Review of College of Midwives Submission Re: Proposal to grant midwives broad authority to order laboratory tests and prescribe drugs within the scope of practice of the profession

Ministry: General Comments

1. The proposal requests that midwives' authority be extended to order all laboratory tests and to prescribe all drugs (including controlled drugs) related to their scope of practice.
2. The key reason given for adopting a broad authority vs. submitting a list of tests or drugs is that testing technology changes rapidly over time and that a list-based approach can be cumbersome and slow to respond to the introduction of new standards of care, emerging health issues or to respond to changes in drug availability. To support this claim, the submission notes specific, recent, examples highlighting the challenges with a list-based model.
3. The ministry has identified two key issues with this proposed approach and its reasoning:
    a) The proposal advocates for broad authority within the scope of the profession but does not address how members would be educated on what is within their scope or outside.
    b) The proposal does not adequately address the process for how or when midwives will respond to test results that indicate conditions beyond their scope of practice.

College response to General Comments:

It is essential to view the College's submission, requesting broader authority for midwives to order laboratory tests and prescribe medications, as midwives working to the full scope of practice for which they are trained. Rather than think of this submission as a request for midwives to order laboratory tests and medications, it is actually about midwives ordering and prescribing for conditions they are already managing but without access to the necessary tools for adequate clinical management. Midwives are educated and clinically trained to order laboratory tests, interpret the results, and refer when the results suggest a management plan beyond the midwifery scope as well as translate that knowledge into accessible language and guidance for their clients. Similarly, midwives are educated in diagnosing a range of medical conditions that require pharmacological treatment, ordering the treatment, referring when the treatment is outside their scope, and following up on the clinical outcomes. This is the way midwives order all tests and medications they currently have the authority to order and prescribe.

Midwives are well trained to practise this way because of their education and clinical training they need to become a registered midwife in Ontario.

Ministry Question: The proposal advocates for broad authority within the scope of the profession but does not address how members would be educated on what is within their scope or outside.

College Response:

Throughout the Midwifery Education Programme (MEP), midwives are increasingly taught how to deal with indications that go beyond normal. One of the senior level courses, Midwifery Complications and Consultation (C&C) is the second in the sequence of four midwifery clinical courses. This course builds on and further consolidates the student's knowledge and skills in normal childbearing and variations of normal. The theoretical and clinical components of C&C focus on the recognition and management of conditions that require consultation. The student learns the role of the midwife in detecting and managing these conditions, including the need for and process involved in inter-professional collaboration and consultation. The next in sequence of clinical courses is Maternal & Newborn Pathology. This course focusses on midwifery managements and includes the recognition and understanding of abnormal situations. Students will learn the signs and symptoms of pathologic conditions of the mother and newborn infant and the appropriate role of the midwife in detecting and managing these problems. Within the clinical placement the student will provide increasingly independent care and will initiate consultation and referral when appropriate. Students will help to manage urgent or emergency situations. The curriculum overview of one of the Midwifery Education Programs can be viewed here: https://midwifery.mcmaster.ca/education/prospective-students/curriculum-overview

At entry to practise the profession, midwives must demonstrate that they have the competencies outlined in Canadian Competencies for Midwives developed by the Canadian Midwifery Regulators Council (CMRC). The 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 or territorial requirements, in the full scope of practice and without supervision requirements on their registration. All midwives must have met the following core competencies upon initial registration with the College.

- identify risk factors before and during pregnancy, labour, birth and the postpartum period; take appropriate action; and/or consult or refer as appropriate;
- order, perform and interpret results of screening and diagnostic tests in accordance with provincial and territorial regulations and standards;
- prescribe, order and administer pharmacologic agents in accordance with provincial and territorial regulations and standards;

- recognize abnormal conditions, recommend and initiate treatment and/or consult or refer as appropriate;
- critically review, appraise and apply new information, including research findings, relevant to midwifery practice.

The following scenarios provide examples of current midwifery practice in order to demonstrate the rigor of their education regarding practising within scope:

