NEWSLETTER

COLLEGE OF MIDWIVES OF BC

AUGUST 2018

CMBC Staff Updates

CMBC is pleased to announce the following staff updates and contact details:

- Kamila Krol-DeProphetis is on maternity leave from July 2018 until December 2019.
- Heidi Schmeiser is now the Inquiry Program Manager
  - » inquiry@cmbc.bc.ca; 604-742-2233
- Sonia Price is the new Quality Assurance Coordinator
  - » qa@cmbc.bc.ca; 604-742-2236
- Anaïs Forest-Cooter is the new Registration Coordinator
  - » registration@cmbc.bc.ca; 604-742-2237
- And our newest staff member, Janelle LeBlanc, is the new Office Administrator
  - » information@cmbc.bc.ca; 604-742-2230

CMBC would like to extend a warm welcome to Janelle and we wish Kamila a wonderful next 18 months!

Inside

Midwifery Records Retention and the Limitation Act

In the *Policy on Record Keeping, Storage and Retention*, the minimum period required for midwifery records retention has been changed from 21 years to 16 years from either the date of last entry or from the age of majority (19 years of age in BC), whichever is later, except as otherwise required by law. This change is in response to the amendment of the *Limitation Act*. CMBC is also applying for bylaw amendments on section 80 *Storage and retention of personal information* to align the change.

As most of the maternal records include baby records and should not be separated, for you as a registered midwife to comply with the legislation, the total minimum retention period should be 35 years (the age of majority at 19 plus 16 years). It is not acceptable to "cull" the portion of the client record that is more than 16 years old. The entire record must be maintained.

For example, the first group of midwives were registered on January 1, 1998. When the first sets of midwifery records were charted from that date onwards, all midwifery records should still have been retained by midwives as the previous requirement was to keep them for 21 years, i.e. until December 31, 2018. With the legislation change, records for babies born in 1998 are now required to be retained until the children turn 19 years old (from the age of majority), plus another 16 years, for a total of 35 years, i.e. up to December 31, 2032. If the last entry for the baby was made in 1999, the entire records must be kept until 2033.

In summary, if a midwifery record does not contain any baby records, retain the entire record for 16 years from the date of last entry. If the midwifery record has baby records, do not separate them and retain the entire record for 35 years from the date of last entry.

Any registrants who are uncertain about this requirement should contact CMBC for clarification.

Cannabis and Pregnancy

As Canada moves towards legalization and the regulation of cannabis for non-medicinal use, midwives may encounter questions and more open disclosure of cannabis use by clients during pregnancy. Just like tobacco, cannabis can affect a growing fetus and breastfeeding newborn, and its use during pregnancy is a CMBC indication for discussion (with a midwife, physician or another regulated health practitioner) to facilitate the creation of an appropriate plan of care.

Do you know your stuff? Review this sampler of client questions you may encounter in clinical practice to see if your knowledge is current:

1. I use CBD (Cannabidiol) oil to help me sleep at night. Is this safe during pregnancy?
2. Can you give me a prescription for marijuana to help with back pain in pregnancy?
3. What are the risks and benefits of cannabis consumption for pain relief during labour?
4. I gave it up during my pregnancy, but can I smoke pot while I'm breastfeeding?

If you require an update in this area, use CMBC's CPD Reflective Exercise when reviewing CPD resources on cannabis to be eligible for CPD credits. Suggested resources include but are not limited to Health Canada's *Information for Health Care Professionals: Cannabis and the Cannabinoids*, and *SOGC's Clinical Practice Guideline No. 349- Substance Use in Pregnancy (October 2017)*. Submit your CPD Reflective Exercise on this subject via the CMBC Registrant Portal and CMBC will create a compilation of learning points for the next CMBC newsletter!

Bylaw Bits & Bytes

The *Health Professions Act* governs the establishment of CMBC and the Board and sets out the Board responsibilities including making college bylaws. Part I of the CMBC Bylaws addresses the Board of the College.

If you are interested in the following topics about the CMBC Board, please read the relevant sections in the bylaws.

- composition (section 2)
- election procedures (sections 3 and 4)
- terms of office (section 6)
- meeting process (section 10)

There are eight Committees named in the bylaws working under the direction of the Board. Each of these Committees (Executive, Registration, Inquiry, Discipline, Quality Assurance, Standards of Practice, Client Relations, Committee on Aboriginal Midwifery) has its own unique role and responsibilities. More information about these Committees can be found in sections 16 to 22.

