

Framework of the Policy Review

Within the mandate of public protection, the CMO is considering revisions to the temporary alternate practice arrangements, the active practice requirements, the policy on continuity of care and the policy that two midwives attend every birth. The proposed revisions are intended to accomplish these goals:

1. Enable opportunities for midwives to work in alternate practice arrangements (outside of the current model of midwifery care) in communities and circumstances where flexibility is required to a) sustain the profession AND/OR b) meet the primary maternity care needs of a particular community.
2. Enable increased flexibility and capacity to support the sustainability of the profession for all midwives, in terms of practice arrangements and organization.

This consultation process is intended to identify the spectrum of member opinions regarding the proposed revisions, and to gain a better understanding of the impacts that they might have on midwifery practice across the province. Should the policy revisions be made, members will not be required to implement them if they do not feel they are required for their practice. The CMO believes that it is midwives who are the experts in regard to the needs of their communities, and is working to allow more flexibility in the application of these policies. All alternate practice arrangements that may result from this revision will be subject to monitoring and tracking by the CMO in order to evaluate their impact and assess safety and satisfaction outcomes.

Supporting the Growth and Sustainability of the Profession

Midwifery has grown over the past 15 years of self-regulation and has become an established part of the Ontario health care system. In light of this, the CMO believes it is important to examine the policies governing the current practice model to assess whether they are still working to support midwives in all communities and circumstances. The College expects that enhancing flexibility in midwifery practice will better support midwives in meeting their own needs and the needs of their community.

Enhanced flexibility may also support midwives to engage in the capacity-building activities required for the continued development of the profession (e.g., midwifery research, teaching in the education programs, policy work in the stakeholder organizations, etc.). The expertise of midwives in these areas is critical to the evolution of the profession, as well as for informing the direction of the midwifery stakeholder organizations and policy makers in government. In terms of enhancing opportunities for midwifery research and education, it is well documented that creating an environment that fosters investigative and evaluative opportunities outside of clinical practice can allow health professions to develop the 'academic infrastructure' to support continued professional development. The CMO views all of these activities as positive opportunities for the profession and the enhancement of midwifery's contribution to the maternity care system.

Continuing to Support the Principles of Midwifery

The current model of regulated midwifery care was developed to protect and promote woman-centred primary maternity care. The satisfaction and clinical outcomes of midwifery to date reflect the success of this approach. However, it has been noted that for some "adherence to protecting the model of

midwifery has come at the price of professional autonomy, flexibility, workplace choices, responsiveness to specific community contexts, and individual professional creativity.”¹

It is important to note that there are already a significant number of midwives working outside of the current model of care, under temporary alternate practice arrangements. The CMO has been monitoring these arrangements through an annual assessment process, and has established criteria to ensure that the principles supporting the midwifery model are maintained.

The proposed revisions to the CMO policies discussed here will seek to balance increased professional flexibility with the protection of the principles guiding midwifery:

- informed choice
- continuity of care
- choice of birthplace
- woman-centred care
- time spent with women
- the appropriate use of technology
- non-authoritarian relationships between midwives and clients
- access to evidence-based high quality maternal and newborn care
- responsive to community needs
- the promotion of pregnancy and birth as normal and healthy life events

While the CMO does not assume to know all of the possible reasons why midwives may be requiring more flexibility in their practice, research and midwife experience tells us that some of the circumstances may include:

- Practicing in rural, remote and/or underserved communities
- Providing care to vulnerable or special needs populations
- Providing care in an interprofessional model
- Working in other areas of maternity care (e.g., at a breastfeeding clinic, in midwifery research, in the education programs, etc.)
- Life and practice circumstances

Health System Support

The CMO recognizes that other health system supports will be required to better establish flexibility for the profession, and will be sharing the results of this consultation with the Association of Ontario Midwives, the midwifery education programs, and the Ontario Midwifery Program to ensure that all midwifery stakeholders are informed in order to make relevant changes with member input at the centre.

¹ Tyson, H. “The Integrity of Midwifery in Ontario and its Integration into the Health Care System.” AOM Journal, Vol. 7-1, 2001.

