INDICATIONS FOR DISCUSSION, CONSULTATION AND TRANSFER OF CARE

As a primary caregiver, the registrant is responsible for decision-making, together with the client. The registrant is responsible for writing orders and carrying them out or delegating them to an appropriate regulated health professional in accordance with the College of Midwives of BC's (CMBC) standards.

The registrant discusses care of a client, consults, and/or transfers primary care responsibility according to the *Indications for Discussion, Consultation and Transfer of Care.* The responsibility to consult with a family physician/general practitioner, obstetrician, pediatrician, other specialist physician or a nurse practitioner[1] lies with the registrant. It is also the registrant's responsibility to initiate a consultation within an appropriate time period after detecting an indication for consultation. The severity of the condition and the availability of a physician will influence these decisions.

CMBC expects registrants to use their professional judgement in making decisions to consult or transfer care. This includes making a decision at an initial visit to assess if a client is appropriate for midwifery care. The list is not exhaustive. Other circumstances may arise where the registrant believes consultation or transfer of care is necessary. The informed choice agreement between the registrant and client should outline the extent of midwifery care, so that the client is aware of the scope and limitations of midwifery care. The registrant should review the *Indications for Discussion, Consultation and Transfer of Care* with the client. Should a client refuse an indicated consultation or transfer of care, the registrant should refer to the *Policy on Informed Choice* and the *Policy on Client Requests Outside of Midwifery Standards of Practice*.

DEFINITIONS

Discussion with a Midwife, a Physician or another regulated health practitioner[2]

It is the registrant's responsibility to initiate a discussion with, or provide information to, another midwife, a physician or another regulated health practitioner in order to create an appropriate plan of care. It is also expected that the registrant will conduct regularly scheduled reviews of client charts with their colleagues to assist in planning care. Discussion should be documented by the registrant in the client record.

Consultation with a Physician[3] or another regulated health practitioner[4]

It is the registrant's responsibility to initiate a consultation in accordance with CMBC standards and to communicate clearly to the consultant that a consultation is requested and why. In requesting a consultation, a registrant uses their professional knowledge of the client and requests the opinion of a physician or another regulated health practitioner qualified to give advice in the area of clinical concern. A registrant may also seek a consultation when another

[1] During the antepartum or postpartum period, a registrant may consult with a nurse practitioner (with a Family, Adult or Pediatric specialty), as appropriate to the nurse practitioners' scope of practice. Nurse practitioners do not provide primary care in the intrapartum period.

[2] Discussion should occur with a physician, or with another primary care provider such as a nurse practitioner, where another midwife is not available.

[3] In this document, consultation with a physician means consultation with a physician licensed by the College of Physicians and Surgeons of BC unless otherwise specifically indicated.

[4] As appropriate to the individual's scope of practice.

opinion is requested by the client. The registrant must document each consultation in the client record in accordance with CMBC standards.

The registrant should expect the consultant to address the problem described in the consultation request, conduct an in-person assessment(s) of the client, and promptly communicate findings and recommendations to the client and to the referring midwife. Discussion will then normally occur between the registrant and the consultant regarding the future plan of care for the client.

Where urgency, distance or climatic conditions do not allow the client to see a physician or another regulated health practitioner for an in-person consultation visit, the registrant should seek advice from the consultant by phone or other similar means. The consultant may use alternative means of communication (e.g. via Telehealth) to assess the client as available and appropriate. The registrant should document such requests for advice in client records, in accordance with CMBC standards, and discuss the advice received with the client.

A consultation can involve the physician or another regulated health practitioner providing advice and information, and/or providing therapy to the client/newborn, or recommending therapy for the client/newborn to the registrant to provide within the midwifery scope of practice.

After consultation with a physician or another regulated health practitioner, primary care of the client and responsibility for decision-making, with the informed consent of the client, may:

a) continue with the registrant;
b) be shared between the registrant, nurse practitioner[5] and/or physician[6]; or
c) be transferred to the physician.

Once a consultation has taken place and the consultant's findings, opinions and recommendations have been communicated to the client and the registrant, the registrant must discuss the consultant's recommendations with the client and ensure that the client understands which health professional will have responsibility for primary care.

Shared primary care

In a shared care arrangement, the consultant may be involved in, and responsible for, a discrete area of the client's care, with the registrant maintaining overall responsibility within the scope of practice, or vice versa. Areas of involvement in client care and the plan for communication between care providers are clearly agreed upon and documented by the registrant and the consultant.

