February 24, 2017

Barbara Borland, President
College of Midwives of Ontario
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Dear Barb:

Re: Proposed changes to General Regulation and Professional Misconduct Regulation

We appreciate the opportunities the CMO has provided to the AOM to ask questions and better understand the College's regulatory transformation. These changes are significant and we are appreciative of the invitation to work together to ensure that clients continue to receive excellent midwifery care while also contemplating potential unintended consequences of these many changes.

At this time, we wish to provide some feedback as part of the public consultation regarding the proposed changes to the General and Professional Misconduct Regulations. This feedback includes perspectives from the AOM's Quality Insurance and Risk Management (QIRM) committee.

It is challenging to provide feedback regarding these regulatory changes without knowing specifically what the full range of changes will be. Removing specifics from the regulations makes sense, but we want to be sure that the regulations' intent continues to be clear in College standards. **However, if standards are to be rescinded, we advise caution to ensure that foundational points related to the practice of midwifery are not lost.** Some of our feedback is centered on ensuring that those points remain somewhere, in standards, if not in regulation. Ideally, there will be another opportunity to provide feedback on the entirety of the changes, once the standards are also updated.

The rationale provided for many suggested changes is to be "more consistent with other health colleges". **We appreciate the broader regulatory climate and a desire for consistency, but standards and regulations also need to respect the uniqueness of midwifery and some inconsistency between colleges may be warranted.** For example, midwifery regulations may need greater detail to address the fact that midwifery is not as well established a profession as others and the scope of practice of midwives remains contentious in many contexts. With that in mind, below is our feedback specific to the proposed changes.

General Regulation: Quality Assurance

We are very supportive of members having quality assurance requirements reflective of their alternate practice arrangement or of their different role within the profession (for example, midwives on staff at the AOM or the CMO). However, we question the need to extend those QA requirements to midwives who are on a type of leave where they are not involved with the profession at all.

When midwives are taking a leave from practice, they either need to or are choosing to focus on another aspect of life and should be able to dedicate their time to that other aspect entirely without worrying about midwifery quality assurance activities. **This is particularly important in the case of a sick or disability leave or retirement; midwives in this situation should be able to take leave without the extra work of having to apply for exemption from QA due to extenuating circumstances.** We recommend that the CMO not require QA of midwives on a leave completely disconnected from the profession of midwifery.

General Regulation: Intubation of the Newborn

The change and broader language may facilitate the provision of care in some areas and an expanded scope for some midwives (for example, midwives in rural communities could be trained in vacuum assist). However, in other areas, this change may result in midwives' scope being further restricted. Moving away from a list of acts has the potential to be very confusing to interprofessional colleagues and may result in other professionals claiming that midwives do not have sufficient knowledge, skill, and judgement to perform the procedure. **We recommend the College develop a "core competencies" document that articulates the scope of practice for the profession to midwives and interprofessional colleagues. This document is a crucial advocacy tool for the 50% of Ontario midwives still facing scope restrictions within their hospitals.**

Also of note, client choice is absent from the prerequisites to perform any procedure. There may be situations where a midwife might determine that under normal circumstances they do not have sufficient knowledge and skill to perform a procedure, but are willing to do the best they can to support their client when the client has refused all other options (for example, a vaginal breech at home when a client has refused a consult with an obstetrician and a transfer into hospital). The current proposed wording makes it unclear how client choices interface with this proposed change in definition of authorized acts. **We recommend clarifying that client choice is a fundamental tenet of midwifery care and must be taken into consideration when performing any procedure.**

Professional Misconduct Regulation

There are important changes being proposed to this regulation that could have profound effects on the profession of midwifery in Ontario.