Member Experiences: Valuable and Diverse

The CMO also recognizes that there are diverse opinions among members regarding these policies, and notes that this diversity is the result of very different experiences with midwifery practice across the province (e.g., different communities, hospitals, practice arrangements, etc.). The CMO will ensure that all member contributions are considered in these revisions, and will be sharing a summary of all survey responses with participants of the upcoming forums.

Discussion Paper

The following discussion paper outlines the CMO's proposed revisions to the policies, and provides background information to assist members in developing informed responses to the survey, which will be available on the CMO website from May 19th to June 1st.

Alternate Practice Arrangements

In an effort to enable opportunities for midwives to work outside of the current model of midwifery care in communities and circumstances where flexibility is required to a) sustain the profession and/or b) meet the needs of a particular community, the CMO is considering revising the temporary alternate practice arrangement (TAPA) policy. This revision would authorize midwives to work in different types of practice arrangements, in addition to the current criteria for TAPAs. The alternate practice arrangement will be the mechanism for facilitating variations on the application of the revised active practice requirements, and policies on continuity of care and two midwives at every birth.

The revised policy may include:

- Criteria for midwives working in circumstances and communities where following the current model poses difficulties (e.g., midwifery research and teaching outside of clinical practice, working in other areas of maternity care, working with special needs populations, etc.)
- Criteria for supporting the transferability of midwifery skills to other areas of the field (e.g., well-woman care, breastfeeding support, prenatal care, etc.)
- Criteria to ensure that the philosophy and principles of midwifery care are protected
- Criteria for monitoring the alternate practice arrangements to enable stakeholder planning for the future of midwifery care

In some of these circumstances a member's ability to meet their active practice or continuity of care requirements, or have two midwives attend every birth, may become compromised. The CMO proposes to work with midwives within a clearly articulated framework to discern what exemptions to CMO policies may be required to foster midwives working in these alternate arrangements.

Background

Approximately 50% of practices currently have temporary alternate practice arrangement approval with the CMO, but not all of them utilize it on a consistent basis. The TAPA has worked to provide support to midwives working outside of the strictly defined team model, but some members have indicated that it is

an ineffective mechanism for change that does not accommodate all alternate arrangements that may be required to meet community need.

As the profession continues to grow and become better established in Ontario's ever-changing health care system, opportunities for participation in variant practice environments, or work outside of the clinical care model, increase. For example:

- The expansion of midwifery into new communities has led to an increase in midwives working in small or solo practices, and therefore the need for sharing care with physicians and employing non-midwife second attendants has also increased.
- There are more midwives interested in pursuing graduate studies, midwifery research projects, and teaching positions in the midwifery education programs.
- There has been interest expressed by some midwives to work exclusively with vulnerable or special needs populations in their communities (e.g., new immigrants, abused women, etc.).
- There has been interest expressed by some midwives to work in policy positions related to midwifery and maternity care.

Continuity of Care

The CMO is considering revising the policy on continuity of care to:

1. Allow flexibility regarding the number of midwives sharing the care of a client.
2. Allow midwives the option of working outside of the small midwifery group model with other maternity care professionals.

It is expected that midwives' commitment to the principles of continuity of care will support the ongoing delivery of continuous care to all midwifery clients, in all practice scenarios. Excellent communication among team members, a shared approach to care, and shared practice protocols will continue to be essential to all team-based maternity care.

The revision is proposed with the intention of maintaining the primary principles of continuity of care:

- A small group of caregivers known to the client
- A shared philosophy and approach to care among the caregivers, including informed choice
- Good communication among caregivers, as well as between caregiver(s) and client, including the development of protocols to support the consistent philosophy and delivery of care
- 24 hour on call availability for clients
- A comfortable, trusting and familiar relationship between caregiver(s) and client
- Time spent with clients to promote relationships of trust and informed decision-making on the part of the client

Background

The model of midwifery in Ontario was informed by the substantial body of literature that links continuity of care to improved maternal and infant health outcomes. For example:

“During pregnancy and childbirth, every effort should be made to provide women with care from the same health care provider or from a familiar group... Evidence indicates that women receiving such care experience many positive outcomes, including less likelihood of prenatal admissions to hospital, greater likelihood of attendance at prenatal education programs, less likelihood of using pharmacological methods of pain relief during labour, less likelihood of their newborns requiring resuscitation, and greater likelihood of satisfaction with their prenatal, labour, birth, and postpartum care” (Health Canada’s *Family-Centred Maternity and Newborn Care: National Guidelines*, 2000).