Part II of the bylaws, sections 23 through 33, addresses college administration, like the Registrar's and Deputy Registrar's power and duties, financial authority of the Board, etc.

If you wish to know more about the CMBC Board and Committee as well as their administration, read Part I and II of the bylaws. Let us know if you want to become a Board or Committee member.

Expectations of Midwives when Consulting Physicians

The College of Physicians and Surgeons of British Columbia (CPSBC) conducted a consultation on their guideline for *Expectations of the Relationship between the Primary Care/Consulting Physician and the Consultant Physician*. Based on the feedback from 944 submissions received in response to the consultation, the following are common themes for midwives to consider when consulting physicians:

- **Referral letter/request completion:** Referral letters should contain relevant information about the client's condition with explicit detail about why the client is being referred.
- **Repeat/retrospective referral:** If a consultant arranges a follow-up appointment with the client, a re-referral for the same client for the same condition should not be necessary.
- **"Shot-gun" referrals:** Referral requests are sometimes sent to multiple physicians in the hopes of avoiding wait-times; respondents agreed that this practice is counterproductive and should be avoided.
- **Process for urgent consultation:** Verbal communication should be required and accommodated in urgent situations rather than a written referral.
- **Responsibilities re: continuity of care:** Referring midwives, consultants and the client must be clear on who is responsible for the provision of ongoing care to the patient following a consultant visit.

The full results of this consultation can be found here: https://www.cpsbc.ca/for-physicians/college-connector/2017-V05-05/03.

Completion of Section 15, Antenatal Record II: Potential or Actual Concerns

The Antenatal Records are a succinct record of a client's maternity care in each pregnancy. The small box at the top right of the Antenatal 2, marked "Potential or Actual Concerns" is meant to further synthesize key issues for any care providers reviewing a client's records.

When Antenatal Records are reviewed as part of the inquiry process, it is quite common to see in Section 15 the name of the doula, 'AMTSL', 'ok to all screening', 'early discharge' or 'plans breastfeeding'. While this is a convenient area to remind us or our practice partners of the client's wishes, it should be used to communicate critical information to all care providers involved in the client's care.

Consider, for example, what information a consultant, briefly scanning your client's antenatal record, would find most valuable to support safe care. Under "Lifestyle" your client's hepatitis C positive status or severe anxiety would be relevant. Under "Pregnancy" placenta previa, IUGR or polyhydramnios would be potential or actual concerns. Carefully consider whether client preferences such as 'expectant mgmt. 3rd stage' or 'no erythromycin' is necessary in this area. If you determine this is important, include preferences only when they fall outside of community standards. This would mean that 'ok to all screening' would not be necessary; however, 'no Vitamin K' would be documented under "Newborn".

If you are ever in doubt of how to complete the records, PSBC provides a Guide, which can be found here: http://www.perinatalservicesbc.ca/health-professionals/forms.

Ask the Midwife

Dear Mentor Midwife,

I have a healthy 38 year old G1P0 client currently 16 weeks pregnant. At our last appointment, she reported a number of sudden onset, severe dizzy spells coupled with right sided cheek pain. I've ruled out pregnancy related causes and referred her to her GP for assessment of any possible medical, non-pregnancy related causes. Her GP diagnosed her with benign paroxysmal positional vertigo and suggested she keep Gravol on hand for future attacks.

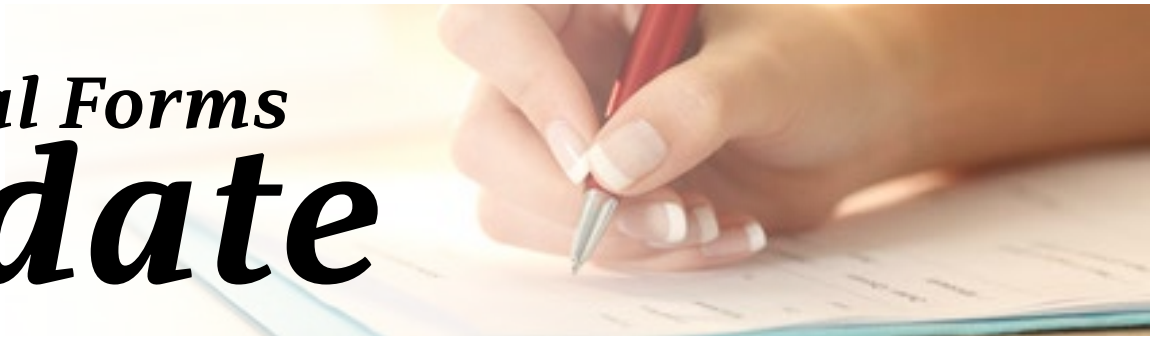
Interestingly, she is an active commercial airline pilot. Are there any special considerations for her to be off work?

