# MIDWIFERY IN BRITISH COLUMBIA: IS IT TIME FOR AN EXPANDED SCOPE OF PRACTICE? FINDINGS FROM A QUESTIONNAIRE ON PRACTICE ISSUES IN BRITISH COLUMBIA

## LA PRATIQUE DE LA PROFESSION DE SAGE-FEMME EN COLOMBIE-BRITANNIQUE : EST-IL TEMPS D'ÉLARGIR LE CHAMP DES COMPÉTENCES ? CONCLUSIONS D'UN QUESTIONNAIRE PORTANT SUR DES QUESTIONS RELATIVES À LA PRATIQUE DE LA PROFESSION EN COLOMBIE-BRITANNIQUE

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**ABSTRACT**
Canada is currently facing a shortage of physicians providing maternity care in both urban centres and rural environments. Although midwives have been regulated in five Canadian provinces, they are currently unable to meet the needs of a diversity of childbearing women. An expanded scope of practice may address some of the current obstacles to the provision of care. A 145-item questionnaire on current practice issues faced by midwives in British Columbia was administered to all registered midwives in the province in March 2002 (n=65). Thirty-five questionnaires were returned for a response rate of 54%. One component of the questionnaire focused on respondents' views of an expanded scope of practice. Out of a possible 32 items, the majority of respondents advocated including an additional 17 items into their current scope of practice. Desired functions included increased prescribing authority and an increase in some technical skills. Conversely, the majority of respondents were not interested in including15 additional items including gynecological surgery and advanced procedures. In order to be a viable long-term contributor to maternity care in Canada, midwives must engage in a dialogue with each other over future directions for their profession, begin consultations with other players in maternity care, and develop a mechanism for evaluating any changes to their scope of practice. The results of this study indicate an interest on the part of some midwives to increase their scope of practice. However, findings may not be representative of the opinions and attitudes of all registered midwives in British Columbia. More research is needed into the nature and implications of such changes.

**KEY WORDS**
midwifery, scope of practice, interprofessional relationships

**RÉSUMÉ**
Présentement, le Canada fait face à un manque de médecins offrant des soins obstétriques, et ce, dans les centres urbains ainsi qu'en milieux ruraux. Quoique les sages-femmes peuvent maintenant exercer leur profession légalement dans cinq des provinces canadiennes, elles sont néanmoins incapables de répondre aux besoins d'une clientèle diversifiée. Un champ de pratique plus étendu pourrait éliminer certains obstacles à l'apport de soins. En mars 2002, un questionnaire fut distribué à toutes les sages-femmes diplômées en Colombie-Britannique (n=65). Ce questionnaire comptait 145 points portant sur des questions relatives à la pratique de la profession. Trente-cinq questionnaires furent remplis, pour un taux de réponse de 54 %. Un des volets du questionnaire se concentrait sur les opinions que les femmes interrogées avaient à l'égard d'un champ de pratique plus étendu. Sur les 32 points disponibles, la majorité des femmes interrogées recommandaient l'ajout de 17 de ces derniers, à leur champ d'activité. On retrouvait parmi les nouvelles fonctions désirées, une plus grande autonomie pour pouvoir prescrire ainsi que l'acquisition de nouvelles compétences techniques. Inversement, la majorité des femmes questionnées n'étaient pas intéressées à rajouter 15 points additionnels, incluant la chirurgie gynécologique ainsi que des procédures plus avancées. Si les sages-femmes désirent contribuer de façon viable, et ce, à long terme aux soins obstétriques au Canada, elles devront en premier lieu se lancer dans une discussion entre elles sur les directions futures de leur profession. Elles devront également entrer en consultations avec d'autres intervenants dans le milieu des soins obstétriques et développer un mécanisme pour évaluer n'importe quel changement dans leur champ de pratique. Les résultats de cette étude démontrent qu'il existe un intérêt de la part de certaines sages-femmes à élargir leur champ de compétence. Toutefois, il est possible que ces résultats ne soient pas représentatifs des opinions et des attitudes de toutes les sages-femmes diplômées en Colombie-Britannique. D'autres recherches sont nécessaires pour étudier la nature et les implications de tels changements.