The CMO’s standard on continuity of care was established as a central component of midwifery in Ontario in an effort to support the consumer-driven move toward woman-centred primary maternity care, as well as to reflect evidence-based research and best practices in maternity care. Women wanted to develop relationships with the professionals providing their maternity care, and to be the decision-makers regarding that care. While there is currently debate among researchers, stakeholders and practitioners about what constitutes continuity of care (see appendix A for further information), in Ontario it was developed as a system of small teams of midwives providing care to a woman throughout pregnancy, birth and six weeks postpartum. This model was identified as the most effective way of ensuring that clients and midwives establish a relationship of trust and respect, while allowing midwives the flexibility to have a healthy work-life balance.

This model has resulted in excellent clinical outcomes and very high rates of client satisfaction to date. However, some members have indicated that the policy does not allow the flexibility that is required to meet the needs of every community in the province where midwives practice, nor does it foster opportunities for the expansion of midwifery services into some Ontario communities where it would be a benefit.

Active Practice Requirements

The CMO is considering modifying the current active practice requirements to allow midwives more flexibility in their practice structures. For example, this modification might enable midwives to:

- Develop innovative clinic and call rotations to better meet their practice needs (e.g., allow a practice member to only do clinic for a period of time, while the other members manage the on-call schedule and births)
- Enable opportunities for locum midwifery positions
- Work in interprofessional maternity care teams, where appropriate
- Provide midwifery care to vulnerable or special needs populations
- Work in other areas of women's health care (e.g., well-woman care, breastfeeding support, etc.)
- Work in research or teaching relevant to the development of the profession, outside of clinical practice

The modification will be made with the intention of maintaining the primary goals of the active practice requirements:

- Maintaining choice of birthplace

- Protecting home birth as an option for women
- Maintaining midwifery skills, confidence and competence

The CMO will establish a process for assessing the active practice requirements of those midwives working under an alternate practice arrangement. Some possible mechanisms for assessment may include:

- Emergency skills certification with a home birth focus
- Level one hospitals and home birth equivalency assessment
- Remote practice numbers (e.g., Arctic placement)
- Skills packages certification (e.g., IV, external fetal monitor, epidural, induction/pump, etc.)

Background

The CMO's active practice requirements were established to support midwives in providing choice of birthplace to all clients, as well as to maintain clinical competency in both the home and hospital settings. As the profession grows there are increasing opportunities for midwives to work in care arrangements outside of the current small group practice model (e.g., in antenatal clinics). Similarly, midwives and midwifery practices may be looking at ways to organize their on-call and clinic time to enhance their work/life balance.

In some of these instances midwives' ability to meet their active practice requirements may be compromised. The CMO is interested in supporting midwives to practice in innovative ways to meet their needs, as well as the maternity care needs of their communities, in order to sustain the profession as it continues to grow.

There are a number of important considerations that will be included in the CMO's decision-making process regarding revisions to the active practice requirements. They include, but are not limited to:

- The skills required for providing care in a level one hospital are similar to those required for home birth
- Attendance at home births does not necessarily ensure competency in general maternity emergency skills
- The importance of supporting and promoting home birth as a safe and viable option for women, and avoiding the erosion of home birth in Ontario
- Recognition that while the number of midwives practicing is increasing, the number of home births is remaining stable, which may impact the distribution of home birth among midwives in the future

Two Midwives at a Birth

In an effort to enhance flexibility for midwives and to foster interprofessional relationships where appropriate, the CMO is considering revising the requirement that two midwives attend every birth to specify that:

- Two qualified persons must attend every birth

- One of the qualified persons attending the birth must be a midwife known to the woman
- Second birth attendants must meet established criteria, outlined in a CMO standard

The CMO has always had a mechanism in place to allow midwives the flexibility to work with a non-midwife second attendant, within the ‘temporary alternate practice arrangement’. In 2007-08 14% of all midwifery births utilized a second attendant who was not a midwife (e.g., qualified second attendant, nurse, etc.).