Dear Colleague,

Great question- and the answer is yes. Under the *Canadian Aviation Regulation* (CAR) 404.06, *Prohibition Regarding Exercise of Privileges*, your client is required to "ground" herself now that she has a condition that might make it unsafe to perform her duties. You should check in with her right away to ensure she has done this; likely she has. In addition, you should remind her that by law, all physicians in Canada must inform a Regional Aviation Medical Officer (RAMO) of any pilot, air traffic controller or flight engineer who has a medical condition that could adversely affect flight safety. Section 6.5 (1) of the *Aeronautics Act* states that:

> *6.5 (1) Where a physician or an optometrist believes on reasonable grounds that a patient is a flight crew member, an air traffic controller or other holder of a Canadian aviation document that imposes standards of medical or optometric fitness, the physician or optometrist shall, if in his opinion the patient has a medical or optometric condition that is likely to constitute a hazard to aviation safety, inform a medical adviser designated by the Minister forthwith of that opinion and the reasons therefor.*

It would be prudent to discuss her case with the physician who made the referral to see if they have informed the RAMO of her diagnosis, and if not, inform them yourself (1-800-305-2059). While this legislation has not yet been updated to include midwives or nurse practitioners, it is prudent to act on this duty to report as primary care providers.



Perinatal Forms Update

Perinatal Services BC (PSBC) is continuing with the redevelopment of the eight PSBC standardized provincial perinatal clinical forms. During the past year, PSBC engaged with clinicians and key stakeholders across all health authorities and, based on feedback received, the following draft clinical perinatal forms have been revised:

- PSBC 1582 – BC Antenatal Record Part 1 and 2
- PSBC 1583 – BC Labour Partogram
- PSBC 1583B – BC Newborn Resuscitation Record
- PSBC 1588 – BC Labour and Birth Summary
- PSBC 1590 – BC Perinatal Triage and Assessment Record

Once piloting and all feedback is received for PSBC 1583 Labour Partogram and PSBC 1588 Labour and Birth Summary, the forms will be revised further and a formal rollout plan will be communicated.

In the fall of 2018, PSBC will further engage clinicians and key stakeholders for review of forms:

- PSBC 1583A – BC Newborn Record Part 1 and 2
- PSBC 1592 – BC Postpartum Clinical Path
- PSBC 1593 – BC Newborn Clinical Path

PSBC will execute a coordinated strategy to implement the forms province wide, which will include ongoing clinician and stakeholder engagement, piloting of each form, updating guides to completion and providing training materials and support.

Professional Boundaries in Client-Midwife Relationships

The client-midwife relationship develops in a safe, comfortable environment that engenders trust and mutual respect. It is that trust that gives midwives the power of their professional position and access to private knowledge. With the advent of the #MeToo movement, there has been greater scrutiny on the actions of those in positions of power and responsibility. While CMBC has not received any complaints of sexual misconduct throughout its history as a regulator, there are many ways in which professional boundary violations can occur between health professionals and clients.

Take for example the recent decision by the College of Physicians and Surgeons of British Columbia (CPSBC) regarding a case in which a psychiatrist admitted to engaging in unprofessional conduct by failing to maintain professional boundaries with a patient including:

- allowing the patient to do work in her home;
- meeting with the patient and the patient's family socially;
- exchanging gifts with the patient;
- communicating with the patient by phone about matters unrelated to medical care;
- going on outings with the patient; and
- visiting with the patient at her home.

Following the issuance of a disciplinary citation, the psychiatrist consented to the following disposition by CPSBC:

a. Transfer from the Full – Specialty class of registration to the Conditional – Disciplined class of registration;
b. A formal reprimand;
c. Participation in continuing medical education in the areas of ethics, boundaries and professionalism; and
d. Attendance at the College for a meeting with the registrar. https://www.cpsbc.ca/files/disciplinary-actions/2018-05-16-Pusztai.pdf

Clear professional boundaries ensure the protection of both clients and midwives. Boundary violations can cause delayed distress which may not be recognized or felt by clients until harmful consequences occur. Professional boundary violations can be subtle intrusions and are often unintentional.