- ***Sub-section 6:*** The proposed language on practicing while "impaired or adversely affected" is very broad and may discriminate against midwives with disabilities without providing a higher degree of public protection. In May 2016, a resolution on disability justice was enthusiastically passed at the AOM AGM with the goal to support midwives with disabilities to continue practicing. The CMO's proposed language change appears to include conditions or dysfunctions that may adversely affect the member's ability to practice midwifery (e.g., PTSD, arthritis, hearing impairment, vision difficulties); however, with some accommodations these conditions may be managed and the members may in fact be able to provide safe care within the context of their disability. **We recommend limiting Sub-section 6 to conditions that "affect the member's ability to practice the profession *safely*". This would clarify that the intent of this point is to protect the public from unsafe practice,** rather than equating conditions or dysfunctions with the inability to practice at all.
- ***Sub-section 8:*** With regards to "discontinuing professional services", we appreciate the explanation in the rationale that clause (ii) "the condition of the client" addresses the concern of abandoning a client in labour but we hope that this is made clear in a standard as well since we did not interpret this new wording in the way the College articulates it in the rationale. "The condition of the client" will not necessarily be interpreted as a client in labour and **we recommend that the expectation of intrapartum non-abandonment be made explicit**.
- ***Sub-section 9:*** Clarification as to what "closes the member's practice" means would be helpful to members. Is this only when a whole midwifery practice group closes its doors or is it also when an associate leaves a practice group and the practice group remains open? In the case where an associate is let go from the practice, does this responsibility fall to the practice group or to the midwife who is leaving the practice? **We recommend clarifying the definition of "closing the member's practice".**
- *Subsections 10 & 11:* **Continuity of care and choice of birthplace** are at the heart of midwifery in Ontario as envisioned by pre-legislation consumers. While we recognize that these original tenets may not apply in every practice context, especially in APAs, there is evidence that continuity of care contributes to positive clinical outcomes. Therefore, it is in the public interest that the CMO continue to promote continuity of care in other College documents, including professional standards.
- ***Subsections 14:*** "Recommending or providing treatment that the member knows or ought to know is inappropriate, ineffective, unnecessary or deleterious" is a complex point especially in relation to client choice. There are a number of treatments that are without evidence, or have questionable therapeutic value (including the placebo effect) but are harmless and can contribute to a positive client experience inclusive of their choices. For example, a midwife may agree, at the request of the client, to order a swab for that client who had GBS bacteriuria earlier in pregnancy; the swab itself is unnecessary according to most accepted GBS guidelines but may still be an appropriate

course of care taking into consideration the client's choices. **We recommend that client choice, notwithstanding risk of harm, be incorporated into this point.** It must also be recognized that there are treatments that may be provided that are "inappropriate, ineffective, unnecessary or deleterious" but are outside of the control of the member. For example, neonatal eye prophylaxis with erythromycin eye ointment is known to be ineffective yet is still entrenched in law; and many hospitals require medically unnecessary transfers of care from the midwife to an obstetrician. These contextual realities need to be acknowledged to avoid placing a member in a position where they are committing professional misconduct but otherwise would be committing an illegal act (in the case of neonatal eye prophylaxis) or in breach of hospital protocols in the case of a medically unnecessary transfer of care.

- ***Subsection 34:*** "Charging for midwifery services on a fee for service basis." The AOM is currently in negotiations with the MOHLTC about the possibility of compensating midwives in a fee for service arrangement for a limited number of services that midwives are currently providing without compensation including ECV for physician clients, first assist at cesarean section, and attending a delivery for a non-midwifery patient in the absence of a physician. These discrete, limited services will contribute to maintaining maternal newborn care in rural and remote areas, and will support the efficient use of health care resources, both of which are in the public interest. **We recommend clarifying that this point applies to charging the client, and not the Ministry of Health and Long Term Care, to facilitate midwives being compensated for services they provide that contribute a public good to the health care system.** This point is also particularly confusing as fee for service is defined in the rationale as "each element of care within the visit, i.e. fee for listening to Fetal Heart Rate", which is different from the OHIP schedule of benefits, how physicians generally define fee for service. If the intent of this regulation is to prevent midwives from charging clients directly for discrete services, this could be more clearly articulated in the regulation.
- ***Subsection 43:*** As written, it appears to apply to ALL statements made by a member publicly (e.g., social media), even those unrelated to the practice of midwifery. "Publishing or publicly making a statement ***related to the professional practice of midwifery*** the member knows or ought to know is false or misleading" would clarify this point.
- ***Subsection 45:*** Even though "conduct unbecoming" is common in professional misconduct regulations, including in the Medicine Act, it is archaic and unclear terminology with the potential for subjective application or even discrimination against a member. **We recommend replacing this wording with "unsuitable to the reputation of a Registered Midwife".**
- ***Subsection 48:*** To whom does this subsection apply? Does it only apply to the supervision of midwives with a formal supervision plan with the CMO? Or does this include mentoring new registrants, administrators or new midwives in the hospital?

Does it apply to all midwives at the practice who would be engaging in professional misconduct for failing to provide supervision, or the partners of the practice, or those midwives identified as responsible for supervision? **We recommend that this be clarified and narrowed such that it only apply in the case where a midwife has failed to supervise based on a formal supervision plan.**

- ***Subsection 52:*** We appreciate the plan to develop a document that discusses each provision of the Professional Misconduct Regulation and hope that the points noted for clarification above will be included if they aren't addressed in the Regulation itself.

We are happy to further discuss any of these points with you at any point and again, appreciate this opportunity to provide feedback.

Yours truly,

Elizabeth Brandeis, RM, President

Cc: Kelly Dobbin, CEO & Registrar, CMO
Kelly Stadelbauer, Executive Director, AOM
Allyson Booth, Director Quality and Risk Management, AOM