Practices may continue to have two midwives attend every birth, if this arrangement meets their needs and the needs of their community. As midwives are well-situated to assess the needs of their communities, it will be the practice’s responsibility to make that choice; the CMO will not be establishing criteria to assess the needs of individual practices/communities.

This revision has the following intentions:

- Maintain the primary tenets of the profession (choice of birthplace, informed choice and continuity of care)
- Support a healthier work/life balance for practicing midwives by increasing flexibility and practice options in the profession
- Reduce the current professional pressures affecting midwives (e.g., some midwives may find respite in a reduced call burden, while others may experience better collaboration with nurses and other hospital staff)
- Offer midwives the flexibility to adapt their practice to better meet their needs as primary maternity care providers

Background

The CMO’s policy that two midwives attend every birth was originally built into the regulatory model of midwifery in Ontario in accordance with the evidence-based standard of care that requires two qualified people to attend every birth. It was also written into the College’s policies to support the integration of the new profession of midwifery into Ontario’s maternity care system. Midwives working in pairs were better equipped to promote and protect the unique model of midwifery care in the broader maternity care system.

Ontario is the only Canadian jurisdiction with regulated midwifery that requires the attendance of two midwives at every birth. All other provinces stipulate that one midwife and a qualified second attendant must be present at every birth, and the clinical outcomes of these provinces indicate safe and effective midwifery care. It has been noted that utilizing nurses as second attendants for hospital births has the potential to enhance positive nurse-midwife relationships.

The CMO has been hearing feedback from midwives regarding the requirement that two midwives attend every birth for a number of years; this issue has been a topic of discussion since the 2001 member symposium. When asked directly in the 2007 CMO member survey whether they believe that having two midwives attend every birth is an essential component of the midwifery model in Ontario, member opinions were evenly split. The CMO has concluded that increased flexibility in regard to this policy is required, as opposed to a more prescriptive approach.

Appendix A – Jurisdictional Review and Literature Review

National Jurisdictional Review

CMO policy under review	Jurisdictional Review
<p>Alternate Practice Arrangements and Active Practice Requirements</p>	<p>One Canadian province explicitly enables alternate practice arrangements in their policies: BC includes in their active practice policy partial exemptions for midwives working in teaching or research positions, as well as for midwives practicing within a project serving women with special needs.</p>
<p>Continuity of Care</p>	<p>Every Canadian province and territory with regulated midwifery has continuity of care as a central component of the profession. Midwifery care in other provinces and territories was largely modeled after Ontario’s system, and there is very little variation in terms of the practical application.</p> <p>A notable deviation from the small midwifery group model is the South Community Birthing Project (SCBP) in BC, which is a multidisciplinary program that brings midwives, family physicians, nurses and doulas together to provide team-based maternity care to women. “The goal of the SCBP is to improve the health outcomes of low-risk pregnant women in the underserved community of South Vancouver, by providing them with collaborative, multidisciplinary care from family physicians, midwives, community health nurses, and doulas. This is the first such multidisciplinary program of its kind in Canada. Care takes place in a community-based, culturally-appropriate, and woman-centered manner during pregnancy, birth and the newborn period.” Continuity of care is provided by all members of the team, and a philosophy of care is shared among the care providers. To date their clinical outcomes have been very positive, and client satisfaction rates are high.¹</p>
<p>Two Midwives at a Birth</p>	<p>Ontario is the only Canadian (or international) jurisdiction that requires two midwives to attend every birth. The national standard is to require two skilled persons to attend every birth, and some provinces state that two midwives is the ideal, particularly for home births. However, second attendants who are not midwives are authorized in every province and territory with regulated midwifery.</p>

¹ See their report at http://www.scbp.ca/main/SCBP_Final_Report.pdf for more information

	<p>While the other jurisdictions do not require that two midwives attend every birth, the philosophy and approach to care is essentially the same as that of Ontario’s midwives (e.g., informed choice, choice of birthplace, continuity of care). The statistics emerging from other provinces indicate that midwifery births that are attended by second attendants who are not midwives have positive clinical outcomes (for example, see the 2007 article <i>Outcomes of Planned Hospital Birth Attended by Midwives Compared with Physicians in British Columbia</i> by Janssen et al., which compares the clinical outcomes of hospital births attended by midwives and those attended by physicians). Nurses provide the majority of the second attendant support for midwives in hospital in BC, while it is common practice for two midwives to attend home births.</p>
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Literature Review