In a publicly funded system midwives will face many challenges in dealing with clients from diverse cultural backgrounds. Clients' perception

of boundary violations will depend on their likes, dislikes, culture, past history and temperament, among other factors. In client-midwife relationships the clients trust the midwives and may not feel free to express themselves in defence against such violations. It is the responsibility of midwives to clients, and to their own professional safety, to be aware of such issues and respond sensitively to the individual needs of clients in this regard.

To assist midwives in ensuring that appropriate professional boundaries are maintained, CMBC has made a number of updates to its *Policy on Appropriate Client-Midwife Relationships* (formerly the *Policy on Appropriate Client Relations)* to establish clear guidance for registrants in a variety of contexts. Midwives should take the time to familiarize themselves with this applicable policy to ensure the protection of clients and themselves.

Registrants seeking additional guidance on recognizing and maintaining professionals boundaries may wish to enroll in *Professionalism in Medical Practice: Avoiding the Pitfalls*, offered through CPSBC.

Client Requests

CMBC first approved the *Policy on Client Requests Outside of Standards* in 1997, prior to the practice of registered midwifery, which began January 1, 1998. The Board recognized the importance of client-centered care and the value of informed choice in the midwifery model. It was originally called the super concise name of *Policy for Client Requests Outside Midwifery Standards of Practice* and *Required Procedures for Midwife-Initiated Termination of Care.* The policy has since been reviewed and updated 10 times over the past 20 years with a recent separation of the two concepts into two separate polices – the *Policy for Client Requests Outside Midwifery Standards of Practice* and the *Policy for Required Procedures for Midwife or Client Initiated Termination of Care.*

These policies are meant to guide a midwife through the process of providing care outside of standards to ensure client-centered care with informed choice is at the forefront of the shared decision-making process. It highlights the need to inform clients, seek consultations, provide expert recommendations, and be open and transparent with local hospitals (accessing complex care planning, if applicable/available). CMBC welcomes midwives to reach out to us for support in interpreting this policy at any time. The following fictitious example will walk through its application in a client setting:

Jo and Lo are a team of two providing shared care midwifery for approximately 100 clients a year. They alternate calls weekly and lessen their client load over the summer so they can both take vacations. They bring Vi into care at 10 weeks. She has had two previous caesarean sections and had recently had a friend tell her about midwifery care. She is convinced that the midwifery model is where she

> ***Lo explains that this request is outside of homebirth and community standards, is against their recommendation, but that they will support Vi's decision through the application of CMBC policy.***

should have been all long, that she would not have had c-sections had she had midwifery care in her previous pregnancies, and she is excited to experience a different model of care. She goes on to have an uneventful first trimester and second trimester with her midwives. She refuses some standard tests, but has a 20 week ultrasound with all reporting normal. It is clear that she is actively reading about natural labour and that she feels she missed out by having had two previous c-sections. When Jo approaches the topic of place of birth – Vi adamantly states she wants a home birth.

Jo explains to Vi the risks of a trial of labour after two caesareans (TOLAC2) at home, her recommendation for a hospital birth, lets her know she will require an OB consult, and sends her home with various articles and links to read about TOLAC/VBAC and particularly TOLAC2/VBAC2. Jo documents the visit with an emphasis on the ICD re: place of birth in the context of having had two previous c-sections. At handover, Jo and Lo have a discussion about Vi. They talk about all the risks and benefits they will ensure are discussed with her in coming to the decision. They realise that their other option is to terminate care as their client is requesting something that may be outside their comfort zone as it is outside homebirth and community standards and puts their professional reputation at risk. Overall, they come to the decision that if Vi understands the risks and wants a homebirth – they will support her. After accepting the handover, Lo documents the discussion with Jo and the decision they came to.

Lo is in clinic at the next visit and reviews this discussion with Vi. They talk abut the research that Vi did and Lo looks to satisfy herself that Vi understands the risks and the clinical implications of her choice of birth place as well as any potential benefits. Both Lo and Jo are hoping that Vi will change her mind because they work in a lower-resource hospital setting and they both are concerned about the risks of a rupture if they aren't in the hospital and if specialists need to be called in. It is clear however, that Vi believes up to a 6% chance of rupture is a risk she is willing to take.