1. A client presents with elevated blood pressure and no other signs or symptoms of pregnancy induced hypertension (PIH). Midwives understand the normal range of blood pressure as well as when and how to respond to abnormal values (i.e. anything value over 140/90) but does not have the authority to order the blood tests to determine who best should manage the care. This means the client is referred to an obstetrician to have bloodwork done to determine the extent of the PIH. With the authority to order the tests, the midwife will order the test and refer on when the results are abnormal or when other clinical indications suggest the client has a problem.
2. A client presents with signs and symptoms of a urinary tract infection (UTI). Midwives take a thorough history of the condition, assesses the signs and symptoms and order a urine culture and sensitivity (C&S) to either diagnose or rule-out a UTI. Midwives determine, based on the C&S of the laboratory results and the gestation of the client's pregnancy, which antibiotic to prescribe. The midwife prescribes the antibiotic providing the client with information about possible side effects and expectant management. When the C&S shows the UTI should be treated with antibiotics that midwives cannot order due to the restricted list, the client is referred to a physician for a prescription, despite the midwife having the knowledge and skills to treat UTIs.
3. A client is in early labour and is requesting analgaesia for pain relief. Midwives provide informed choice discussions and the benefits and risks to a client and her fetus at this early stage of labour. The client decides to have a narcotic administered intramuscularly (IM) so she can sleep. Midwives discuss the situation with the physician providing all the necessary history and current client information required for the physician to order the narcotic. Midwives draw up the narcotic and anti-nausea medication, administer the narcotic and anti-nausea medication IM, provides monitoring of the client and fetus to ensure there are no side effects, and discharges the client home to rest with instructions about when to call the midwife or come back to the hospital. The physician writes the order – all assessment, monitoring, and follow-up is managed by the midwife.

Ministry Question: The proposal does not adequately address the process for how or when midwives will respond to test results that indicate conditions beyond their scope of practice.

College Response:

Midwives are primary care providers and already respond to test results that indicate conditions beyond their scope practice. This is a routine part of what midwives, as specialists in normal pregnancy, birth and the postpartum, do. As primary care providers, midwives work according to the scope of practice defined by the *Midwifery Act, 1991*, the controlled acts authorized to them, as well as Appendix B of the *Laboratory and Specimen Collection Centre Licensing Act, R.S.O 1990 L.1.* In addition to practising within the legislative and regulatory framework, midwives practise in accordance with a set of College standards (Consultation and Transfer of Care Standard (CTCS)) that clearly articulate the indications that require a consultation or transfer of care to a physician. The CTCS simply spells out what midwives already know according to their scope and the acts authorized to them. The foundation for this kind of knowledge is rooted in the core competencies.

According to the Canadian Competencies for Midwives, midwives must be:

> fully responsible for the provision of primary health services within their scope of practice, making autonomous decisions in collaboration with their clients. 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.

Midwives are required to comply with the regulations governing their profession and practice in accordance with the CTCS – all of which clearly define when clinical situations are no longer normal and require another type of care (in the same way a family physician refers a pregnant client to an obstetrician for care they do not have the knowledge or skills to provide). As a result, midwives consult and transfer care to a more specialized provider for all clinical conditions, including abnormal laboratory screening and diagnostic tests, that they are not competent to manage. Midwives respond to test results that indicate conditions beyond their scope of practice on a daily basis for tests such as glucose tolerance tests, low platelets, abnormal findings on an obstetrical ultrasound, repeatedly low hemoglobin, positive tests for HIV, Hepatitis B, Chlamydia and Gonorrhea, elevated newborn bilirubin levels, prolonged labour or any abnormal finding on a newborn exam. In all of these situations, midwives must demonstrate sound clinical judgment, clinical decision-making and an understanding of midwifery scope or negative and potentially life-threatening situations will ensue. Recognizing, managing and

referring for potentially life-threatening medical complications are a part of every midwife's practice.

The following scenarios provide examples of how midwives currently practice and respond to test results that indicate conditions beyond their scope of practice:

1. A client is tested for hemoglobin to determine if the symptoms she is experiencing (e.g. tired, lacking energy) are normal variations of pregnancy or a sign of iron deficiency anaemia. The result comes back in the normal range. The midwife rules out anaemia and continues to monitor. If the client's symptoms disappear then any health care provider, including a midwife, will not do further testing. If the test is normal but the symptoms persist, the client is no longer experiencing a normal variation of pregnancy and the midwife will consult with a physician in accordance with the scope, the CTCS, and the limits of her own knowledge, for further evaluation.
2. A client has a 20-week anatomy scan that finds the baby below average size with a suspected cardiac defect. The midwife immediately refers the client to a specialist physician who can pursue further testing and diagnose the situation. Even though midwives have access to follow-up ultrasounds to evaluate the fetal size and assess the fetal heart, the ultrasound suggests a fetus that may be medically compromised, and midwives do not have the knowledge or skills to manage such a pregnancy. As a result, they do not order the follow-up tests.

Specific Comments from the Ministry: The proposal suggests broad authority for laboratory testing and prescribing within the scope of midwifery. The scope of practice of midwifery is the assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries. The ministry is seeking further details regarding specific examples of laboratory tests and drugs that are within the scope of practice of the profession that are currently not available to midwives and would be captured under this new authority.