Alternate Practice Arrangements

The primary goal of this proposed policy revision is to enable flexibility for midwives in their practice. It is widely cited that flexibility in work hours and practice organization positively impacts health professional satisfaction and retention (most often cited for nurses and physicians). For example, in a recent article entitled *The Economy Plus Flexibility Keep Physicians In Practice* nearly half of the physicians surveyed agreed that part-time options encourage physicians to stay while meeting family or personal needs (Medical News Today, April 16, 2009).

Enhanced flexibility in midwifery may better enable midwives to participate in the capacity-building activities - like research, teaching, and policy development - required to sustain the profession. For example, in *Nurse Practitioner’s Characteristics and Job Satisfaction* (Journal of the American Academy of Nurse Practitioners 18: 544–549, 2006) it was found that the aspects of the job that showed significant levels of satisfaction for NPs were flexibility of hours and interprofessional relationships. NPs were least satisfied with not having professional opportunities such as participation in nursing research, writing/publishing, and belonging to a department committee.

Despite midwifery’s unique on-call requirements and time demands, there is still potential for increased flexibility in the current model of midwifery care. As Holliday Tyson notes in *The Integrity of Midwifery in Ontario and its Integration into the Health Care System* (AOM Journal, Vol. 7-1, 2001):

“I think it is possible to apply the same integrity demonstrated in protecting a vulnerable model to the challenge of building more flexibility within the current model of practice. It may also be possible to support more choice for midwives in other working environments, while defining new ways to protect the central values of midwifery in Ontario. Evolution will be necessary for the health, growth and relevance of midwifery.”

In the UK, the Royal College of Midwives has developed a position paper entitled *Refocusing the Role of the Midwife* (RCM position paper number 26, January 2006), which reiterates that the role of the midwife has been, and should continue to be, the care of women and infants within the midwifery philosophy that supports pregnancy and birth as normal and healthy life events. However, it also acknowledges the need for flexibility in midwifery models, in the face of the evolution of the profession and maternity care:

“It is important for the effective working of the NHS (National Health Service) that staff groups are reasonably flexible. It is important...that midwives can access opportunities to develop and enhance their skills and interests.”

Continuity of Care

The model of midwifery in Ontario was informed by the growing body of literature that links continuity of care to improved maternal and infant health outcomes. For example:

“Evidence indicates that women receiving such [continuous] care experience many positive outcomes, including less likelihood of prenatal admissions to hospital, greater likelihood of attendance at prenatal education programs, less likelihood of using pharmacological methods of pain relief during labour, less likelihood of their newborns requiring resuscitation, and greater likelihood of satisfaction with their prenatal, labour, birth, and postpartum care” (Health Canada’s *Family-Centred Maternity and Newborn Care: National Guidelines*, 2000).

However, there remains a debate in the literature regarding what actually constitutes continuity of care. It is unclear whether the positive outcomes of continuous care are the result of one-to-one primary maternity care from an individual midwife or physician, or if similar results can be found in continuous care from a small group of professionals.

Examples from the Literature:

1. Health Canada’s *Family-Centred Maternity and Newborn Care: National Guidelines* state:

“During pregnancy and childbirth, every effort should be made to provide women with care from the same health care provider, or from a familiar group. Women have repeatedly stressed the importance of such continuity of care...Groups are most effective when there is a shared philosophy and approach to caring for women. As well, continuity of care and teaching is enhanced by documentation systems that provide effective communication between providers. Such documentation decreases the possibility of repetition and gaps in care.

2. The UK’s National Institute for Health and Clinical Excellence (NICE) provides clinical guidelines regarding maternity care. In their guideline *Routine care for the healthy pregnant woman* they recommend that:

“Antenatal care should be provided by a small group of carers with whom the woman feels comfortable. There should be continuity of care throughout the antenatal period. A system of clear referral paths should be established so that pregnant women who require additional care are managed and treated by the appropriate specialist teams when problems are identified.”