Lo explains that this request is outside of homebirth and community standards, is against their recommendation, but that they will support Vi's decision through the application of CMBC's policy. Lo and Vi review the policy together and see that their next step is to have a consultation. Vi is not happy as she doesn't care about another opinion, but understanding it is the midwives' professional responsibility, she agrees and meets with the local OB. Lo carefully documents these discussions and decisions in Vi's medical record.

Vi reports to Jo at their next visit that the OB went over the risks and the benefits of being in a hospital setting – even suggesting that she would be better to move to the nearby city to have access to a higher level of resources. She said that the OB mentioned a few things that make her think, but that she was still going to have a home birth. Jo again said this was outside of standards, and against their recommendation, but that they would support her decision. This visit is documented.

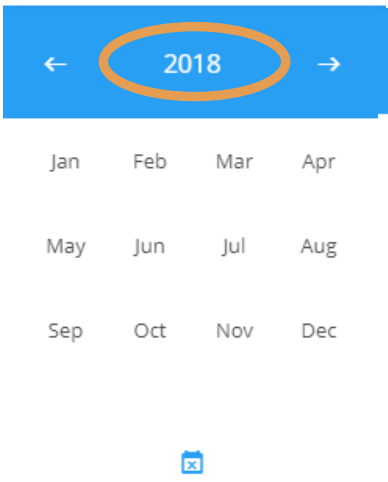
Over the next months, Jo and Lo touch base with Vi on her pregnancy and choice of birth place and document small notations. They are assured that no other clinical indications have arisen that may create additional risk, but are ready to have those conversations should they arise. Jo and Lo consider calling MPP to review their risk and CMBC to ensure they are applying the policy correctly and documenting accordingly. They use every opportunity when in the hospital over the month approaching Vi's due date to communicate with any of the health professionals that may become involved in Vi's care about their client's decision. They are transparent with the hospital and have meetings with the care team about when they would call when Vi was in labour, who would be on alert, and what the hospital's plan was in the case of a transfer. These discussions and meetings are documented in Vi's record. While everyone is uncomfortable with the risk to some degree – everyone works together collaboratively to create the safest environment given Vi's choice.

The scenario will be left hanging here because the outcome is not relevant to the application of the policy. If CMBC was to receive a complaint about the midwives providing a home birth to a double VBAC client, the panel would be looking to see if this *Policy for Client Requests Outside Midwifery Standards of Practice* was properly applied. The documentation and witness statements from those noted above should provide the intellectual footprint for a panel to follow with regards to the clinical picture, what discussions took place, when, with whom, what was discussed, and the evolving management plan. As presented, the midwives properly applied the policy and worked with this client to provide care outside of standards.

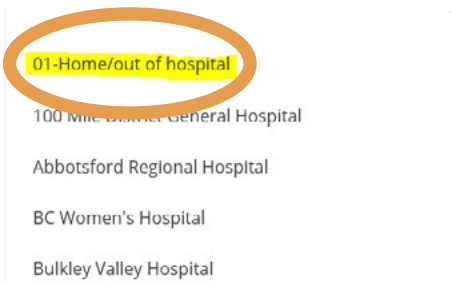
Birth Roster Tips & Tricks

CMBC would like to thank registrants for their patience and enthusiasm for the new online birth roster system, as well as the feedback we have received. While some of the larger changes can't be made immediately, here are some tips and tricks for using the system based on comments we've received.

- Using the calendar is easier than you think! When the calendar opens, click on the month and year displayed in the center. This will pull you out to all of 2018, so that you can select a month. If you continue to do this, it will pull out to larger time periods. You can then use the arrows to move backwards and forwards through the year. If you would like to enter the date manually, please do so as MM/DD/YYYY and NOT MM/DD/YY.



- There is a home/out of hospital choice in the "Actual" field. As the list is alphabetical, we have had this moved to the top of the list by adding a 01 to the front. Please look for:



- For "Transfer of Care": If another care provider delivers the baby, i.e. forceps, vacuum, c-section, you would indicate transfer of care. This field is for the birth only and shouldn't include information about a prenatal transfer that transferred back prior to birth.
- If you are reporting "No Births" for a month, PLEASE enter your first and last name as well.
- Remember that you can access and pull reports on your data. Use your notes column for extra information you'd like to capture.
- There is no "SUBMIT" button once your births are entered in for the month! Simply enter your births, and CMBC will be periodically checking to ensure that they have been entered.
- You can now edit and delete your own entries! Simply click on the entry and choose "Edit" or "Delete" next to "New". Make sure you are deleting the correct one, as it will be permanently removed!