College response

The College submitted a list to the Ministry in April 2018 (Appendix 1), and it is included here as Table 1:

Chemistry
Alanine transaminase (ALT)
Alkaline phosphatase
Aspartate transaminase (AST)
Bilirubin unconjugated

Blood tests to detect the genetic carrier status of the mother
e.g. hemoglobin electrophoresis
Haematology
Cross match
Partial thromboplastin time (PTT)
Prothrombin time, international normalized ratio (PT/INR)
Microbiology
Urine culture and sensitivities
Urine chlamydia and gonorrhea nucleic acid detection
Serology/Immunology
Cytomegalovirus antibody
Varicella Zoster antibody
Parvovirus antibody
Zika antibody
Other
Non-invasive prenatal testing
Blood urea nitrogen (BUN)
Direct Coombs
Creatinine
Fibrin split products
Fetal fibronectin
Gamma glutamyl transferase (GGT)
Lactate dehydrogenase (LDH)
Thyroid-stimulating hormone (TSH)
Triiodothyronine (T3)
Thyroxine (T4)
Total protein
24-hour urine for protein
Uric acid
Vitamin B12

Ministry Question: The proposal notes that of controlled drugs and substances, midwives would be prescribing narcotics and benzodiazepines (pg. 21) and that the majority of prescribing would be for treating infections, prescribing contraception and managing labour pain (pg. 19). Please specify which narcotics and benzodiazepines would be used for these purposes.

College response

The College submitted a list to the Ministry in April 2018 (Appendix 2) and it is included here as Table 2. On that list the following drugs were included along with their indications for use:

Controlled Substances: Prodromal labour and early postpartum
Lorazepam
Oxazepam
Controlled substances: Labour
Fentanyl citrate
Morphine Sulfate (+/1 Dimenhydrinate - Gravol)
Meperidine
Controlled Substances: Postpartum
Acetaminophen with Codeine
Acetaminophen with Oxycodone
Hydromorphone

Ministry Question: Which opioids will midwives be expected to prescribe and for what purposes? Has the college considered additional training for members prescribing controlled drugs and substances?

College response

The College submitted a list to the Ministry in April 2018 (Appendix 2) of the opioids and their indications which are also included in Table 2.

The College asked the membership if they felt additional training is needed to broaden their authority to prescribe drugs according to scope. 22% of participants said they need additional training to broaden their scope to include narcotics. Despite the fact that the majority of participants did not explicitly state there was a need for training to prescribe narcotics (many are already administering controlled substances), it is difficult for any clinician to understand what they might not know about a new authority. With this in mind, as well as the identified opioid crisis, the College intends to make mandatory a training in controlled substances, until it can be added to the Midwifery curriculum. The training will be an adaptation of the University of British Columbia (UBC) course developed for BC midwives when they were granted the authority to prescribe controlled substances. This course has been chosen based on the recommendations of a consultant who reviewed courses for the College earlier this year.

Ministry Question: The province has updated its opioid strategy. Please provide further information on the QA and other activities that the college would consider to align with the opioid strategy. Please consider areas such as diversion and safe prescribing.

College Response

It is important to recognize that the vast majority of cases of abuse, misuse and diversion occur as a result of physician prescribing for chronic pain (Fischer, Rehm & Tyndall, 2016) and that chronic pain is not in the midwifery scope. Midwives will have limited opportunities to prescribe narcotics with the vast majority occurring during labour. Thus, midwives will not be at great risk of misuse, abuse or diversion by virtue of their scope. In addition, despite having regulated health care professionals, Canada has the second highest rate of opioid prescribing in the world (Fischer, Rehm & Tyndall, 2016) suggesting policy solutions may be more effective than regulatory solutions to ensure safe prescribing. The College will also look at how midwives can work within existing and new system-wide policy solutions.

The Colleges Quality Assurance Program (QAP) is designed for ongoing learning to assure the quality of care delivered by midwives. As part of the QAP, members are expected to self-assess what their learning needs are, identify learning goals, and reflect on the learning they have done. In the laboratory testing and prescribing survey, many members mentioned their ongoing participation in continuing education activities when they identify a learning need and stated that they would approach prescribing narcotics similarly. Ongoing education and learning is only part of the solution to ensure safe prescribing. Equally important will be educating clients as well as safeguards implemented system-wide such as prescription monitoring programs, requiring photo identification at pick-up and referrals to pain and addiction specialists (Fischer, Rehm & Tyndall, 2016).

For midwives who feel they would like to update their knowledge regarding prescribing drugs, they will be directed to resources that can help them improve their knowledge and practice regarding their authority to prescribe. The College will develop context specific information and implement enforceable standards about prescribing narcotics based on the available evidence from the prenatal, intrapartum and postpartum period. Members will also be provided with access to the growing body of resources that exist to alert members to issues of diversion and safe prescribing. The College and the Association of Ontario Midwives will work together to follow the emerging evidence and ensure the membership is continually aware of the evidence using webinars and FAQs. The College is also committed to working with the Ministry and other stakeholders, in particular other midwifery jurisdictions, such as BC, and other Ontario regulators, such as the College of Nurses of Ontario, who have recently added narcotics to their scope, to ensure public safety is protected.