3. Page and McCandlish, in *The New Midwifery: Science and Sensitivity in Practice*, note that “continuity can most usefully be defined as a hierarchical concept ranging from the basic availability of information about the woman’s past history to a complex interpersonal relationship between provider and woman characterized by trust and a sense of responsibility” (2006).

While the exact definition of continuity of care is not agreed upon, there are particular elements that reflect the purpose of the approach, which is to provide an enhanced quality of maternity care to women and infants. These elements include:

- A small group of care providers
- A comfortable, trusting and familiar relationship between caregiver(s) and client
- Good communication among caregivers, as well as between caregiver(s) and client

Active Practice Requirements

The CMO’s active practice requirements were implemented as a central component of regulation to ensure that midwives remained competent in both home and hospital deliveries, and therefore protect women’s right to choose their preferred birthplace. However, as the profession has evolved, so too has the practice environment and client population being served by midwives across the province. While protecting home birth and women’s right to choose where they want give birth remain central to the model of midwifery practice in Ontario, the CMO recognizes that there are opportunities to enhance flexibility in order to make midwifery care more accessible and responsive to women’s needs in the wide range of communities and circumstances where midwives are now practicing. Modifying the active practice requirements for midwives authorized under an alternate practice arrangement may enable this flexibility, while at the same time maintaining the philosophy of midwifery, and excellent care for women and infants, as the highest priorities.

The consensus among Canadian maternity care stakeholders is that attending a specific number of births does not necessarily imply competence. This issue can be particularly relevant for midwives practicing in rural and remote communities where the number of births may be low. The joint policy statement of the Society of Obstetricians and Gynaecologists of Canada, the College of Family Physicians of Canada and the Society of Rural Physicians of Canada *Number of Births to Maintain Competence* states:

“The belief that attending a specific number of births can imply a competence threshold for all providers fails to take into account several important variables. These include stage of a provider’s career (early, middle, or approaching retirement) and hence the value of

accumulated experience; the shared experience of the members of a practice group; well developed collegial relationships among family physicians, specialists, and subspecialists; practice setting and organization; and use of risk management or quality assurance programs.

Although the literature clearly supports volume thresholds for complex surgical and some rare medical conditions there is no evidence to support extrapolation of these volume concepts to normal pregnancy and newborn care. Rather, findings demonstrate good outcomes in low-volume settings when access to specialist consultation and timely transfer is available and used appropriately.

In light of this evidence, the Society of Obstetricians and Gynaecologists of Canada, the College of Family Physicians of Canada, and the Society of Rural Physicians of Canada affirm that competence in obstetric care is not dependent on number of births attended annually.

Maintaining competence in all elements of practice is the professional responsibility of every practitioner. Maintaining competence depends on an appropriate, ongoing, and self-directed program of continuing professional development that should be structured to the needs and responsibilities of individuals and practice groups. This program can include, but is not limited to, consultation with colleagues, attendance at meetings and courses, and participation in special workshops, such as Advances in Labour and Risk Management (ALARM) and Advanced Life Support in Obstetrics (ALSO) provider courses.

Maintaining hospital privileges to provide intrapartum care should be based on locally determined quality assurance programs and on individual participation in self-directed maintenance of competence programs. Requiring attendance at a minimum number of births should not be an element of any credentialing program.”

Two Midwives at a Birth

There is little published research available to support the model of two midwives at a birth. However, it is a well-documented standard that two skilled people attend every labour and delivery. For example, Health Canada’s *Family-Centred Maternity and Newborn Care: National Guidelines* state that:

“All facilities (e.g. hospitals, birth centres) providing planned care during labour, birth, and the immediate postpartum period for women, newborns, and families should...have a family physician, obstetrician, or midwife available for birth *and* a second professional, skilled in resuscitation, available for each baby.”

No other Canadian jurisdiction with regulated midwifery requires two midwives to attend every birth, all though some models recommend two midwives for out-of-hospital births. For example, the College of Midwives of BC states, in their policy on the Midwifery Model of Practice

Appendix B: Case Studies

In an effort to assist members in envisioning the potential impact of the proposed revisions, the CMO has developed a selection of example alternate practice arrangements that may be enabled through the policy revisions. (Note: in each of these scenarios the CMO would be working with the midwife within a clearly established framework to ensure that the principles of midwifery care are maintained, as well as monitoring the arrangements for impact assessment purposes.)