**MOTS-CLÉS**
pratique sage-femme, champ de compétence, relations interprofessionnelles

## INTRODUCTION

Canada is currently facing a practitioner shortage in maternity care in both urban centres and rural environments. This is due to the attrition rate for physicians currently providing maternity care and the difficulty of attracting new practitioners to the specialty because of its demanding lifestyle, practitioner's fear of litigation and lack of adequate remuneration.[1] Today less than half of the family physicians in Canada offer maternity care to their patients.[2] Although obstetricians are attending the majority of births in all provinces, they are also leaving practice at a higher rate than those entering.[i] Furthermore, few obstetricians practice in rural locations.[3]

The nascent profession of midwifery is currently regulated and funded in four Canadian provinces (Ontario, British Columbia, Manitoba, and Quebec) and regulated but not publicly funded in Alberta. Midwives attend five percent of the births in provinces where midwifery is regulated and two percent nation-wide.[4]

Several factors influence midwifery's ability to provide care to a larger percentage of the population. They include inequitable regional access to funded services, conditions that threaten the sustainability of midwifery (such as attrition due to burnout, inadequate remuneration and a lack of additional benefits), obstacles to interprofessional collaboration and limits to midwifery's current scope of practice.[5]

Within this context, rapid changes are occurring as midwives are increasingly collaborating with other health care professionals in the provision of care to their clients beyond transferring when indicated (for example sharing a client load or call schedules).[ii] We are also witnessing a shift in socio-cultural conceptions of childbirth, evidenced by the pathologization of vaginal birth and the concomitant rise in maternal request for caesarean sections.[6,7] Related to this are overall advances and changes in the use of medical technology in childbirth. There is also a growing awareness of the need for specialized care for populations who, due to age, socio-economic status, education, ethnicity or place of residence are disadvantaged in health status and access to resources. Due to mandated aspects of the model of care, such as a focus on women-centred care, continuity of care and informed choice, midwives are well-suited to meet the needs of these populations. An expanded scope of practice may address some of the current obstacles to the provision of care.

A profession's scope of practice is at the heart of its identity as it involves the intersection of skills and competencies with its model and philosophy of care. Midwives' scope of practice is based on the provision of care to childbearing women and their families within the context of offering informed choice and informed consent, the choice of birthplace, evidence-based practice, respect for normal birth, continuity of care and the judicious and appropriate use of medical technology. Within this context, midwives are required to "act responsibly and with integrity and maintain appropriate levels of competence."[8] However, the scope of practice also influences the nature of midwives' interprofessional collaborative relationships through the requirements for discussion, consultation and transfer of care. Changes in scope of practice alter interprofessional boundaries and both internal and external definitions of midwifery.

As the scope of midwifery practice not only reflects clinical concerns and competencies but also is directly tied to the profession's philosophy and model of care, it is essential that any change to the current model of care be initiated by its membership. This study examines the results of a questionnaire administered to British Columbia midwives to elicit their views on additional activities and functions they would and would not like included in their scope of practice. Results are analysed from within a discussion on a definition of scope of practice, mechanisms for changes and possible implications of such changes.

## MIDWIFERY IN BRITISH COLUMBIA – PHILOSOPHY AND MODEL OF CARE

Midwives in British Columbia (B.C.) are autonomous care providers who incorporate principles of continuity of care, informed choice, choice of birth settings, collaborative care, accountability and evidence-based practice into the care they provide.[9] They must acquire hospital admitting and discharge privileges within their communities in order to provide care in all settings to low risk women from early pregnancy, through labour and delivery and into the postpartum period.

Their current scope of practice involves assessing, monitoring, and caring for women during the childbearing year and counselling, supporting and advising women during labour and delivery and the postpartum period. Midwives can manage spontaneous, normal vaginal deliveries and care for, assess and monitor healthy newborns and young infants. They can deliver contraceptive advice and information regarding care for newborns and young infants and deliver contraceptive services during the three months following birth.[10] The options provided in the questionnaire administered for this study reflect skills and activities that are not currently within B.C. midwives' scope of practice.

