatement and entering revocation

(5) Where a suspension or the imposition of limitations, terms or conditions is revoked under subsection (4), the Complaints Officer shall notify the Registrar without delay and the Registrar shall, without delay,

(a) in the case of the revocation of a suspension, reinstate the registered midwife in the Midwifery Register; and

(b) in the case of the revocation of the imposition of limitations, terms or conditions, enter a notation of the revocation in the Midwifery Register.

Réinscription de la sage-femme et inscription de la révocation

(5) Si la suspension ou l'imposition de restrictions ou de conditions est révoquée en application du paragraphe (4), le préposé aux plaintes en avise immédiatement le registraire qui, dans les plus brefs délais :

a) dans le cas de la révocation d'une suspension, réinscrit la sage-femme autorisée au registre des sages-femmes;

b) dans le cas de la révocation de l'imposition de restrictions ou de conditions, inscrit la révocation au registre des sages-femmes.

Appeal

(6) A registered midwife who is suspended under paragraph (1)(a), or who has limitations, terms or conditions imposed on his or her entitlement to practice under paragraph (1)(b), may appeal the Complaints Officer's decision to the Supreme Court by filing a notice of appeal with the Supreme Court and serving it on the Minister.

Appel

(6) La sage-femme autorisée qui fait l'objet d'une mesure visée à l'alinéa (1)a) ou b) peut interjeter appel de la décision du préposé aux plaintes devant la Cour suprême en déposant un avis d'appel auprès de ce tribunal et en le signifiant au ministre.

Decision

(7) If, on hearing an appeal under subsection (6), the Supreme Court finds that the suspension of the registered midwife or the imposition of limitations, terms or conditions on the registered midwife's entitlement to practice is unreasonable, the Supreme Court may

(a) make a decision or an order that reverses or modifies the decision of the Complaints Officer;

(b) refer the matter, or any issue, back to the Complaints Officer for further consideration; or

(c) provide any direction that it considers appropriate.

Décision

(7) Si elle conclut, après avoir instruit l'appel, que la mesure dont la sage-femme autorisée fait l'objet est déraisonnable, la Cour suprême peut :

a) rendre une décision ou une ordonnance qui infirme ou modifie la décision du préposé aux plaintes;

b) renvoyer la cause, ou une question s'y rapportant, au préposé aux plaintes pour examen;

c) donner les directives qu'elle estime indiquées.

Costs

(8) The Supreme Court, on hearing an appeal under subsection (6),

Frais

(8) La Cour suprême peut, après avoir instruit l'appel en vertu du

may make any order as to costs that it considers appropriate.

paragraphe (6), rendre toute ordonnance qu'elle estime indiquée quant aux frais.

Alternative Dispute Resolution

Mode amiable de règlement des conflits

Alternative dispute resolution

22. (1) At any time after a complaint is filed, but before a hearing into the complaint is complete, the Complaints Officer may refer the complaint to an alternative dispute resolution process if

(a) the complainant and the registered midwife who is the subject of the complaint agree to attempt to have the complaint settled through the process; and

(b) the Complaints Officer is of the opinion that an attempt to settle the complaint through the process is appropriate in the circumstances.

22. (1) Le préposé aux plaintes peut, à tout moment après que la plainte soit déposée mais avant la fin de l'audience y afférente, soumettre la plainte à un mode amiable de règlement des conflits dans le cas où :

a) d'une part, le plaignant et la sage-femme autorisée qui fait l'objet de la plainte conviennent de recourir à ce mode pour tenter d'en arriver à un règlement de la plainte;

b) d'autre part, il estime qu'il est opportun de le faire dans les circonstances.

Mode amiable de règlement des conflits

Prescribed processes

(2) If alternative dispute resolution processes are prescribed, the alternative dispute resolution process referred to in subsection (1) must be one that is prescribed.

(2) Le mode amiable de règlement des conflits choisi en application du paragraphe (1) doit être un mode prescrit par règlement.

Choix du mode

Approval by Complaints Officer

(3) No settlement of a complaint under this section comes into effect unless the Complaints Officer approves the terms and conditions of the settlement.

(3) Si la plainte est réglée en application du présent article, le règlement ne prend effet que lorsque ses modalités sont approuvées par le préposé aux plaintes.

Approbation du règlement par le préposé aux plaintes

Deemed orders

(4) The terms and conditions of the settlement of a complaint approved under subsection (3) are deemed to be orders of a Board of Inquiry under subsection 32(2) or section 33, and any contravention of or failure to fulfill the terms and conditions may be treated in the same manner as a contravention of or a failure to fulfill an order of a Board of Inquiry made under those sections.

(4) Les modalités du règlement approuvé en vertu du paragraphe (3) sont réputées constituer des ordonnances rendues par une commission d'enquête sous le régime du paragraphe 32(2) ou de l'article 33. Le défaut de les observer ou leur violation peut être traité de la même manière qu'un défaut d'observer les ordonnances d'une commission d'enquête ou qu'une violation de celles-ci.

Ordonnances présumées

Time limit

(5) If a complaint referred to an alternative dispute resolution process, or part of it, is not settled within 60 days after the referral or within such further

(5) La plainte soumise à un mode amiable de règlement des conflits ou les questions non réglées dans les 60 jours suivant la date à laquelle la plainte

Délai

period of time as is agreed to by the Complaints Officer, the complainant and the registered midwife who is the subject of the complaint, then the complaint, or the unsettled part, shall be dealt with under this Part as if there had been no referral to an alternative dispute resolution process.

est soumise à ce mode amiable de règlement des conflits ou dans le délai supplémentaire dont conviennent le préposé aux plaintes, le plaignant et la sage-femme autorisée qui fait l'objet de cette plainte, sont traitées en conformité avec la présente partie comme si elles n'avaient jamais été soumises à un mode amiable de règlement des conflits.

Investigation

Enquêtes

Designation of investigator

23. The Complaints Officer shall, in writing, designate one or more investigators to investigate any complaint that

(a) is not dismissed under subsection 20(2);

(b) is not referred to an alternative dispute resolution process under subsection 22(1); or

(c) was referred to an alternative dispute resolution process under subsection 22(1) that did not result in a settlement of the complaint and approval of the settlement.

Désignation d'un enquêteur

23. Le préposé aux plaintes désigne par écrit un ou des enquêteurs afin que ceux-ci enquêtent sur toute plainte qui :

a) n'est pas rejetée sous le régime du paragraphe 20(2);

b) n'est pas soumise à un mode amiable de règlement des conflits visé au paragraphe 22(1);

c) a été soumise sans succès à un mode amiable de règlement des conflits visé au paragraphe 22(1).

Inquiries and production

24. (1) For the purpose of investigating a complaint, an investigator may

(a) make oral or written inquiries of any person who has or may have information relevant to the complaint; and

(b) demand the production for examination of documents, records and other materials that are or may be relevant to the complaint.

Demande de renseignements et de production

24. (1) Aux fins de l'enquête, l'enquêteur peut :

a) d'une part, demander des renseignements, oralement ou par écrit, à quiconque possède ou peut posséder des renseignements ayant trait à la plainte;

b) d'autre part, demander formellement la production, pour examen, d'éléments matériels, y compris des documents et des dossiers, qui ont ou peuvent avoir trait à la plainte.

Copies

(2) An investigator may copy documents, records and materials that are produced under subsection (1).

Reproduction

(2) L'enquêteur peut faire des copies des éléments matériels produits en application du paragraphe (1).

Application to Supreme Court

(3) Where a person refuses or fails to respond to any inquiry or to comply with a demand made by an investigator under subsection (1), the Complaints Officer may apply to the Supreme Court for an order requiring the person to respond to the inquiry or to comply with the demand.

(3) En cas de refus ou d'omission de la part d'une personne de répondre à une demande de renseignements ou de se plier à une demande formelle faite en vertu du paragraphe (1), le préposé aux plaintes peut demander à la Cour suprême d'ordonner à la personne de répondre à la demande de renseignements ou de se plier à la demande formelle.

Demande à la Cour suprême

Failure or refusal to respond or comply

(4) Where a registered midwife who is the subject of a complaint fails or refuses, without reasonable cause, to respond to any inquiry or to comply with a demand made by an investigator under subsection (1), the investigator may file a complaint with the Complaints Officer and the failure or refusal may be found by a Board of Inquiry to be unprofessional conduct.

(4) Si la sage-femme autorisée qui fait l'objet de la plainte omet ou refuse, sans raison valable, de répondre à une demande de renseignements ou de se plier à une demande formelle faite en vertu du paragraphe (1), l'enquêteur peut déposer une plainte auprès du préposé aux plaintes, auquel cas une commission d'enquête peut conclure que l'omission ou le refus constitue un manquement aux devoirs de la profession.

Omission ou refus de répondre ou de se plier à une demande

Other matters

(5) An investigator may investigate any other matter that arises during the course of an investigation that may constitute unprofessional conduct by the registered midwife who is the subject of the complaint.

(5) L'enquêteur peut enquêter sur toute autre question qui se présente au cours de l'enquête et à l'égard de laquelle la sage-femme autorisée qui fait l'objet de la plainte pourrait s'être rendue coupable de manquement aux devoirs de la profession.