1. Flexible midwifery practice structures

- a) A midwife has recently had a child and has now returned to work. In an effort to allow her predictable work hours for the first few months, the practice arranges to have her manage the clinic appointments, while the other practice members take care of the on-call coverage and births. Continuity of care and informed choice would be maintained for clients, and the midwife would apply to the CMO for an alternate practice arrangement and temporary exemption from her active practice requirements. The CMO would establish criteria to assess her competency upon her return to full midwifery care.
- b) A practice of six midwives decides that they would be able to arrange a more flexible on-call schedule for all members of the group if clients met, and were provided with continuity of care from all six midwives in the practice as opposed to four. The practice would apply to the CMO for an alternate practice arrangement. Continuity of care and informed choice would be maintained for clients, and the practice would keep the CMO informed of any revisions to their practice arrangement.

2. Midwifery research and teaching

- a) A midwife pursues graduate studies in an area relevant to midwifery/maternity care. She continues to work part-time as a midwife, and applies to the CMO for an alternate practice arrangement and a temporary exemption to her active practice requirements. The CMO will establish criteria to assess her competency upon her return to full midwifery care.
- b) A midwife recognizes the need for maternity care/midwifery research in her community. She receives funding from a granting body for a full time research project; she does not continue to practice as a midwife, but will be returning to practice when the research project is completed. The CMO will establish criteria to assess her competency upon her return to full midwifery care.
- c) A midwife begins to teach in the midwifery education program, and continues to provide midwifery care on a part time basis. She applies to the CMO for an alternate practice arrangement and a temporary exemption to her active practice requirements. The CMO will establish criteria to assess her competency upon her return to full midwifery care.

3. Interprofessional care

A group of midwives and physicians in an underserved community decide that they would be better able to meet the maternity care needs of their community by working as a team. They agree to provide

care within the philosophy of midwifery care, including informed choice, choice of birthplace and continuity of care. The midwives apply to the CMO for an alternate practice arrangement.

4. Working in other areas of women's health care

A midwife requiring a more predictable schedule decides to work in an antenatal clinic or breastfeeding clinic for a period of time. She applies to the CMO for an alternate practice arrangement and a temporary exemption to her active practice requirements. The CMO will establish criteria to assess her competency upon her return to full midwifery care.

5. Providing midwifery care to a vulnerable or special needs population

A midwife recognizes the need in her community for maternity care for HIV positive women. She and a physician team up to provide midwifery care to this community, on a full time basis. They provide continuity of care together, and nurses act as the second-attendant for all births. Because HIV positive women are expected to deliver in hospital, the midwife's homebirth active practice requirements will not be met. She will apply to the CMO for an alternate practice arrangement and exemption from her active practice requirements. The CMO will establish criteria to assess her competency upon her return to full midwifery care.

(2007): “The second midwife comes to assist near the time of delivery when the birth is occurring at home while in hospital the principal midwife is assisted by the nursing staff.”

Holliday Tyson writes, in *The Integrity of Midwifery in Ontario and its Integration into the Health Care System* (AOM Journal, Vol. 7-1, 2001):

“No midwifery jurisdiction in the world requires this for safe midwifery, including British Columbia and New Zealand, in which community practice is nearly identical to that in Ontario. The practice is not based on research evidence. It constrains midwives permanently in a position of inefficiency, low productivity and makes innovative on call and time off arrangements difficult. It contributes to poor integration with labour and delivery staff, as the message to nurses is: the quality of care midwives provide would be compromised by a nurse attending, so a midwife from outside the hospital will be called in instead. A second message to nurses is that if midwifery births increase substantially, they will lose their jobs. This practice has prolonged and stalled midwifery’s integration into hospitals, and the health care system, creating two separate professional worlds in hospitals, lacking trust and respect between them. I think it is questionable whether having two midwives at births improves quality of care or facilitates over-dependence by midwives on one another for common clinical decisions.”