Ministry Question: Impact on timeliness to care

The college notes that the proposal would reduce waiting times for referral and testing. To support this statement, does the college have data on the frequency of referrals by midwives to physicians for testing or prescribing? Or the most common referral scenarios?

College response

On May 23, 2018 the College opened a 2-week online survey to understand how the membership views replacing the current lists of laboratory tests and prescription drugs with broader authority to order laboratory tests and prescription drugs (including controlled substances) based on the scope of practice as defined by the *Midwifery Act, 1991* (the analysis is included as Appendix 3). The purpose of the survey was to gather midwives' perspectives about ordering laboratory tests and prescribing drugs in order to inform this next stage of our submission to the Ministry requesting that midwives be given the authority to order and prescribe according to the midwifery scope of practice rather than the current list structure. According to our survey, approximately 90% of midwives consult at least once a month for one of many laboratory tests or prescription drugs that they cannot access. We extrapolated this data to show that roughly 16,000 times a year, clients express dissatisfaction because midwives order laboratory tests and prescribe drugs according to lists that cannot keep up with an evolving health care system.

The number of referrals is so high because any routine laboratory test or routine treatment that is not included on the list must be referred to a physician which means that there are necessarily delays in testing and treatment. The provincial database for maternal and newborn care (Better Outcomes Registry and Network (BORN)) does not collect data regarding the frequency of referrals by midwives to physicians for prescribing or testing. However, if we extrapolate BORN data from 2013-2014, 4.7 percent of pregnant women had some kind of pregnancy related hypertension issue. This means that of the 24,000 women who had midwifery care that year, approximately 1,000 would have developed a pregnancy related hypertension. While all 1,000 women would have been referred to a physician for management of PIH, the initial bloodwork could have been done by their midwife. This translates into 1,000 women who were unable to get immediate access to this bloodwork and would have waited to be seen by a family doctor, emergency room physician or obstetrician and who were not able to receive care from their midwife during a potentially anxious time in their pregnancy.

It is within the midwifery scope of practice to test for sexually transmitted infections. These tests are done routinely in pregnancy. This is an important preventative health measure which permits detection, treatment and the avoidance of transmission of infection for both the sexual partner and the newborn. There is no situation where a

health care provider would not treat a positive swab for chlamydia during pregnancy. In the case of a positive swab, midwives must refer to a physician for treatment. Appendix B authorizes midwives to order testing for sexually transmitted infections, which involves taking a medical history, recognizing signs and symptoms, understanding the risks to the woman and her fetus/newborn, testing for the infections and follow-up. The treatments, however, are not included in the designated drugs.

While an increased waiting time for clients (i.e. delays in care) is the most important issue to address, it is also essential to consider how the limitations placed on midwives working to their scope undermines the autonomy of a primary health care provider and potentially erodes public confidence in the profession. The vast majority of family physicians do not provide prenatal care and transfer all pregnant clients to an obstetrician between 26-32 weeks' gestation, where clients remain for the duration of their pregnancy, birth and the immediate postpartum. Despite the fact that these family physicians do not provide third trimester prenatal care and intrapartum care, they still have access to all the laboratory tests and prescription drugs that are a part of this care, things midwives might not have access to. It is an interesting part of the regulation of health care professions that these physicians who do not provide the full range of maternal/newborn care are authorized to order relevant laboratory tests and prescribe drugs while midwives, who are extensively trained in and only practice maternal/newborn care, cannot. Using this as an example, it is interesting to imagine a health care system where physicians are required to refer their clients to midwives to order a routine genetic screening test, or where physicians have to refer to midwives to prescribe oral contraceptives. This would clearly have an impact on quality of care and patient safety. The exact same scenario currently exists where midwives refer to physicians to order routine tests and treatments.

Ministry Question: Impact on quality and client safety

The college notes two recent examples of inefficiencies created by a list model. Does the college have information on the risks to patients created by these inefficiencies? For example, what was the patient pathway for Zika testing? Did that pathway increase risk to the patient?

College response

The patient pathway for Zika virus testing can be found in the following public health document:
https://www.publichealthontario.ca/en/ServicesAndTools/LaboratoryServices/Documents/Testing_directions_and_algorithms_for_patients_suspected_of_Zika_infection.pdf.