It is recommended that one health professional take responsibility for coordinating the client's care. This arrangement should be clearly communicated to the client and documented in the records. Responsibility can be transferred temporarily from one health professional to another, or be shared between health professionals, according to the client's preferences and needs for care or expertise. Transfer of care or an arrangement for sharing care should be discussed with the client, and agreed to between the registrant, client and consultant(s), and documented in the client record.

[5] Only for the antenatal and/or postpartum period.

[6] In a shared primary care arrangement, the physician, registrant and client agree on which aspects of care each provider is assuming responsibility for and have a written plan in place for communicating with each other to coordinate that care.

Shared primary care arrangements may vary depending on community and on the experience and comfort levels of the care providers involved. Registrants who gain more skills, abilities and experience over time may be able to manage more complex care within their scope of practice in collaboration with their physician colleagues.

Transfer to a physician for primary care
When primary care is transferred permanently or temporarily from the registrant to a physician, the physician assumes full responsibility for subsequent decision-making, together with the client.

When primary care is transferred to a physician, the registrant may continue to provide supportive care with the client's consent. The registrant may provide care within the midwifery scope of practice as arranged with the physician who has assumed the primary care role.

INDICATIONS: Initial History and Physical Examination

Discussion:

- adverse socio-economic conditions
- age less than 17 years or over 40 years
- cigarette and/or cannabis use
- grand multipara (5 or more previous births)
- history of substance use
- history of infant over 4,500 g
- history of one late miscarriage (after 14 weeks) or pre-term birth
- history of one small for gestational age infant
- less than 12 months from last delivery to present due date
- low or high BMI[7]
- poor nutrition
- previous antepartum hemorrhage
- previous postpartum hemorrhage
- one documented previous low-segment cesarean section
- history of hypertensive disorders of pregnancy
- known uterine malformations or fibroids
- history of trauma or sexual abuse

Consultation:

- current medical conditions that may affect pregnancy or are exacerbated due to pregnancy, family history of genetic disorders, hereditary disease or significant congenital anomalies
- pre-existing (chronic) hypertension
- history of cervical cerclage
- history of three or more first-trimester spontaneous abortions
- history of more than one second-trimester spontaneous abortion
- history of more than one preterm birth, or one preterm birth less than 34 weeks
- history of more than one small for gestational age infant
- history of eclampsia
- history of significant medical illness

[7] Consider consultation based on local hospital capability and community standards.

- previous myomectomy, hysterotomy or cesarean section other than one documented previous low-segment cesarean section
- previous neonatal mortality or stillbirth
- age less than 14 years
- history of postpartum hemorrhage requiring transfusion

Transfer:

- current medical condition(s) that may adversely affect or are exacerbated by pregnancy that require specialized medical care (common examples include cardiac disease, renal disease, pre-existing insulin-treated diabetes mellitus)

INDICATIONS: Prenatal Care

Discussion:

- no prenatal care before 28 weeks gestation
- uncertain expected date of delivery

Consultation:

- medical conditions arising during prenatal care, including but not limited to hyperemesis unresponsive to pharmacologic therapy, endocrine disorders, renal disease, and suspected or confirmed significant viral or bacterial infection[8]
- presentation other than cephalic at 37 weeks
- anemia (unresponsive to therapy)[9]
- documented post-term pregnancy (≥ 42 completed weeks)
- suspected or diagnosed fetal anomaly that may require physician management during or immediately after delivery
- intrauterine fetal demise
- abnormal fetal growth confirmed by ultrasound
- polyhydramnios or oligohydramnios
- asymptomatic placenta previa persisting into third trimester
- vasa previa
- gestational hypertension without evidence of pre-eclampsia
- isoimmunization, haemoglobinopathies, blood dyscrasia
- thrombophlebitis or suspected thromboembolism
- mental health concerns presenting or worsening during pregnancy[10]
- pain which persists, worsens and/or is unresponsive to therapy within the midwife's scope of practice
- substance use in pregnancy
- sexually transmitted infection requiring treatment[11]
- urinary tract infection unresponsive to pharmacologic therapy
- twins[12]

[8] Consultation with a physician and possibly referral to Public Health is required for all strains of influenza and any significant viral upper respiratory illness such as SARS, H1N1, COVID-19 or similar; co-management or transfer of care may be necessary based on the physician's assessment.

[9] Consultation may be with a physician or another regulated healthcare practitioner.

[10] Consultation may be with a physician, clinical psychologist, mental health worker, or nurse practitioner.