Autres questions

Written report to Complaints Officer

(6) On completing an investigation, the investigator shall provide a written report to the Complaints Officer.

(6) Une fois l'enquête terminée, l'enquêteur remet un rapport écrit au préposé aux plaintes.

Rapport écrit au préposé aux plaintes

Dismissal of complaint

25. (1) On review of an investigation report provided under subsection 24(6), the Complaints Officer may dismiss a complaint if he or she finds that

25. (1) Après avoir examiné le rapport d'enquête déposé en application du paragraphe 24(6), le préposé aux plaintes peut rejeter la plainte s'il conclut, selon le cas :

Rejet de la plainte

(a) the allegations made in the complaint do not pertain to conduct that is regulated under this Act or the regulations;

a) que les allégations qu'elle contient ne concernent pas une conduite régie par la présente loi ou les règlements;

(b) the complaint is frivolous or vexatious; or

b) qu'elle est frivole ou vexatoire;

(c) there is insufficient evidence of unprofessional conduct to provide a reasonable basis for referring

c) qu'il n'existe pas d'éléments de preuve suffisants quant au manquement aux

the complaint to a hearing.

devoirs de la profession pour justifier la tenue d'une audience relativement à la plainte.

Service of dismissal

(2) On dismissing a complaint under this section, the Complaints Officer shall cause the complainant and the registered midwife who is the subject of the complaint to be served with written notice of and reasons for the dismissal.

Signification du rejet

(2) S'il rejette la plainte en vertu du présent article, le préposé aux plaintes fait signifier au plaignant et à la sage-femme autorisée qui en fait l'objet un avis écrit motivé du rejet.

Hearing

Audience

Establishment of Board of Inquiry

26. (1) If a complaint is not dismissed under subsection 25(1) or referred to an alternative dispute resolution process under subsection 22(1),

(a) the Complaints Officer shall notify the Minister who shall

(i) establish a Board of Inquiry to hear the matter, composed of at least three members appointed by the Minister, including two persons who are registered midwives or who are registered and in good standing as midwives in a province or another territory and one person who is a member of the public, and

(ii) designate one member as chairperson of the Board of Inquiry; and

(b) the Complaints Officer shall refer the complaint to the Board of Inquiry for a hearing.

Établissement d'une commission d'enquête

26. (1) Si la plainte n'est pas rejetée en application du paragraphe 25(1) ou soumise à un mode amiable de règlement des conflits en application du paragraphe 22(1) :

a) le préposé aux plaintes en avise le ministre qui doit :

(i) établir une commission d'enquête afin qu'elle instruise l'affaire, cette commission devant se composer d'au moins trois membres nommés par le ministre, dont deux sages-femmes autorisées ou personnes dûment inscrites à titre de sage-femme dans une province ou un autre territoire et un membre du public,

(ii) désigner un membre qui agira à titre de président de la commission d'enquête;

b) le préposé aux plaintes renvoie la plainte à la commission d'enquête afin que celle-ci tienne une audience.

Further allegations

(2) If the investigation report into the complaint contains information that, in the opinion of the Complaints Officer, may support allegations of unprofessional conduct by the registered midwife who is the subject of the

Allégations supplémentaires

(2) Si le rapport d'enquête relatif à la plainte comprend des renseignements qui, selon le préposé aux plaintes, peuvent appuyer des allégations de manquement aux devoirs de la profession par la sage-femme autorisée faisant l'objet

complaint, in addition to those contained in the complaint, the Complaints Officer may refer the further allegations to the Board of Inquiry for a hearing.

de la plainte, en plus de celles que contient la plainte, le préposé aux plaintes peut renvoyer les allégations supplémentaires à la commission d'enquête afin qu'elle tienne une audience.

Service of further allegations

(3) Where the Complaints Officer refers further allegations to the Board of Inquiry under subsection (2), the Deputy Complaints Officer referred to in paragraph 16(1)(b) shall cause the registered midwife who is the subject of the complaint to be served with written notice of those allegations.

(3) Lorsque le préposé aux plaintes renvoie des allégations supplémentaires à la commission d'enquête en application du paragraphe (2), l'adjoint du préposé aux plaintes mentionné à l'alinéa 16(1)b), fait signifier à la sage-femme autorisée qui fait l'objet de la plainte un avis écrit de ces allégations supplémentaires.

Signification des allégations supplémentaires

Hearing

27. (1) A Board of Inquiry shall conduct a hearing into a complaint that is referred to it.

27. (1) La commission d'enquête tient une audience relativement à la plainte qui lui est renvoyée.

Audience

Notice of hearing

(2) The Board of Inquiry shall cause the complainant and the registered midwife who is the subject of the complaint to be served with written notice stating the date, time and place of the hearing at least 30 days before its commencement.

(2) La commission d'enquête fait signifier au plaignant et à la sage-femme autorisée qui fait l'objet de la plainte un préavis écrit d'au moins 30 jours indiquant la date, l'heure et le lieu de l'audience.

Avis d'audience

Absence of member

(3) Subject to subsection (4), if a person appointed to a Board of Inquiry under subparagraph 26(1)(a)(i) becomes unable to continue with the conduct of the hearing into the complaint, the Board of Inquiry may, in the absence of the member, continue with and complete the hearing and render a decision.

(3) Sous réserve du paragraphe (4), si une des personnes désignées en application du sous-alinéa 26(1)a)(i) ne peut poursuivre l'audience, la commission d'enquête peut, en son absence, poursuivre et terminer l'audience, et rendre une décision.

Absence d'un membre

Requirement

(4) No Board of Inquiry may continue with less than two members, or without an appointed member of the public.

(4) La commission d'enquête ne peut poursuivre l'audience si elle compte moins de deux membres ou si elle ne compte aucun membre du public.

Conditions

Adjournment

(5) A Board of Inquiry

(5) La commission d'enquête :

Ajournement

(a) shall adjourn a hearing into a complaint if notified by the Complaints Officer that the complaint is being referred to an alternative dispute resolution process; and

a) ajourne l'audience si le préposé aux plaintes l'avise que la plainte est soumise à un mode amiable de règlement des conflits;

(b) shall only resume a hearing into a complaint if

b) ne reprend l'audience que si le préposé

notified by the Complaints Officer that the complaint has not been settled.

aux plaintes l'avise que la plainte n'a pas été réglée.

Assistance for hearing

28. (1) The Board of Inquiry may engage, at the expense of the Government of the Northwest Territories, any legal or other assistance that it considers necessary for the conduct of any hearing.

28. (1) La commission d'enquête peut recourir, aux frais du gouvernement des Territoires du Nord-Ouest, à l'assistance qu'elle estime nécessaire au déroulement de l'audience, notamment à l'assistance d'avocats.

Assistance lors de l'audience

Rights of complainant

(2) A complainant has the same right to attend and be heard at a hearing as a registered midwife who is the subject of a complaint.

(2) Le plaignant a le droit d'être présent et de se faire entendre lors de l'audience au même titre que la sage-femme autorisée qui fait l'objet de la plainte.

Droits du plaignant

Legal representation

(3) A complainant and a registered midwife who is the subject of a complaint may be represented by legal counsel at a hearing.

(3) Le plaignant et la sage-femme autorisée qui fait l'objet de la plainte peuvent se faire représenter par un avocat lors de l'audience.

Droit de se faire représenter par un avocat

Hearings in public

(4) A hearing must be open to the public unless the Board of Inquiry is of the opinion that the interests of a person, other than the registered midwife who is the subject of the complaint, may be detrimentally affected if the hearing, or part of the hearing, is not held in private.

(4) L'audience est publique sauf si la commission d'enquête est d'avis que le fait de ne pas la tenir en tout ou en partie à huis clos peut porter atteinte aux intérêts d'une personne, à l'exclusion de la sage-femme autorisée qui fait l'objet de la plainte.

Audience tenue en public

Rules

(5) The Board of Inquiry may, subject to this Act and the regulations, make rules of procedure respecting the conduct of hearings.

(5) Sous réserve des autres dispositions de la présente loi et des règlements, la commission peut établir des règles de procédure concernant le déroulement des audiences.

Règles

Non-attendance at hearing

(6) If a registered midwife who is the subject of a complaint does not attend a hearing into the complaint, the Board of Inquiry, on proof of service of the notice of hearing, may proceed with the hearing and take any action authorized by this Act without further notice to the registered midwife.

(6) Si la sage-femme autorisée qui fait l'objet de la plainte ne se présente pas à l'audience, la commission d'enquête peut, sur preuve de signification de l'avis d'audience, procéder à celle-ci et prendre toute mesure que la présente loi autorise sans donner d'autre avis à la sage-femme autorisée.

Absence lors de l'audience

Notice to attend hearing

29. (1) The attendance of a witness before a hearing and the production of documents, records or other materials may be enforced by a notice that is issued by the Complaints Officer and served on the witness, requiring the witness to attend and

29. (1) La comparution d'un témoin lors de l'audience et la production d'éléments matériels, notamment de documents ou de dossiers, peuvent être obtenus par avis délivré par le préposé aux plaintes et signifié au témoin, lequel avis

Avis de comparution

stating the date, time and place at which the witness is to attend and the documents, records and other materials, if any, that the witness is required to produce.

enjoint à celui-ci de comparaître tout en lui indiquant les date, heure et lieu de sa comparution ainsi que, le cas échéant, les éléments matériels qu'il est tenu de produire.