In accordance with this document, the only population of women midwives would be testing for Zika virus falls into category D, asymptomatic pregnancy women. All others

are outside of the scope of practice or are symptomatic pregnant women who would require a consultation with a physician. If all midwives worked in the same office as physicians and had immediate access to physicians, then the list model would not create delays in care. But this is not the case. Midwives provide primary care in Ministry funded midwifery practice groups (MPGs) which means that the client pathway to Zika testing cannot even be initiated in midwifery care. Risks to the client include needing to find a care provider, possible anxiety related to seeking out another health care provider or to delayed testing, as well as delayed testing itself. In 2015-2017, 35 pregnancies in Canada were Zika-infected of which 2 infants had Zika-related anomalies (Tataryn et al., 2018). While the numbers are low – the outcomes are potentially devastating for women and newborns.

Zika virus testing is an excellent example highlighting the inherent problem with the list format of Appendix B. The Ministry is asking the College to describe specific examples of laboratory tests and medications when, in fact, it is these specifics that continually change in an evolving health care system. An equally important question to ask is what evidence is there that the list structure protects the public from harm more than primary care providers exercising their knowledge, skills and judgement when it comes to ordering and prescribing? The question then becomes "How does not allowing midwives to screen for emerging health concerns in their clients, such as the Zika virus, protect the public"?

Ministry Question: Impact on quality and client safety

On Page 10, the proposal cites management of high blood pressure being an example of a time sensitive treatment in other countries – is this example also relevant to the practice of midwives in Ontario? Are there examples of testing or treatment that is time sensitive in nature that midwives cannot currently provide? Please describe the risk of harm from delayed testing in any examples.

College response

The management of high blood pressure is a time sensitive treatment in all countries. The examples listed were meant to draw attention to the fact that where timely treatment is not available, maternal morbidity and mortality increase.

All laboratory testing in pregnancy is time sensitive as pregnancy is a discrete period of time. When testing does not occur when it should, two clients are put at risk - the mother and her fetus/newborn. As such, all the laboratory tests currently included in Appendix B, as well as those requested on the list and within the scope of midwifery practice are time sensitive.

In addition to examples such as Zika virus testing (described above), harm resulting from delayed testing can occur when thyroid disease, one of the most common endocrine disorders among in women of reproductive age, is not diagnosed. As with other tests, midwives determine which clients should have their levels of Thyroid Stimulating Hormone (TSH) tested according to who is at risk. Currently, however, they must refer clients to a physician for the test as they are unable to order it. When thyroid disease is not treated, pregnant women are at increased risk of spontaneous abortion, placental abruption, hypertensive disorders and fetal growth restriction (Carney, Quinlan & West, 2014).

Ministry Question: Impact on quality of care and client safety

On page 11, the College notes that it "receives reports from clients dissatisfied with having to go to physicians to have a test ordered'. Has the college tracked these reports or complaints? If so, please provide the ministry with any data on the frequency of these reports.

College response

The College has recently begun to track these calls and we have data from the previous 18 months. Since that time – we have received 12 calls from clients questioning why their midwife cannot order a specific laboratory test. While the number is small, it represents 100 percent of the calls we received from the public to the practice advisory department. In all of these situations, our practice advisory department must cite Appendix B and acknowledge the limitations of the list so that clients understand that their midwives are working to their scope and counter the assumption some clients have that their midwives are simply trying to shirk their responsibilities to provide care.

According to the recent survey of our membership, approximately 90% of midwives reported that they experience at least one client a month who complains about having to be referred to a physician for a routine laboratory test or prescription drug that they cannot access. We extrapolated this data to show that, every year, there are 16,000 examples of clients in midwifery care who are dissatisfied with having to go to a physician because midwives order laboratory tests and prescribe drugs according lists that cannot keep up with an evolving health care system.

Ministry Question: Impact on quality of care and client safety

On page 13, the proposal notes physician frustration with referrals from midwives. Does the college have data on this or a letter of support from any organizations representing physicians for this scope proposal?

College response

The College's survey asked the membership if they encounter physicians who are frustrated when they receive referrals from midwives for laboratory tests or prescription drugs that physicians believe should be in the midwifery scope of practice. More than 80% of participants agree or strongly agree that physicians are frustrated when they receive such referrals and 63% report that working according to a prescribed list negatively affects their interprofessional relationships.

The survey also asked respondents if they were willing to provide the names of physicians or organizations that would support this submission for broader authority to order tests and prescribe drugs according to scope. If the Ministry would like the results, we have a list of 13 contacts (physicians, hospitals and health centres) that could be contacted. With the consent of the participants and the physicians or organizations, the College can send you this list for the purpose of consultation.

In 2015, when consideration was being given to authorized midwives in British Columbia to prescribe narcotics, the Dr. J. Galt Wilson, Senior Deputy Registrar of the College of Physicians and Surgeons of British Columbia wrote a letter in support of midwives. Dr. Wilson and has granted us permission to submit it here (Appendix 4) as that same rationale applies.

Ministry Question: Prescribing Contraceptives

Please describe how the prescribing of contraceptives fits within the scope of practice of midwifery.