## METHODS

A 145-item questionnaire on current practice issues faced by midwives in British Columbia was administered to all registered midwives in the province in March 2002 (n=65). Participant addresses were obtained from the provincial regulatory college, the College of Midwives of British Columbia (CMBC). The results presented here are one component of the questionnaire and are based on a series of questions regarding whether or not respondents thought items listed were appropriate to include in their scope of practice, given proper training.[iii] The questionnaire design was based on international literature on midwifery practice issues and concerns and circulated to 12 midwives similar to the intended research population.[iv] The literature review did not reveal any previous research on midwives' attitudes towards an expanded scope of practice in other jurisdictions. A draft questionnaire was pilot-tested on four midwives and minor revisions were made. Ethical approval for the study was obtained through the Behaviour Research Ethics Board, University of British Columbia. A total of 35 responses were received for a response rate of 54%.

## RESULTS

*Comparison of respondents to registered midwives in B.C.*

The response rate to this questionnaire represented slightly over half of the population of registered midwives in B.C. at the time the questionnaire was administered. A qualitative comparison of the demographics of the respondents with the demographics of registered midwives in B.C. shows that, overall, the respondents had less formal midwifery education then aggregate numbers for the profession and fewer respondents had degrees in nursing.[11] Less urban (and more rural) practitioners responded to the questionnaire when compared to the profession in B.C. and the average age of respondents was older than the average age of registered midwives in B.C. (56 as opposed to 45 years).

*Demographic characteristics of the sample*

The 35 respondents ranged in age from 28 to 58 years, with a mean age of 45.4 (SD=8.7). Their duration of practice ranged from two months to 30 years with a mean of 13 years (SD=9.8). Three respondents were conditional registrants (9%).[v] Fifteen (43%) were urban based, 10 (29%) were rural and 10 (29%) were urban-rural mix. Twenty respondents (57%) were trained through a direct-entry midwifery program and 15 (43%) completed a degree program. Twenty-five respondents (71%) were part of a group practice and 10 (29%) were solo practitioners.

*Views on an expanded scope of practice*

Out of a possible 32 items, the majority of respondents advocated including an additional 17 items into their current scope of practice. Desired functions included increased prescribing authority and an increase in some technical skills (see Tables 1a-1d below). Conversely, the majority of respondents were not interested in including15 additional items within their scope of practice. Most of these items involved gynecological surgery and advanced procedures (see Tables 2a-2c, below). In a separate question, 25 respondents (71%) reported that they would be interested in providing well-woman gynecological care (such as prescribing birth control, fitting diaphragms, contraceptive counselling) outside of the childbearing year. An additional seven (20%) reported they might be interested in performing these tasks (eight respondents [23%] reported they currently provide well-woman gynecological care to women who are not their maternity care clients).

Although the sample size and response rate were too low to allow for a statistical comparison of differences between respondents who desired an increase scope of practice for individual items and those who did not, a qualitative examination of the data revealed that no patterns were indicated within positive or negative responses based on age, number of years in practice and whether or not respondents practiced in a rural or urban environment.

TABLE 1A: DESIRED ADDITIONS TO MIDWIVES' SCOPE OF PRACTICE - PAIN MANAGEMENT

| *Skill or Activity* | *Level of Support* |
|---|---|
| Administer $N_20$ at home | 29 (83%) |
| Monitoring epidurals | 25 (71%) |
| Prescribe sedatives | 32 (91%) |
| Prescribe narcotics in labour in hospital | 34 (97%) |

TABLE 1b: DESIRED ADDITIONS TO MIDWIVES' SCOPE OF PRACTICE - INDUCTION/AUGMENTATION

| *Skill or Activity* | *Level of Support* |
|---|---|
| Augmentation of labour | 26 (74%) |
| Post-dates induction of labour | 29 (83%) |
| Insertion of prostin gel | 33 (94%) |

TABLE 1c: DESIRED ADDITIONS TO MIDWIVES' SCOPE OF PRACTICE - TECHNICAL/SURGICAL

| *Skill or Activity* | *Level of Support* |
|---|---|
| Fetal scalp sampling | 21 (60%)[vii] |
| Insertion of IUPC | 20 (57%) |
| 1st assist with C-sections | 26 (74%)[viii] |
| Suturing 3rd degree tears | 19 (54.3%)[ix] |
| Vacuum extraction in hospital | 29 (83%)[x] |