Issue of notice on request

(2) On the written request of the registered midwife who is the subject of the complaint, the complainant, or legal counsel for the registered midwife or the complainant, the Complaints Officer shall, without charge, issue and deliver to that person the notices that he or she may require for the attendance of witnesses or the production of documents, records or other materials.

Délivrance de l'avis sur demande

(2) Le préposé aux plaintes délivre gratuitement à la sage-femme autorisée qui fait l'objet de la plainte, à son avocat ou au plaignant, sur demande écrite, les avis que cette personne peut exiger pour la comparution de témoins ou la production d'éléments matériels.

Testimony of non-resident witness

(3) For the purpose of obtaining the testimony of a witness who is outside of the Northwest Territories, the Supreme Court, on *ex parte* application by the chairperson of the Board of Inquiry, the complainant or the registered midwife who is the subject of the complaint, may make an order appointing an examiner for the obtaining of the evidence of the witness under the Rules of the Supreme Court, with such modifications as the circumstances may require.

Témoignage d'un non-résident

(3) Aux fins de l'obtention du témoignage d'une personne qui ne réside pas aux Territoires du Nord-Ouest, un juge de la Cour suprême peut, sur demande *ex parte* présentée par le président de la commission d'enquête, le plaignant ou la sage-femme autorisée qui fait l'objet de la plainte, rendre une ordonnance nommant un auditeur afin que soit recueilli le témoignage de cette personne en conformité avec les Règles de la Cour suprême, lesquelles s'appliquent avec les adaptations nécessaires.

Witness fees

(4) A witness, other than the registered midwife who is the subject of the complaint, who has been served with a notice to attend or a notice for the production of documents, records or other materials, is entitled to be paid the usual fees payable to witnesses in an action in the Supreme Court by the party requiring the witness to attend or to produce.

Indemnité des témoins

(4) Tout témoin, à l'exclusion de la sage-femme autorisée faisant l'objet de la plainte, à qui un avis de comparution ou un avis de production d'éléments matériels a été signifié a le droit de recevoir de la partie qui demande la comparution ou la production, les indemnités habituelles versées aux témoins dans les actions intentées devant la Cour suprême.

Oath or affirmation

(5) Any Board of Inquiry member has the power to administer an oath or affirmation to a witness who is to give evidence before the Board of Inquiry.

Serments ou affirmations solennelles

(5) Tout membre de la commission d'enquête peut faire prêter serment à une personne qui s'apprête à témoigner devant la commission ou recevoir son affirmation solennelle.

Rules of evidence

(6) Evidence may be given before a Board of Inquiry in any manner that it considers appropriate, including by telephone or by an audiovisual method, and a Board of Inquiry is not bound by the rules of evidence pertaining to actions and proceedings in courts of justice, but may proceed to ascertain the facts in the

Règles de preuve

(6) Les dépositions peuvent être faites devant la commission d'enquête de la manière que celle-ci estime indiquée, notamment par téléphone ou à l'aide d'équipement audiovisuel. Elle n'est pas liée par les règles de preuve qui s'appliquent aux actions intentées et aux instances introduites devant les tribunaux

manner that it considers proper.

judiciaires, mais peut établir les faits de la manière qu'elle juge appropriée.

Civil contempt

30. (1) On application to the Supreme Court in accordance with the Rules of the Supreme Court, proceedings for civil contempt of court may be brought against a witness

(a) who fails

(i) to attend before a hearing of the Board of Inquiry after receiving a notice to attend,

(ii) to produce documents, records or other materials as required by a notice to produce them, or

(iii) in any way to comply with a notice referred to in subparagraph (i) or (ii); or

(b) who refuses to be sworn or affirmed, or to answer any question allowed by the Board of Inquiry before whom the hearing is being conducted.

Outrage civil

30. (1) Sur demande adressée à la Cour suprême en conformité avec les Règles de la Cour suprême, les poursuites applicables en cas d'outrage civil au tribunal peuvent être intentées contre le témoin qui, selon le cas :

a) omet :

(i) soit de comparaître à une audience de la commission d'enquête après avoir reçu un avis de comparution,

(ii) soit de produire les éléments matériels, notamment les documents ou les dossiers, exigés par un avis de production,

(iii) soit de se conformer d'une façon quelconque à l'avis mentionné au sous-alinéa (i) ou (ii);

b) refuse de prêter serment, de faire une affirmation solennelle ou de répondre à une question permise par la commission d'enquête qui tient l'audience.

Unprofessional conduct

(2) If the witness referred to in subsection (1) is the registered midwife who is the subject of the complaint, the failure or refusal may be held by the Board of Inquiry to be unprofessional conduct.

Manquement aux devoirs de la profession

(2) Si le témoin visé au paragraphe (1) est la sage-femme autorisée qui fait l'objet de la plainte, la commission d'enquête peut assimiler l'omission ou le refus à un manquement aux devoirs de la profession.

Compellable witness

31. (1) A registered midwife and any other person who, in the opinion of the Board of Inquiry, has knowledge in respect of a complaint, is a compellable witness at a hearing into that complaint.

Témoins contraignables

31. (1) Les sages-femmes autorisées et les autres personnes qui, de l'avis de la commission d'enquête, possèdent des renseignements à l'égard d'une plainte sont des témoins contraignables lors d'une audience relative à cette plainte.

Registered midwife as witness

(2) A registered midwife may be examined on oath or affirmation on all matters relevant to the hearing and shall not be excused from answering a question on the ground of professional privilege or on the ground that the answer might

(a) tend to incriminate the registered midwife,

(b) subject the registered midwife to punishment under the disciplinary provisions of this Act, or

(c) tend to establish the liability of the registered midwife

(i) in a civil proceeding at the instance of the Government of the Northwest Territories or any person, or

(ii) to prosecution under an Act of the Northwest Territories or an Act of Canada,

but if the answer so given

(d) tends to incriminate the registered midwife,

(e) subjects the registered midwife to punishment, or

(f) tends to establish the liability of the registered midwife,

it may not be used or received against the registered midwife in any civil proceedings or in any proceedings under any other Act of the Northwest Territories, except in a prosecution for or proceedings in respect of perjury or the giving of contradictory evidence.

Témoignage d'une sage-femme autorisée

(2) Une sage-femme autorisée peut être interrogée sous serment ou sous affirmation solennelle sur tout point ayant trait à l'audience et n'est pas dispensée de répondre à une question pour le motif qu'elle est liée par le secret professionnel ou pour le motif que la réponse pourrait, selon le cas :

a) tendre à incriminer la sage-femme autorisée;

b) exposer la sage-femme autorisée à une sanction prévue par les dispositions de la présente loi qui portent sur les mesures disciplinaires;

c) tendre à établir la responsabilité de la sage-femme autorisée :

(i) soit dans une instance civile introduite par le gouvernement des Territoires du Nord-Ouest ou par toute personne,

(ii) soit dans une poursuite intentée sous le régime d'une loi des Territoires du Nord-Ouest ou d'une loi fédérale.

La réponse qui tend à incriminer la sage-femme autorisée, l'expose à une sanction ou tend à établir sa responsabilité ne peut être utilisée ni reçue en preuve contre elle dans une poursuite civile ou dans une poursuite intentée sous le régime de toute autre loi des Territoires du Nord-Ouest, sauf dans une poursuite pour parjure ou témoignage contradictoire ou dans une instance y afférente.

Decision

Action where conduct not unprofessional

32. (1) If, on completion of a hearing, the Board of Inquiry finds that the conduct under review is not unprofessional conduct, the Board of Inquiry shall dismiss the complaint.

Action on finding of unprofessional conduct

(2) If, on completion of a hearing, the Board of Inquiry finds that an act or omission of a registered midwife constitutes unprofessional conduct, the Board of Inquiry may, by order:

(a) reprimand the registered midwife;

(b) suspend the registration and certificate of the registered midwife for a stated period;

(c) suspend the registration and certificate of the registered midwife until the Complaints Officer is satisfied

(i) that the registered midwife has completed a specified course of studies or obtained supervised practical experience,

(ii) as to the general competence of the registered midwife, or in the registered midwife's competence in a particular area of practice, or

(iii) that a disability or condition is unlikely to result in further unprofessional conduct;

Décision

Absence de manquement aux devoirs de la profession

32. (1) Si elle conclut, au terme de l'audience, que la conduite faisant l'objet de l'examen ne constitue pas un manquement aux devoirs de la profession, la commission d'enquête rejette la plainte.