College Response

The midwifery scope of practice extends to 6 weeks postpartum which is an ideal time to ensure postpartum clients have adequate counselling and a method of contraception prescribed, if desired. Midwives have an established relationship with their clients and are well-suited to provide informed choice discussions on subsequent pregnancies.

> contraceptive selection requires consideration of patient preferences and medical factors unique to this period. For postpartum women, additional issues include the timing of contraceptive initiation, risk of venous thromboembolism, resumption of ovulation, and impact on lactation (Kaunitz, 2018).

Best practice suggests the following…

> prompt initiation of postpartum contraception increases utilization and continuation and thus reduces the risk of unintended pregnancy. The woman's

> preferences and the risks and benefits of various contraceptive options are ideally discussed during prenatal care, so the woman has adequate time to consider her options and have her questions answered (Kaunitz, 2018).

Since women are being seen prenatally by their midwives, midwives can begin these discussions as recommended by current guidelines and follow best practices.

Midwives are educated and trained in all aspects of women's reproduction and counsel women about contraceptive choices postpartum. Prescribing contraception would simply be acting on the management plan they have already determined. Midwives' postpartum discharge records require that family planning be discussed and a midwife's discharge letter back to a client's family physician includes information gathered about the client's choice of contraception. Similar to the argument for midwives providing treatment of UTIs and STIs, midwives already provide the bulk of the care regarding contraception including counselling, risks and benefits, timing and choice, and are limited only in their ability to prescribe it. With the ability to prescribe, discharge letters back to family physicians would include the method of contraception currently prescribed rather than the contraception the client would like prescribed. This pathway adheres to current best practice.

Ministry Question: Prescribing Contraceptives

Please describe the training and competencies that midwives have to safely prescribe contraceptives.

College response

Midwives have a 4-year education focussed on women's sexual and reproductive health. This is more exposure than almost any other health care provider with the exception of an obstetrician. Midwifery students take a 6 unit anatomy and physiology course that covers basic concepts of human structure and function as well as genetics and embryology and a 3 unit pharmacotherapy course covering basic concepts in pharmacy, pharmacology and therapeutics relevant to the practice of midwifery in Ontario (e.g. pharmacokinetics, toxicology, adverse drug reactions during pregnancy and lactation and pharmacology in the neonate). The curriculum overview of one of the Midwifery Education Programs can be viewed here: https://midwifery.mcmaster.ca/education/prospective-students/curriculum-overview.

As a result of their training, midwives graduate with the knowledge, skills and judgement to prescribe contraceptives. Midwives already manage every aspect of contraception except for the prescription. Inserting IUDs is in the scope of practice and there are midwives currently performing this care. Follow-up will always be done by a physician or

a nurse practitioner because the midwifery scope does not extend beyond 6 weeks. Thus, the only part missing from the care they provide is the actual prescription.

In accordance with the Canadian Competencies for Midwives, at entry to practise, midwives in Ontario must have the following competencies:

1. Maternal anatomy and physiology in the postpartum period, and the normal progress of the postpartum period;
2. emotional, psychological, social, cultural and sexual aspects of the postpartum period, breastfeeding and early parenting;
3. family planning, methods of contraception and their risks and benefits;
4. Conduct a six-week postpartum assessment of the woman, including vaginal and speculum examination where appropriate;
5. Counsel clients in decision-making and use of contraceptive methods;
6. provide appropriate referrals for ongoing care.
7.

In addition – there is an entire section of the competencies dedicated to well woman care, sexuality and gynecology:

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.

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.

Gaining the authority to prescribe contraceptives would bring Canada in with other midwifery jurisdictions in Canada such as BC, Nova Scotia, Northwest Territories, Manitoba and Saskatchewan.

Ministry Question: Prescribing Contraceptives

Please describe the follow-up care and monitoring necessary for the prescribing of contraceptives and how midwives would be equipped to provide this care/monitoring.

College response

The midwifery scope of practice ends at 6 weeks postpartum according the *Midwifery Act, 1991.* As such, follow-up care would need to be provided by an alternate care provider such as a family physician or nurse practitioner. Midwives current practice is to discharge all postpartum clients to their family physician or alternate care provider and provide complete records of their care. Any contraception would be included in this discharge letter. No additional training is required for follow-up care because it is beyond the scope of practice.

Ministry Question: Economic Impact

Does the college have any data on how often patients are referred by midwives to physicians for routine testing or the prescription of medication that would be captured under the broader authority?