TABLE 1d: DESIRED ADDITIONS TO MIDWIVES' SCOPE OF PRACTICE - WELL WOMAN CARE AND OTHER

| *Skill or Activity* | *Level of Support* |
|---|---|
| IUD insertion | 23 (63%) |
| Prescribe oral contraceptives | 27 (77%) |
| Administer 1st dose antibiotics at home w/o physicians orders | 28 (80%) |
| Hang IV fluids at home in labour (non-emergency) | 31 (87%) |
| Prescribe antibiotics for UTI's in pregnancy | 32 (91%) |

## DISCUSSION

Canadian midwives currently attend two percent of births Canada-wide, more in provinces where midwifery is regulated and funded. The profession is addressing ways to increase its contribution to maternity care, including engaging in discussions on expanding their scope of practice.[12] To date, however, no comprehensive data has been gathered regarding midwives' attitudes towards an expanded scope of practice, despite the importance of member-initiated change. This questionnaire solicited the views of registered midwives in British Columbia regarding items they may want to add to their current scope of practice, if any, and found consistency among the respondents. However, given the response rate of 54%, it must be noted that these findings may not represent the attitudes of all midwives in B.C.

The majority of respondents reported an interest in an increased

TABLE 2a: UNDESIRED ADDITIONS TO MIDWIVES' SCOPE OF PRACTICE - GYNECOLOGICAL SURVEY

| *Skill or Activity* | *Number of respondents who did not want skill or activity included in scope of practice* |
|---|---|
| Removal of cervical polyp | 24 (69%) |
| Colposcopy | 30 (86%) |
| Cryosurgery | 31 (89%) |
| Cervical cerclage | 30 (86%) |
| D & C | 30 (86%) |
| Endometrial biopsy | 31 (89%) |
| (Perform) therapeutic abortions | 28 (80%) |

TABLE 2b: UNDESIRED ADDITIONS TO MIDWIVES' SCOPE OF PRACTICE - INCREASED TECHNICAL SKILLS

| *Skill or Activity* | *Number of respondents who did not want skill or activity included in scope of practice* |
|---|---|
| Amnioinfusion | 22 (63%) |
| Perform OB ultrasounds | 20 (57%) |
| Vacuum extraction at home | 28 (80%) |
| Outlet forceps under supervision | 16 (46%) [xi] |

TABLE 2c: UNDESIRED ADDITIONS TO MIDWIVES' SCOPE OF PRACTICE - OTHER

| *Skill or Activity* | *Number of respondents who did not want skill or activity included in scope of practice* |
|---|---|
| Circumcision | 34 (97%) |
| Prescribe narcotics in labour at home | 32 (91%) |
| Insert Norplant | 19 (54%) |
| Prescribe Methodone | 30 (86%) |

depth of practice; that is, caring for low risk women in a greater variety of situations. This includes increased prescribing authority (for example, narcotics in labour in the hospital) and the induction or augmentation of labour. The desire for an increase in breadth was expressed only in relation to well-woman gynecological care (i.e. IUD insertion and prescribing oral contraceptives). Consistently, respondents reported an overwhelming lack of support for surgical procedures that would extend breadth of care to include a gynecological focus (i.e., removing cervical polyps or performing colposcopies).

Although one rationale for an expanded scope of practice is to enable midwives to better meet the needs of women living in rural and remote communities where access to other care providers may be restricted, very few respondents indicated support for an increased scope "only in rural areas."[vi] This indicates consistency within the model and philosophy of care and the belief that one model can meet a diversity of needs.

**CONCLUSION**

Although respondents to this questionnaire indicated consistency in their responses regarding desired additions to the scope of practice, actual changes to practice involve amendments at a governmental level to the Midwives Regulations, Health Professions Act and at a professional level, the CMBC's by-laws. These changes are predicated on the feasibility and availability of education and training required to ensure competent and safe practice. Mechanisms for training may include focused programs or workshops to gain competency in a specific skill, completing educational programs within nursing or medicine subsequent to, or concurrent with, midwifery education, on-the-job learning with a mentor or teacher or self-directed learning. It also requires a desire on the part of individual practitioners to undertake additional educational requirements and take on added responsibilities and duties. An increased scope of practice must also be integrated into a practice setting by developing a protocol for client care when practise partners do not share the same expanded skill set.