Mesures prises en cas de manquement

(2) Si elle conclut, au terme de l'audience, qu'un acte ou qu'une omission de la sage-femme autorisée constitue un manquement aux devoirs de la profession, la commission d'enquête peut, par ordonnance :

a) réprimander la sage-femme autorisée;

b) suspendre l'inscription et le certificat de la sage-femme autorisée pour une période déterminée;

c) suspendre l'inscription et le certificat de la sage-femme autorisée jusqu'à ce que le préposé aux plaintes soit convaincu, selon le cas :

(i) qu'elle a suivi un programme d'études déterminé ou a obtenu une expérience pratique sous surveillance,

(ii) quant à ses compétences générales ou quant à ses compétences dans un domaine particulier d'exercice,

(iii) qu'un handicap ou qu'une affection n'entraînera vraisemblablement pas un autre manquement aux devoirs de la profession;

d) accepter, au lieu

(d) accept, in place of a suspension, the registered midwife's undertaking to limit his or her practice for a stated period or until the Complaints Officer is satisfied that the limit is no longer required;

(e) impose limitations, terms or conditions on the registered midwife's entitlement to practice for a stated period or until the Complaints Officer is satisfied that they are no longer required;

(f) direct the registered midwife to complete a specified course of studies or to satisfy the Complaints Officer as to the registered midwife's competence generally, or in a particular area of practice;

(g) direct the registered midwife to take counselling or to undergo treatment that, in the opinion of the Board of Inquiry, is appropriate;

(h) direct the registered midwife to satisfy the Complaints Officer that a condition or disability has been, or is being, successfully treated, or that the condition or disability does not impair the registered midwife's capacity to provide midwifery services in accordance with accepted standards;

(i) direct the registered midwife to waive, reduce or repay a fee for services rendered by the registered midwife that, in the opinion of the Board of Inquiry, were not rendered or were rendered improperly;

(j) remove the

d'infliger une suspension, l'engagement de la sage-femme autorisée de restreindre son exercice pour une période déterminée ou jusqu'à ce que le préposé aux plaintes soit convaincu que cette mesure n'est plus nécessaire;

e) imposer à la sage-femme autorisée des restrictions ou des conditions relativement à son droit d'exercer pour une période déterminée ou jusqu'à ce que le préposé aux plaintes soit convaincu que cette mesure n'est plus nécessaire;

f) enjoindre la sage-femme autorisée de suivre un programme d'études déterminé ou d'établir de façon satisfaisante pour le préposé aux plaintes ses compétences générales ou ses compétences dans un domaine particulier d'exercice;

g) enjoindre la sage-femme autorisée de recevoir de l'aide ou de suivre le traitement qu'elle estime indiqué;

h) enjoindre la sage-femme autorisée de convaincre le comité qu'une affection ou qu'un handicap a été ou est traité avec succès ou que cette affection ou ce handicap n'affaiblit pas sa capacité de fournir des services de sage-femme en conformité avec les normes établies;

i) enjoindre la sage-femme autorisée de renoncer aux honoraires relatifs à des services qui, selon la commission, n'ont pas été fournis ou n'ont pas été fournis comme il se doit, de réduire ces honoraires ou de les rembourser;

j) radier le nom de la sage-femme du registre des

registered midwife from the Midwifery Register and cancel the registered midwife's certificate;

(k) make any further or other order that it considers appropriate.

sages-femmes et annuler son certificat;

k) prendre toute autre mesure qu'elle estime indiquée.

Costs and fine

33. The Board of Inquiry may, in addition to the orders that may be made under subsection 32(2), order the registered midwife to pay to the Government of the Northwest Territories, within the time stated in the order,

(a) all or part of the costs of the hearing;

(b) a fine not exceeding $5,000; or

(c) both costs and a fine.

Frais et amende

33. En plus des ordonnances qu'elle peut rendre en vertu du paragraphe 32(2), la commission d'enquête peut ordonner à la sage-femme autorisée de payer au gouvernement des Territoires du Nord-Ouest, dans le délai que précise l'ordonnance :

a) soit la totalité ou une partie des frais de l'audience;

b) soit une amende maximale de 5 000 $;

c) soit les frais et l'amende.

Decision in writing

34. (1) A decision or an order of a Board of Inquiry at the completion of a hearing into a complaint must be in writing and must include the findings of fact on which the decision or order was based and the reasons for the decision or order.

Décision écrite

34. (1) Toute décision ou ordonnance rendue par la commission d'enquête au terme de l'audience relative à une plainte revêt la forme écrite, contient les conclusions de fait ayant servi à la fonder et expose ses motifs.

Alteration of decision where hearing in private

(2) If all or part of a hearing is held in private under subsection 28(4), the Board of Inquiry may issue directions to the Complaints Officer concerning the manner in which the decision or order must be altered before it is included in the public register referred to in section 43.

Modification de la décision en cas d'audience

(2) Si l'ensemble ou une partie de l'audience a lieu à huis clos en vertu du paragraphe 28(4), la commission d'enquête peut donner des directives au préposé aux plaintes concernant la façon dont la décision ou l'ordonnance doit être modifiée avant d'être incluse dans le registre public visé à l'article 43.

Service of decision

(3) The Board of Inquiry shall

(a) cause a copy of the decision or order to be served on the complainant and the registered midwife who is the subject of the complaint; and

(b) notify the Registrar in writing of the

Signification de la décision

(3) La commission d'enquête doit :

a) faire signifier une copie de la décision ou de l'ordonnance au plaignant et à la sage-femme autorisée qui fait l'objet de la plainte;

b) aviser le registraire par écrit de la décision ou de l'ordonnance.

decision or order.

General

Dispositions générales

Contravention of order

35. (1) If the Complaints Officer is satisfied that a registered midwife has contravened or failed to fulfill an order under subsection 32(2), the Complaints Officer may, without a further hearing, order that the registration and certificate of the registered midwife be suspended and the Complaints Officer may provide in the order any terms and conditions that he or she considers appropriate for reinstatement.

35. (1) S'il est convaincu qu'une sage-femme autorisée a violé une ordonnance rendue en vertu du paragraphe 32(2) ou a omis de l'observer, le préposé aux plaintes peut, sans tenir une autre audience, ordonner que l'inscription et le certificat de la sage-femme autorisée soient suspendus, auquel cas il peut fixer dans l'ordonnance les conditions de réinscription qu'il estime indiquées.

Inobservation de l'ordonnance

Service of order

(2) The Complaints Officer shall cause the registered midwife to be served with a copy of any order made under subsection (1).

(2) Le préposé aux plaintes fait signifier à la sage-femme autorisée une copie de l'ordonnance rendue en vertu du paragraphe (1).

Signification de l'ordonnance

Suspension for non-payment

(3) If the Complaints Officer is satisfied that a registered midwife who has been ordered to pay a fine, costs or both under section 33, has failed to pay the amount within the stated time, the Complaints Officer may suspend the registration and certificate of the registered midwife until the amount is paid, and shall cause the registered midwife to be served with written notice of the suspension.

(3) S'il est convaincu que la sage-femme autorisée à qui il a été ordonné de payer une amende, des frais ou les deux en vertu de l'article 33 a omis de payer le montant dans le délai précisé, le préposé aux plaintes peut suspendre l'inscription et le certificat de cette sage-femme autorisée jusqu'au paiement du montant, auquel cas il fait signifier à celle-ci un avis écrit de la suspension.

Suspension pour non-paiement

Recovery of fine or costs

36. A fine or costs ordered to be paid under this Part is a debt due to the Government of the Northwest Territories and may be recovered by the Government of the Northwest Territories by civil action for debt.

36. L'amende ou les frais qui doivent être payés en vertu de la présente partie constituent une créance du gouvernement des Territoires du Nord-Ouest; celui-ci peut la recouvrer en intentant une poursuite civile.

Recouvrement de l'amende ou des frais

Prohibition

37. A registered midwife whose registration and certificate are suspended under this Part shall not engage in the practice of registered midwives until notified by the Complaints Officer that the suspension has expired in accordance with its terms or that the suspension is revoked and he or she has been reinstated in the Midwifery Register.

37. La sage-femme autorisée dont l'inscription et le certificat sont suspendus sous le régime de la présente partie ne peut exercer la profession de sage-femme jusqu'à ce qu'elle soit avisée par le préposé aux plaintes de la fin de la suspension en conformité avec les conditions prévues ou de la révocation de la suspension et de sa réinscription au registre des sages-femmes.

Interdiction

Appeal

Appel

Appeal

38. A registered midwife who is subject to a decision or an order made under subsection 32(2) or section 33, or a complainant, may, within 30 days after service of the decision or order, appeal the decision or order to the Supreme Court by filing a notice of appeal with the Supreme Court and serving it on the Complaints Officer.

38. Le plaignant ou la sage-femme autorisée qui fait l'objet d'une décision ou d'une ordonnance rendue en vertu du paragraphe 32(2) ou de l'article 33, selon le cas, peut, dans les 30 jours suivant la signification de la décision ou de l'ordonnance, en appeler devant la Cour suprême en déposant un avis d'appel auprès de ce tribunal et en le signifiant au préposé aux plaintes.

Appel

Appeal on the record

39. An appeal to the Supreme Court shall be based on the record of the hearing before the Board of Inquiry and on the decision or order of the Board of Inquiry.

39. L'appel à la Cour suprême est fondé sur le dossier de l'audience tenue par la commission d'enquête et sur la décision ou l'ordonnance de celle-ci.