College response

The recent survey asked midwives how many times a month they referred to physicians for 4 basic indications requiring tests they current cannot access; genetic screening, hypertensive disorders, thyroid function and haemoglobinopathies. The survey showed that majority of respondents refer to these tests at least once a month. If we take a respondent who reports 1 referral per month for each of these tests, that is 4 referrals a month for a test that the midwife has the knowledge, skills and judgment to order. When reviewing the responses about the prescription medication, even more referrals are made. Participants were asked how many times a month they refer to physicians for 8 basic indications for prescription medications and the overwhelming majority refer at least once month. For example, 59% (125) of participants said they referred to a physician at least 3 times a month for contraception. This means that among the participants, 375 referrals are made each month for contraception which is more than approximately 4,500 referrals are made per year for this group. In fact, 14% of participants refer for contraception at least once a month and 14 % refer at least 6 times a month. This translates into more than 7,000 referrals a year for contraception by participants in this survey. When looking at this as part of an economic evaluation, if each of these visits is billed as a Midwife Recommended Assessment (MRA) under the Schedule of Benefits, then this costs the health care system $712,000 (7,000 multiplied by the MRA cost of $101.70). If we factor in the total number of referrals for contraception reported by participants (estimated at more than 42,300 per year) and extrapolate this to the entire membership, then the cost to the health care system is more than 4 million dollars a year

for contraceptive referrals alone; a number that will continue to grow as more clients are cared for by midwives. This cost is not concerning when a physician assessment occurs to optimize the health of a client but is problematic when a client can be cared for equally well, and continuity of care preserved, without the additional assessment.

Ministry Question: Patient Safety – over-testing and over-utilisation

Does the college currently have any current standards to address over-testing and over-utilisation? If so, please share them with the ministry.

College response

The College has a standard of prescribing and administering but does not have a standard to address over-testing and over-utilization. Up to this point at the College, over-testing and over-utilization have not been the cause of any complaints or discipline hearings and have not been brought to the College's attention as areas requiring guidance by members of the public, the profession, or any other stakeholders. Our current Prescribing and Administering Standard is currently being revised but we are waiting to hear about the status of our submission, so we know how to proceed with the revisions.

It is essential to note that research on the value of standards shows that the standards themselves are rarely what keep the public safe but that it is the professionalism of individual practitioners. Over-testing and over-utilization can and will occur with or without broader prescribing authority.

It is, however, relevant to this discussion to report that, as the last national jurisdiction in Canada to allow nurse practitioners (NP) to prescribe controlled substances, the College of Nurses of Ontario (CNO) asked the other jurisdictions whether there had been any patient safety issues related to NPs prescribing controlled substances. They were told there were none. Also relevant is that since NPs have been prescribing controlled substances, the CNO has not experienced an increase in client safety issues, nor has the College of Midwives of British Columbia (CMBC) their members gained authority to prescribe narcotics.

If the submission is approved, the College will work with the Ministry and other stakeholders, particularly members of the profession and other jurisdictions where midwives have these broader authorities, to address any gaps and implement new guidance or standards to ensure our pubic protection mandate is rigorously observed.

Ministry Question: Consultation

Consultation is a key process encouraged by the ministry for all proponent of a scope of practice change. The information gleaned from consultation activities can help inform answers to questions relating to the impact of the proposal on patients or the health system, on other Ontario Businesses, on inter-professional care delivery, and quality of care. Moreover, these activities can identify risks and issues that will need to be mitigated. The ministry would encourage the college to undertake consultative activities on this proposal, including updated perspectives from:

- Patients
- Members of the profession
- Members of other affected professions in Ontario – especially physicians
- Other affected third-parties

College response: Patients

The College requires that midwives provide informed choice and continuity of care to their clients. Unfortunately, this can be difficult to do with the current list of laboratory tests and drugs. The lists allow midwives to discuss all of the options and perform many of the tests. The lists, however do not allow midwives to perform some of the tests they must provide informed choice on (e.g. NIPT) or prescribe some of the drugs they tested for (e.g. chlamydia). This fractures the care clients receive and prevents continuity of care. The College did not consult with the public. As noted earlier, we do receive questions about it from some midwifery clients but in general the public can be difficult to reach with a College survey. Instead, we included some questions on the membership survey and we heard the following:

- When asked if continuity of care is often compromised when clients are referred to physicians for laboratory tests and prescription drugs that midwives can competently manage, 76% and 81% agree or strongly agree respectively;
- When asked if clients usually are pleased to see a physician for laboratory tests and prescription drugs that midwives are unable to order, 81% and 90% disagree or strongly disagree respectively; and
- When asked if working with a list of laboratory tests and prescription drugs limits they ability to provide the best possible care to my clients 93% and 86% disagree or strongly disagree respectively.