The discussion around an expanded scope of practice for midwives is timely, given the context of the challenges faced by Canada's maternity care system due to high attrition rates of family physicians offering obstetrical care and the urban-rural maldistribution of practitioners. It is essential for midwifery to respond to the dynamic nature of maternity care provision if it is to contribute to this care in a meaningful way.

All of these changes are occurring in a setting of health care reform and restructuring, including reduced public expenditures on health care, reduced hospitalization and institutional care, privatization of the delivery of health care services, adopting private sector management techniques, and regionalization, which have direct implications for the provision of maternity care.[13] In order to be a viable long-term contributor to maternity care in Canada, midwives must engage in a dialogue with each other over future directions for their profession, begin consultations with other players in maternity care, and develop a mechanism for evaluating any changes to their scope of practice.

An evaluative context for changes to scope of practice is crucial as changes will inevitably lead to changes in the profession itself and alterations in midwives' relationships with other collaborating professionals. For example, some may see including first assisting with Caesarean sections or post-dates induction of labour as part of a more medicalized or technologized approach to care, incompatible with a conceptualization of midwives as "guardians of normal birth". Likewise, an increased scope of practice may lead to confusion over professional boundaries between the professions and exacerbate tensions that already exist.[14,15]

Other considerations include the potential for an increase in malpractice suits directed against midwives, a trend which may have consequences for continued practice from an insurer's perspective. Discussions regarding increasing the scope of practice must also take into consideration the implication of changes in practice for midwives who do not want an increased scope of practice and guard against both explicit penalization (i.e. in the form of unequal remuneration for core responsibilities) and implicit penalization (i.e. through reduced employment opportunities).

The results of this study indicate an interest on the part of some B.C. midwives to increase their scope of practice in some areas. More research is needed into the nature and implications of such changes.

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## FOOTNOTES

[i] A recent survey conducted by the SOGC shows that 34 percent of practitioners - more than 560 of the country's estimated 1,650 obstetricians/gynecologists - plan to leave practice in the next five years. [cited 2000 Mar 6]; Available from: URL: http://www.oma.org/pcomm/omr/jul/02tt.htm

[ii] See Murdock Jennifer. Project link: low risk integrated maternity services responding to the crisis in care. Proceedings from the working symposium on midwifery: building our contribution to maternity care. Kornelsen, J, editor. May 11-13, 2002, Vancouver, B.C.

[iii] The list of possible options was taken from examples of expanded scope of practice supported by the American College of Nurse Midwives.

[iv] See for example:

Bakker Rudi HC, Groenewegen PP, Jabaaij L, Wouter Meiger HS, de Veer A. 'Burnout' among Dutch midwives. Midwifery 1996;12:174-81.

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Watson L, Potter A, Donohue L. Midwives in Victoria, Australia: a survey of current issues and job satisfaction. Midwifery 1999;45:216-31.

[v] The College of Midwives of B.C. states, "A person who has been granted conditional registration under subsection (1) for insufficient educational requirements [or experience] may only perform the services of a registrant under the supervision of an initial registrant, a general registrant or another health care practitioner acceptable to the registration committee, until proof of completion of the required upgrading course has been received from the supervisor and is accepted by the committee." http://www.cmbc.bc.ca/ April 30 2003.

[vi] One exception was the 20% of respondents who advocated for including vacuum extraction in hospitals only in rural areas.

[vii] Four of the 21 respondents felt it was only appropriate to do fetal scalp sampling in rural locations.

[viii] Five of the 26 respondents felt it was only appropriate to 1st assist with Caesarean sections in rural locations.

[ix] Four of the 19 respondents felt it was only appropriate to suture 3rd degree tears in rural locations.

[x] Seven of the 29 respondents felt it was only appropriate to use vacuum extraction in the hospital in rural locations.

[xi] Although 16 respondents replied that they did not think it was appropriate to include this is their scope of practice, 15 respondents said it was, with one additional responding it was appropriate only in rural areas.

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