Appel sur dossier

Security for costs

40. Where a complainant other than the Complaints Officer appeals a decision or order to the Supreme Court, the Supreme Court may, on application by the registered midwife who is subject to the decision or order under appeal, require the complainant to provide a sum as security for costs.

40. Si un autre plaignant que le préposé aux plaintes interjette appel d'une décision ou d'une ordonnance à la Cour suprême, celle-ci peut, sur demande de la sage-femme autorisée qui fait l'objet de la décision ou de l'ordonnance portée en appel, exiger du plaignant qu'il verse une somme à titre de cautionnement pour frais.

Cautionnement pour frais

Decision

41. (1) The Supreme Court, on hearing an appeal from a decision or an order of a Board of Inquiry, may

(a) make any finding of fact that, in its opinion, should have been made;

(b) make an order that affirms, reverses or modifies the decision or order of the Board of Inquiry;

(c) refer the matter, or any issue, back to the Board of Inquiry for further consideration; or

(d) provide any direction that it considers appropriate.

41. (1) La Cour suprême saisie d'un appel interjeté à l'égard d'une décision ou d'une ordonnance de la commission d'enquête, peut :

a) tirer toute conclusion de fait qui, selon elle, aurait dû être tirée;

b) confirmer, infirmer ou modifier la décision ou l'ordonnance de la commission d'enquête;

c) renvoyer la cause ou une question s'y rapportant à la commission d'enquête pour examen;

d) donner les directives qu'elle estime indiquées.

Décision

Costs

(2) The Supreme

(2) La Cour suprême

Frais

Court, on hearing an appeal from a decision or an order of a Board of Inquiry, may make any order as to costs that it considers appropriate.

saisie d'un appel interjeté à l'égard d'une décision ou d'une ordonnance de la commission d'enquête peut rendre toute ordonnance qu'elle estime indiquée quant aux frais.

No further appeal

42. A decision or an order of the Supreme Court on an appeal under section 41 is final and conclusive and is not subject to further appeal.

Décision définitive

42. La décision ou l'ordonnance que rend la Cour suprême dans le cadre d'un appel interjeté en vertu de l'article 41 est définitive et sans appel.

Public Register of Decisions and Orders

Registre public des décisions et des ordonnances

Public register

43. The Minister shall maintain a public register of decisions and orders made by Boards of Inquiry under this Act.

43. Le ministre tient un registre public des décisions et des ordonnances que rendent les commissions d'enquête sous le régime de la présente loi.

Registre public

PART 4

GENERAL

PARTIE 4

DISPOSITIONS GÉNÉRALES

Continuing Competence Program

Programme de maintien des compétences

Establishment or adoption of program

44. The Commissioner, on the recommendation of the Minister, may,

(a) by regulation, establish a continuing competence program for registered midwives; or

(b) where a continuing competence program for the midwifery profession has been established by an association, person or body of persons and is available in written form, adopt by regulation the program or the program as amended from time to time, and upon adoption the program is in force in respect of registered midwives either in whole or in part or with such variations as may be specified in the regulations.

44. Le commissaire, sur recommandation du ministre, peut :

a) par règlement, établir un programme de maintien des compétences pour les sages-femmes autorisées;

b) si un programme de maintien des compétences concernant l'exercice de la profession de sage-femme a été établi par une association, une personne ou un groupe de personnes et peut être obtenu sous forme écrite, adopter par règlement le programme ou la version modifiée du programme, auquel cas ce programme s'applique dès son adoption aux sages-femmes, en tout ou en partie ou avec les modifications que peuvent préciser les règlements.

Établissement ou adoption d'un programme

Code of Professional Conduct

Code déontologique

Establishment or adoption of code

45. The Commissioner, on the recommendation of the Minister, may,

(a) by regulation, establish a code of rules or standards respecting the conduct of registered midwives; or

(b) where a code of rules or standards respecting

45. Le commissaire, sur recommandation du ministre, peut :

a) par règlement, établir un code de règles ou de normes concernant l'exercice de la profession de sage-femme;

b) si un code de règles ou de normes concernant l'exercice de la profession de

Établissement ou adoption d'un code déontologique

the conduct of midwives has been established by an association, person or body of persons and is available in written form, adopt by regulation the code or the code as amended from time to time, and upon adoption the code is in force in respect of registered midwives either in whole or in part or with such variations as may be specified in the regulations.

sage-femme a été établi par une association, une personne ou un groupe de personnes et peut être obtenu sous forme écrite, adopter par règlement le code ou la version modifiée du code, auquel cas ce code s'applique dès son adoption aux sages-femmes autorisées, en tout ou en partie ou avec les modifications que peuvent préciser les règlements.

Miscellaneous

Dispositions diverses

Right to recover reasonable charges

46. A person may bring an action for the recovery of reasonable charges for professional services, advice or visits provided and the costs of any materials or appliances supplied by that person during the time the person was a registered midwife.

46. Toute personne peut intenter une action en vue du recouvrement de sommes raisonnables pour les services professionnels qu'elle a fournis, y compris les conseils et les visites, et du coût du matériel ou des appareils qu'elle a procurés pendant qu'elle était sage-femme autorisée.

Droit de recouvrer des sommes raisonnables

Liability

47. (1) No action lies against the Registrar, the Complaints Officer, a mediator, an investigator or a member of a Board of Inquiry for anything done or not done by that person in good faith in the exercise of his or her powers or the performance of his or her duties.

47. (1) Le registraire, le préposé aux plaintes, le médiateur, les médiateurs, l'enquêteur et les membres des commissions d'enquête bénéficient de l'immunité pour les actes accomplis ou les omissions commises de bonne foi dans l'exercice de leurs attributions.

Immunité

Defamation

(2) No action for defamation may be founded on a communication regarding the conduct of a registered midwife if the communication is made or is published in accordance with this Act or the regulations by a person described in subsection (1) in good faith and in the course of any proceedings under this Act or the regulations.

(2) Aucune poursuite en diffamation ne peut se fonder sur des communications relatives à la conduite d'une sage-femme autorisée si ces communications sont faites ou sont publiées de bonne foi en conformité avec la présente loi ou les règlements par l'une des personnes mentionnées au paragraphe (1) au cours d'une instance introduite sous le régime de la présente loi ou des règlements.

Diffamation

Service on Minister

48. (1) Where this Act requires that a notice or other document be served on the Minister, the notice or document may be

48. (1) Tout avis ou autre document qui doit, en vertu de la présente loi, être signifié au ministre peut, selon le cas :

Signification au ministre

(a) served personally on the Complaints Officer; or

a) être signifié en personne au préposé aux plaintes;

(b) sent by registered mail to the office of the Complaints Officer.

b) être envoyé par courrier recommandé au bureau

du préposé aux plaintes.

Service on a person

(2) Where this Act requires that a notice or document be served on a person, the notice or document may be

(a) served personally on the person; or

(b) sent by registered mail to the person.

Signification à une personne

(2) Tout avis ou document qui doit, en vertu de la présente loi, être signifié à une personne peut, selon le cas :

a) lui être signifié en personne;

b) lui être envoyé par courrier recommandé.

Address of complainant

(3) If a person to be served is a complainant who has filed a complaint under subsection 19(1), the address provided by that person in his or her complaint is deemed to be his or her address unless he or she has provided the Complaints Officer with written notice of another address.

Adresse du plaignant

(3) Si la personne qui doit recevoir signification est une personne qui a déposé une plainte en application du paragraphe 19(1), l'adresse que cette personne a fournie dans sa plainte est réputée être son adresse, à moins qu'elle n'ait fourni par écrit au préposé aux plaintes une autre adresse.

Address of registered midwife

(4) If a person to be served is a registered midwife, the most recent address provided by him or her in writing to the Registrar is deemed to be his or her address.

Adresse d'une sage-femme

(4) Si la personne qui doit recevoir signification est une sage-femme autorisée, l'adresse la plus récente que cette personne a fournie par écrit au registraire est réputée être son adresse.

Emergencies

Urgences

Emergency midwifery services

49. Nothing in this Act restricts the rendering of midwifery services in case of an emergency.

Soins d'urgence

49. La présente loi n'a pas pour effet de restreindre la prestation de services de sage-femme en cas d'urgence.

Emergency services

50. (1) Nothing in the *Dental Profession Act*, the *Medical Profession Act*, the *Nursing Profession Act,* the *Pharmacy Act* or the *Veterinary Profession Act* prohibits a registered midwife from

(a) in the course of administering emergency medical aid or treatment, doing anything for which a licence is required under those Acts; or

(b) doing anything in an emergency in an attempt to relieve the pain and suffering of a person or animal.

Services d'urgence

50. (1) La *Loi sur les professions dentaires*, la *Loi sur les médecins*, la *Loi sur la profession infirmière*, la *Loi sur la pharmacie* et la *Loi sur les vétérinaires* n'empêchent pas les sages-femmes autorisées d'accomplir :

a) lorsqu'elles administrent un traitement ou des soins médicaux d'urgence, tout acte pour lequel une licence ou un permis est exigé par ces lois;

b) en cas d'urgence, tout acte permettant de soulager la douleur et la souffrance d'une personne ou d'un animal.