College response: Members of the profession

Please review the Survey findings to find out more about how the membership views the proposed changes to laboratory testing and prescribing (Appendix 3)

College response: Members of other affected professions in Ontario – especially physicians

The College liaises with other regulators about a variety of matters but not regarding scope of practice. It is not the College's role to elicit feedback from other professionals, including physicians, about changes to the midwifery scope of practice. All our consultations are public, and that includes the most recent revisions to the laboratory testing and prescribing. We did not receive any responses from our stakeholders, including the College of Physicians and Surgeons of Ontario (CPSO), Society of Obstetricians and Gynaecologists of Ontario (SOGC), the Canadian Pediatric Society (CPS), the College of Pharmacists of Ontario, the College of Medical Laboratory Technologists of Ontario (CLMTO) or any other physician or health care provider regulator, association or organization or group regarding the laboratory testing and prescribing consultation. We did, however, ask midwives if they experience physicians who are frustrated when they receive referrals from midwives for laboratory tests or prescription drugs that physicians believe should be in the midwifery scope of practice and those results were discussed above. To reiterate those conclusions, more than 80% of participants agree or strongly agree that physicians are frustrated when they receive such referrals and 63% report that working according to a prescribed list negatively affects their interprofessional relationships. In addition, 82% report that continuity of care is compromised and only 10% of participants believe prescribing according to a list is in the best interest of the public leading the College to feel confident that broader authority can be recommended, without explicit and targeted consultation with physicians or other care providers, because it is in the best interest of the public and provides a higher quality of care then exists with the current laboratory and drug lists.

Also noted in a previous section – survey participants provided the names of 13 contacts (physicians, hospitals and health centres) that can be contacted to support this submission.

College Response: Other affected third-parties

The College was unable to think of other affected third-parties that would contribute to this submission regarding broader prescribing authority. We know midwives are frequently in contact with laboratory technicians and pharmacists regarding ordering laboratory tests and prescribing drugs but there were no specific questions we felt would add to this submission. The College periodically responds to questions from laboratory technologists and pharmacists about specific laboratory tests and prescribing authority. In all interactions, these organization ask for clarification about what midwives are authorized to order or prescribe. It is clear that many related health professions do not know the midwifery scope of practice and acts authorized to midwives, so we were unable

to target questions that would contribute in a meaningful way to the College's request for broader authority to work according to scope.

Ministry Question: Laboratory Test specific questions

Are there tests captured under the broad authority that midwives would be unable to provide the follow up care for? What referral processes are or would be in place for such tests?

College response

As with all medical practitioners, there are tests that midwives can perform but not provide follow-up care because follow-up care is dependant not on the testing but on the result. For example, when routine tests have normal results then midwives continue care. When the exact same test, however, has an abnormal result then midwives must refer. Physicians have the same type of referral process sending clients to other physician specialists when the results of a test exceed their knowledge or scope of practice. For midwives, examples of tests they order but do not treat are sexually transmitted infections, pap smears, routine prenatal ultrasounds, routine prenatal bloodwork (e.g. Hepatitis B, HIV testing). With broader prescribing authority, midwives will be able to manage some of these abnormal results (e.g. sexually transmitted infections) but will still refer clients with positive or abnormal results for tests like pap smears, routine prenatal ultrasounds, and routine prenatal bloodwork (e.g. Hepatitis B, HIV). Midwives will need to refer whenever a test suggests the client requires care that is not in the scope of midwifery in exactly the same way as they do now.

Conclusion

The College is committed to ensuring the public benefits from any changes to midwives' scope regarding laboratory testing and prescribing drugs. This can only be achieved with an evaluation of any changes that will be made once they have been implemented. The College collects data on practice advice, client complaints and referrals to discipline and intends to compare these data pre and post regulation changes. The College will also survey the membership after the changes to determine how it has influenced practice and if the revised scope is meeting the needs of their clients. With the knowledge gained from this evaluation, we will understand what new risks may have developed or what current risks have been mitigated by midwives ordering laboratory tests and prescribing drugs according to scope. This information will be used to develop new guidance and inform any subsequent discussions around scope of practice.

References

Carney, L. A., Quinlan, J. D., & West, J. M. (2014). Thyroid disease in pregnancy. American family physician, 89(4).

Fischer, B., Rehm, J., & Tyndall, M. (2016). Effective Canadian policy to reduce harms from prescription opioids: learning from past failures. CMAJ: Canadian Medical Association Journal, 188(17-18), 1240.

Kaunitz, A.M. (2018). Postpartum contraception: Initiation and Methods. In k. Eckler (Ed.), UpToDate. Retrieved May 7, 2018 from https://www.uptodate.com/contents/postpartum-contraception-initiation-and-methods#H1

Tataryn, J., Vrbova, L., Drebot, M., Wood, H., Payne, E., Connors, S., ... & Buck, P. A. (2018). Emergency Planning: Travel-related Zika virus cases in Canada: October 2015–June 2017. Canada Communicable Disease Report, 44(1), 18.