Protection from action

(2) A registered midwife shall not be held liable for civil damages as a result of acts or omissions performed in good faith under subsection (1) unless it is established that injuries or death were caused by gross negligence on his or her part.

Immunité

(2) La sage-femme autorisée bénéficie de l'immunité en matière civile pour les actes accomplis ou les omissions commises de bonne foi sous le régime du paragraphe (1), sauf s'il est établi que les blessures ou le décès ont résulté d'une faute lourde qui lui est imputable.

Offences and Punishment

Infractions et peines

Prohibitions

51. (1) No person shall

(a) hold himself or herself out to the public by any title, designation or description as a registered midwife or under that title, designation or description render or offer to render services of any kind to a person for a fee or other remuneration, unless he or she is a registered midwife;

(b) use the title "Registered Midwife" or a variation or an equivalent in another language of the title or a designation that is an abbreviation of the title, variation or equivalent, unless he or she is a registered midwife; or

(c) knowingly employ or engage a person to provide the services of a registered midwife unless the person so employed or engaged is a registered midwife.

Interdictions

51. (1) Il est interdit :

a) de s'attribuer le titre ou la désignation de sage-femme autorisée ou de l'utiliser pour fournir ou offrir de fournir des services à une personne moyennant des honoraires ou toute autre rémunération, à moins d'être une sage-femme autorisée;

b) d'utiliser le titre ou une abréviation du titre sage-femme autorisée, une variante ou un équivalent dans une autre langue du titre ou d'une abréviation, à moins d'être une sage-femme autorisée;

c) d'employer ou d'engager sciemment une personne pour qu'elle agisse à titre de sage-femme autorisée, à moins que cette personne ne soit une sage-femme autorisée.

Offence and punishment

(2) Every person who contravenes this Act or the regulations is guilty of an offence and liable on summary conviction to a fine not exceeding $5,000 or to imprisonment for a term not exceeding 90 days, or to both.

Infraction et peine

(2) Quiconque contrevient à la présente loi ou aux règlements commet une infraction et encourt, sur déclaration de culpabilité par procédure sommaire, une amende maximale de 5 000 $ ou un emprisonnement maximal de 90 jours, ou ces deux peines.

Limitation period

(3) A prosecution for an offence under this Act or the regulations may not be commenced more than two years after the day when the offence is alleged to have been committed.

Prescription

(3) Les poursuites pour infraction à la présente loi ou à ses règlements se prescrivent par deux ans à compter de la date à laquelle l'infraction alléguée aurait été commise.

Burden of proof

(4) In a prosecution under this Act, a person against whom a charge is laid has the burden of proving that, at the time of the alleged offence, the person was a registered midwife.

Fardeau de la preuve

(4) Dans une poursuite pour infraction à la présente loi, il incombe à l'accusée de prouver qu'elle était sage-femme autorisée au moment de la présumée infraction.

Regulations

Règlements

Regulations

52. The Commissioner, on the recommendation of the Minister, may make regulations

Règlements

52. Le commissaire, sur recommandation du ministre, peut par règlement :

(a) prescribing screening and diagnostic tests for the purposes of paragraph 2(1)(j);

a) régir l'ordonnance des tests de dépistage et de diagnostic aux fins de l'alinéa 2(1)j);

(b) respecting the prescribing and administering of drugs by a registered midwife;

b) régir la prescription et l'administration des médicaments par une sage-femme autorisée;

(c) respecting standards for the practice of registered midwives;

c) régir les normes qui s'appliquent à l'exercice de la profession de sage-femme;

(d) prescribing conditions, limits and restrictions on the practice of registered midwives;

d) fixer des conditions, des limites et des restrictions relativement à l'exercice de la profession de sage-femme autorisée;

(e) respecting the powers and duties of the Registrar and the Complaints Officer;

e) déterminer les attributions du registraire et du préposé aux plaintes;

(f) prescribing other information pertaining to registered midwives that shall be entered in the Midwifery Register;

f) déterminer les renseignements additionnels relatifs aux sages-femmes qui doivent être inscrits au registre des sages-femmes;

(g) prescribing fees and requiring the payment of fees;

g) fixer ou exiger le paiement des cotisations;

(h) respecting the establishment of registration criteria and requiring the Registrar to consider the registration criteria when considering an application

h) déterminer les conditions d'inscription et veiller au respect de ces conditions par le registraire lorsqu'une demande est présentée en application du paragraphe 8(1);

under subsection 8(1);

(i) respecting the information that the Registrar may require a registered midwife to supply annually or at such other times as the Registrar may consider appropriate;

(j) prescribing other requirements that an applicant must meet to be qualified to be a registered midwife;

(k) respecting applications under subsections 8(1) and 11(2) and (5);

(l) respecting the manner of proof as to matters required to be proven by applicants for registration as registered midwives;

(m) respecting the issuance, suspension and cancellation of certificates of registration and the annual renewal of certificates of registration;

(n) prescribing other requirements that a registered midwife must meet to be eligible for an annual renewal of his or her certificate of registration;

(o) respecting the suspension or removal of a person from the Midwifery Register and the reinstatement of persons who have been suspended or removed from the Midwifery Register;

(p) prescribing acts and omissions of registered midwives that constitute unprofessional conduct;

(q) establishing a procedure for the suspension of

i) déterminer les renseignements que le registraire peut exiger d'une sage-femme autorisée, annuellement ou à tout autre moment qu'il juge opportun;

j) déterminer toute autre exigence qu'un postulant doit remplir pour obtenir le titre de sage-femme autorisée;

k) déterminer les modalités des demandes déposées en application des paragraphes 8(1) et 11(2) et (5);

l) régir le mode de preuve s'appliquant aux points que doivent établir les personnes qui demandent leur inscription à titre de sages-femmes autorisées;

m) régir la délivrance, la suspension et l'annulation des certificats d'inscription et leur renouvellement annuel;

n) déterminer toute autre exigence que doit remplir une sage-femme autorisée pour le renouvellement annuel de son certificat d'inscription ;

o) régir la suspension ou la radiation du nom d'une personne du registre des sages-femmes autorisées et les réinscriptions des personnes qui ont été suspendues ou radiées du registre;

p) désigner les actes et les omissions des sages-femmes autorisées qui constituent des manquements aux devoirs de la profession;

q) établir les modalités s'appliquant soit à la suspension de l'inscription des sages-femmes autorisées, soit à

a registered midwife's registration and certificate, or for the imposition of any limitations, terms or conditions on his or her entitlement to practice, while his or her conduct is under review;

(r) prescribing alternative dispute resolution processes that may be used in the settlement of complaints of unprofessional conduct;

(s) respecting investigations into the conduct of registered midwives;

(t) respecting rules of procedure regarding the conduct of hearings into complaints of unprofessional conduct;

(u) respecting continuing competence and the establishment or adoption of a continuing competence program for registered midwives;

(v) respecting the establishment or adoption of a code of rules or standards respecting the conduct of registered midwives; and

(w) respecting other matters that are provided for in this Act or any other matter that the Commissioner considers necessary or advisable to carry out the intent and purposes of this Act.

l'imposition de restrictions ou de conditions relativement à leur droit d'exercer la profession, pendant que leur conduite fait l'objet d'un examen;

r) prévoir les modes amiables de règlement des conflits pouvant être utilisés en vue du règlement de toute plainte portant sur un manquement aux devoirs de la profession;

s) régir les enquêtes sur la conduite des sages-femmes autorisées;

t) régir les règles de procédure concernant la tenue des audiences relatives aux plaintes portant sur un manquement aux devoirs de la profession;

u) régir le maintien des compétences et l'établissement ou l'adoption d'un programme de maintien des compétences;

v) régir l'établissement ou l'adoption d'un code de règles ou de normes concernant la conduite des sages-femmes autorisées;

w) prendre toute autre mesure prévue par la présente loi ou que le commissaire estime nécessaire ou souhaitable pour l'application de la présente loi.

CONSEQUENTIAL AMENDMENTS

Disease Registries Act

53. The definition "health care professional" in section 1 of the *Disease Registries Act* is amended by

(a) striking out "and**" at the end of paragraph**

MODIFICATIONS CORRÉLATIVES

Loi sur les registres des maladies

53. La définition de «professionnel de la santé», à l'article 1 de la *Loi sur les registres des maladies* est modifiée par insertion de «, les sages-femmes autorisées au sens de la *Loi sur la profession de sage-femme*» après «*Loi sur les professions dentaires*».

(c);

(b) striking out the semi-colon at the end of paragraph (d) and by substituting ", and**";**

(c) adding the following after paragraph (d):

(e) a registered midwife under the *Midwifery Profession Act*;

Evidence Act

54. Section 13 of the *Evidence Act* is amended

(a) in the definition "health care professional", by

(i) striking out the period at the end of paragraph (j) and by substituting a comma,

(ii) striking out the semi-colon at the end of paragraph (k) and by substituting ", and**",**

(iii) adding the following after paragraph (k):

(l) is entitled to practise as a registered midwife in the Territories under the *Midwifery Profession Act*; and

(b) in subparagraph (b)(i) of the definition "legal proceedings", by adding ", the *Midwifery Profession Act*,**" after "**the *Medical Profession Act*"**.**

Loi sur la preuve

54. L'article 13 de la *Loi sur la preuve* est modifié par :

a) suppression du point après l'alinéa k) de la définition de «professionnel de la santé», par substitution d'un point-virgule et par adjonction de ce qui suit :

l) est habilitée à exercer la profession de sage-femme autorisée dans les territoires en application de la *Loi sur la profession de sage-femme.*

b) insertion, au sous-alinéa b)(i) de la définition de «procédure judiciaire», de «de la *Loi sur la profession de sage-femme,***» après «***Loi sur les médecins,***».**

Medical Profession Act

55. Section 46 of the *Medical Profession Act* is amended by

(a) striking out "or**" at the end of paragraph (i);**

(b) striking out the period at the end of paragraph (j) and by substituting "; or**";**

(c) adding the following after paragraph (j):

(k) any person engaged in the practice of registered midwives in accordance with the *Midwifery Profession Act*.

Loi sur les médecins

55. L'article 46 de la *Loi sur les médecins* est modifié par suppression du point qui suit l'alinéa j), par la substitution d'un point-virgule et par adjonction de ce qui suit :

k) une personne qui exerce la profession de sage-femme autorisée en application de la *Loi sur la profession de sage-femme*.

Pharmacy Act

56. (1) The *Pharmacy Act* is amended by this section.

(2) Section 1 is amended by adding the following definition in alphabetical order:

"registered midwife" means a registered midwife under the *Midwifery Profession Act;* (*sage-femme autorisée*)

(3) Section 2 is amended by

(a) adding the following after paragraph (a.1):

(a.2) a registered midwife from exercising a privilege conferred by the *Midwifery Profession Act* relating to the practice of registered midwives in the Territories;

Loi sur la pharmacie

56. (1) Le présent article modifie la *Loi sur la pharmacie*.

(2) L'article 1 est modifié par insertion, selon l'ordre alphabétique, de la définition suivante :

«sage-femme autorisée» Sage-femme autorisée au sens de la *Loi sur la profession de sage-femme*. (*registered midwife*)

(3) L'article 2 est modifié par :

a) insertion, après l'alinéa a.1) de ce qui suit :

a.2) la sage-femme autorisée d'exercer un privilège qui lui est conféré par la *Loi sur la profession de sage-femme* et relatif à l'exercice de sa profession dans les territoires;

(b) adding ", registered midwife**" after "**veterinary surgeon**" in paragraph (c).**

(4) That portion of section 20 preceding paragraph (a) is amended by adding ", registered midwife**" after "**nurse practitioner**".**

(5) Subsections 21.1(1) and (2) are each amended by adding "or a registered midwife**" after "**nurse practitioner**".**

(6) Paragraph 27(b.1) is amended by adding "or a registered midwife**" after "**nurse practitioner**".**

COMMENCEMENT

Coming into force

57. This Act or any provision of this Act comes into force on a day or days to be fixed by order of the Commissioner.

b) insertion, à l'alinéa c), de «, la sage-femme autorisée**» après «** vétérinaire**».**

(4) Le passage introductif de l'article 20 est modifié par insertion de «, une sage-femme autorisée**» après «**un infirmier praticien**».**

(5) Les paragraphes 21.1 (1) et (2) sont modifiés par insertion de «ou une sage-femme autorisée**» après «**un infirmier praticien**».**

(6) L'alinéa 27b.1) est modifié par insertion de «ou une sage-femme autorisée**» après «**un infirmier praticien**».**

ENTRÉE EN VIGUEUR

Entrée en vigueur

57. La présente loi ou telle de ses dispositions entre en vigueur à la date ou aux dates fixées par décret du commissaire.

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College of Midwives of Ontario - Summary of Scope of Practice Consultation

All CMO members, midwifery stakeholders, maternity system stakeholders and health system stakeholders (listed in question 8 of the May 30th CMO submission to HPRAC) were invited to complete an online survey that detailed the proposed changes to the midwifery scope of practice (attached as appendix D of the May 30th submission).

Every hospital in Ontario where midwives hold privileges (n = 67) was invited to participate (requests were directed to the obstetric and family physician departments, depending on the facility). Further, other health profession colleges and associations were invited to comment (26 invitations), and sixteen transfer payment agencies (TPA's) received a request for participation. Finally, seventeen midwifery stakeholders were invited to respond to the survey.

What follows is a summary of the responses received by the CMO. It should be noted that the survey provided little context in which to view the questions. The full submission to HPRAC addresses all of the contextual concerns that were expressed in the survey responses.

Total number of responses

Members: 271 (67% of the CMO membership)
Maternity system stakeholders: 14
Health system stakeholders: 10
Midwifery stakeholders: 8

Members

Overall, members are supportive of the proposed changes to the midwifery scope of practice. The results of the survey indicate an overwhelming focus on *safety* among members (i.e. education and training, maintaining competency, supporting normal birth, follow-up with physicians). There is diversity in the range of responses the CMO received. Below is a table that demonstrates the percentage of members who agreed or disagreed with the proposed changes. As well, the general themes that emerged from the responses are identified.

Survey Question/ Proposed Scope Change	**% Agree**	**% Disagree**	**Identified Themes/Issues**
Authorize well-woman/well-baby (>6 weeks) care	81.6	19.2	- Payment for these services needs to be addressed - Do not want to be on call for this care - Education & training needed - Some members express awareness that this
Authorize pre-conception counseling	82.5	17.9	

Survey Question/ Proposed Scope Change	% Agree	% Disagree	Identified Themes/Issues
			might be a benefit for women in underserviced areas, and others see it as beneficial for all women, still others don't think it's a good idea to move out of prenatal care - Parameters and limits are required - Some see this as an optional part of scope (i.e. not routine)
Remove "spontaneous" from the scope of practice statement	85.4	14.9	- Epidurals/augmentations need to be addressed - Useful in underserviced areas - Education & training required - Hospital support required
Authorize manual removal of placenta	96.2	4.2	- Useful in underserviced areas - Only for emergency - Already do in emergency - The most skilled attendant should be doing it
Authorize vacuum assisted delivery	75.1	25.3	- Maintaining competency may be difficult - Useful in underserviced areas - Payment - Education & training needed
Authorize scalp clip	91	9.4	- Indicative of a broader issue that may require consult - Focus on normal birth, avoiding interventions - Maintaining competency might be difficult - Education & training needed - Useful in underserviced areas
Authorize scalp Ph	69.9	30.5	- Maintaining competency - Education & training needed - Indicative of a broader issue requiring consult - Payment
Authorize taking blood from fathers/donors	94.4	6	- Payment
Remove "spontaneous" from Authorized Act of managing labour	88.5	11.9	- Maintaining focus on normal birth - Payment - Nursing support required

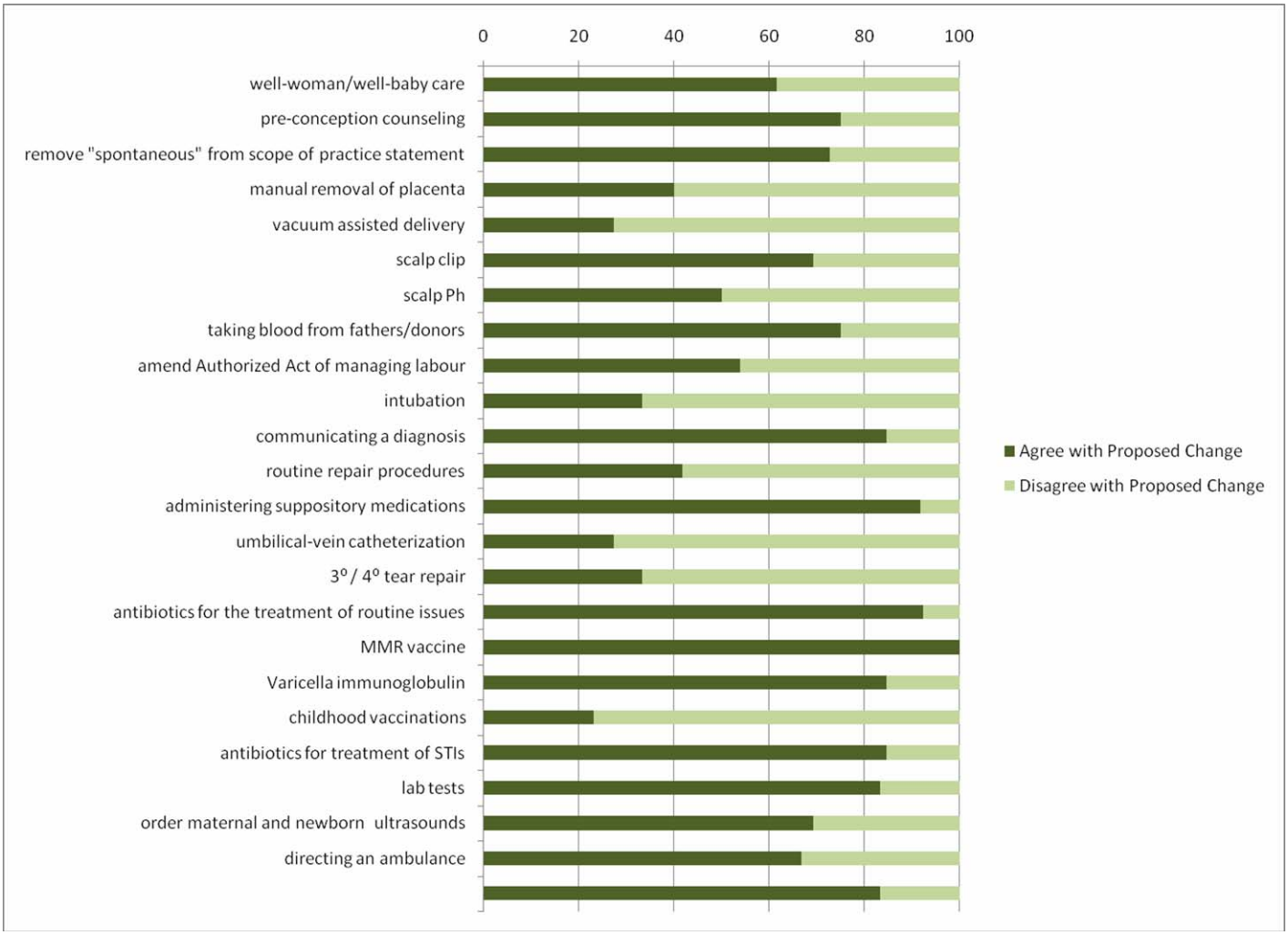
Survey Question/ Proposed Scope Change	% Agree	% Disagree	Identified Themes/Issues
Authorize intubation	87.8	12.5	- Useful in underserviced areas - Maintaining competency - Normal birth
Authorize communicating a diagnosis	97.3	3.1	- Payment
Authorize “beyond the anal verge” for routine repair procedures	61.4	39	- Maintaining competency - Education & training needed
Authorize administering suppository medications	97.3	3	- Payment - Access to suppository drugs in regulation
Authorize umbilical-vein catheterization	60.5	39.9	- Education & training needed - Maintaining competency - Focus on normal birth - Indicative of broader issue requiring consult
Authorize 3º / 4º tear repair	47.1	53.2	- 3rd, but not 4th - Education & training needed - Payment - Maintaining competency
Authorize antibiotics for the treatment of: mastitis, GBS, bacterial vaginosis and UTI's	98.9	1.1	- Drug categories needed - Suggestions of more drugs were given - Mitral valve prolapsed another important issue - Education & training needed
Authorize MMR vaccine	89	11	- Underserviced areas - Education & training needed
Authorize Varicella immunoglobulin	88.9	11.1	- Payment - Training & education needed
Authorize childhood vaccinations	61.6	38.4	- Payment - Education & training needed

Survey Question/ Proposed Scope Change	% Agree	% Disagree	Identified Themes/Issues
Authorize antibiotics for treatment of STIs	90.5	9.5	- Education & training needed - Maintaining competency - Payment
Authorize cord blood gases, drug screen, PIH diagnostic test, and father/donor blood tests	95.4	4.6	- Payment - Many more tests required - Some members already required to do tests as hospital protocol - Routine part of primary maternity care - Training & education needed
Authorize ordering maternal postpartum ultrasounds and newborn follow-up ultrasounds	93.5	6.5	- Maternal yes, newborn not sure - Appropriate follow-up - Education needed - Part of primary maternity care
Authorize directing an ambulance	97.7	2.3	- Proximity to hospital - Best care is the issue - Privileges at closest hospital - Hospital space sometimes dictates - Suggestion to authorize temporary privileges at closest hospital
Clarify participation in hospital Medical Advisory Committees and other decision-making committees	100	0	- Some midwives do sit on MAC's already - Hospital issues are the biggest barrier to midwifery care - This is a very important issue

Maternity System Stakeholders

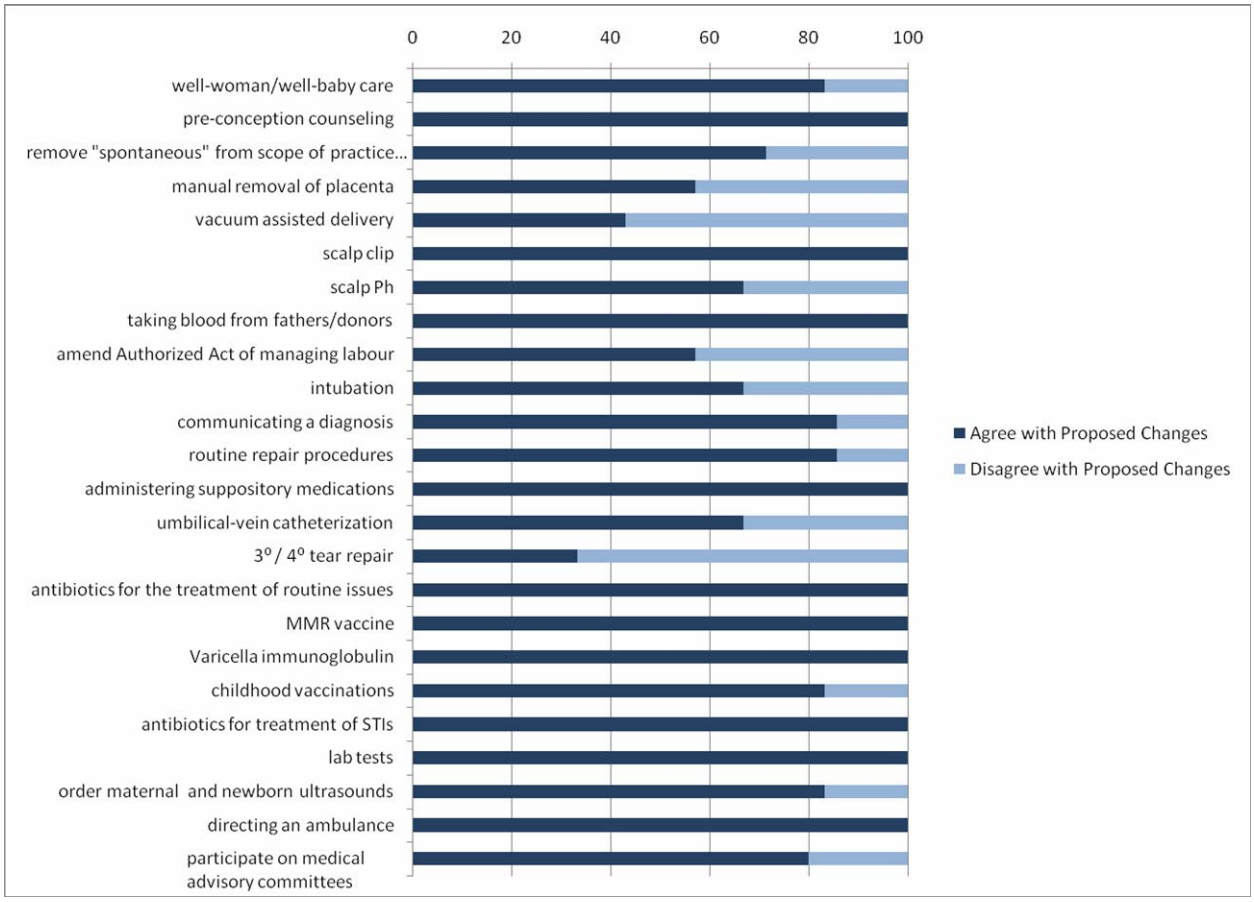
Fourteen maternity care stakeholders completed the survey. The results of their responses are outlined in the chart below. The participants included chiefs of staff and relevant department heads (e.g. OB/GYN and family physician departments), clinical directors, and managers from maternity and child health departments of hospitals. As with members, the maternity system stakeholders expressed diverse responses to the proposed changes, ranging from full support to significant concerns, the majority of which were focused on safety. Education and training for the proposed additions to midwifery scope of practice, as well as maintaining competence, were identified as

general concerns. Also, an emphasis on limiting midwifery care to ‘normal’ pregnancy and labour was expressed.



Health System Stakeholders

Ten health system stakeholders completed the survey. Participants included staff at other health colleges and hospitals. Their responses to the proposed changes to the midwifery scope of practice are charted below. Again, the majority of concerns related to safety, which we have clarified in the full Scope of Practice submission to HPRAC (May 30th).



Midwifery Stakeholders

The eight midwifery stakeholders who completed the survey responded with overwhelming support for the proposed changes to scope of practice. The only items for which they did not demonstrate 100% support were: maternal and newborn ultrasounds, childhood vaccinations, umbilical vein catheterization, and the repair of 3rd and 4th degree tears. In each of these instances only one of the eight participating stakeholders disagreed with the proposed changes. Seven (or 87.5% of) participants agreed. The majority of their concerns focused on clarifying which scope of practice activities would be part of routine care, and which would be an extended scope skill.