[11] Consultation may be with a physician or a nurse practitioner. Midwives holding Specialized Practice Certification in Sexually Transmitted Infections Management do not need to consult if they can treat the infection.

- repeated vaginal bleeding other than transient spotting or uncomplicated spontaneous abortion before 14 weeks
- spontaneous abortion at or after 14 weeks
- insulin-treated gestational diabetes
- declining all blood products[13]

Transfer:

- molar pregnancy
- cardiac or renal disease with failure
- multiple pregnancy (other than twins)
- severe hypertension, pre-eclampsia[14], eclampsia or HELLP syndrome
- symptomatic placental abruption or previa

INDICATIONS: During Labour and Delivery

Discussion:

- no prenatal care

Consultation:

- breech presentation[15]
- twins[16]
- unengaged head in active labour in nullipara
- pre-term labour or preterm prelabour rupture of membranes (PPROM) between (34+0 – 36+6 weeks)
- meconium-stained amniotic fluid[17]
- active genital herpes at time of labour or rupture of membranes
- labour dystocia unresponsive to therapy
- suspected placenta abruption and/or previa
- substance use in labour
- retained placenta
- temperature of 38°C or greater on more than one occasion
- third- or fourth-degree tear

Transfer:

- pre-term labour or PPROM (less than 34+0 weeks)

---

[12] In many settings the management of a twin pregnancy will involve shared or transfer of care to an obstetrician. Responsibility can be transferred temporarily from one health professional to another, or be shared between health professionals, according to the client's preferences and needs for care or expertise.

[13] Consultation may be with both an obstetrician and an anesthetist depending on community standards.

[14] As defined by SOGC Clinical Practice Guideline No. 206 Diagnosis, Evaluation, and Management of the Hypertensive Disorders of Pregnancy 2014.

[15] While many of these deliveries may become transfers of care, breech presentation and twins are listed as indications for consultation. Where a spontaneous birth is anticipated, a registrant may conduct the delivery under the direct supervision of an obstetrician. In a remote area, the availability of an experienced midwife who has the confidence of obstetrical colleagues can prevent a client from having to leave family and community. Registrants may also gain important hands-on experience under obstetrical supervision. Responsibility can be transferred temporarily from one health professional to another, or be shared between health professionals, according to the client's preferences and needs for care or expertise.

[16] In many settings the management of a twin pregnancy will involve shared or transfer of care to an obstetrician. Responsibility can be transferred temporarily from one health professional to another, or be shared between health professionals, according to the client's preferences and needs for care or expertise.

[17] At minimum, at time of birth, due to the increased risk of neonatal resuscitation.

- abnormal presentation (other than breech)
- multiple pregnancy (other than twins)
- severe hypertension, pre-eclampsia, eclampsia or HELLP syndrome
- prolapsed cord
- placenta abruption, placenta previa or vasa previa
- abnormal fetal heart rate pattern unresponsive to therapy
- suspected embolus
- uterine rupture
- uterine inversion
- hemorrhage unresponsive to therapy
- obstetric shock

INDICATIONS: Postpartum (Maternal)

Consultation:

- breast infection unresponsive to therapy[18]
- wound infection[19]
- uterine infection
- uterine prolapse
- cervical prolapse[20]
- signs of urinary tract infection unresponsive to therapy[18]
- temperature over 38°C on more than one occasion[18]
- persistent or new onset hypertension
- thrombophlebitis or thromboembolism
- persistent bladder or rectal dysfunction[19]
- mental health concerns presenting or worsening during postpartum[21]
- pain which persists, worsens and/or is unresponsive to therapy within the midwife's scope of practice

Transfer:

- hemorrhage unresponsive to therapy
- eclampsia
- postpartum psychosis[22]

INDICATIONS: Postpartum (Infant)

Discussion:

- feeding problems[23]
- excessive moulding
- cephalohematoma

Consultation:

- suspicion of or significant risk of neonatal infection

[18] Consultation may be with a physician or a nurse practitioner.
[19] Consultation may be with a physician or nurse practitioner
[20] Consultation may be with a physician or a physiotherapist.
[21] Consultation may be with a physician, clinical psychologist, mental health worker, or nurse practitioner.
[22] Transfer of care may be to a mental health care specialist. The registrant shall remain in the role of primary obstetrical care provider, within the midwifery scope of practice.
[23] Discussion may be with another midwife, a physician, a nurse practitioner or a lactation consultant.

- 34 to 36+6 weeks gestational age[18]
- in utero exposure to substances with known or suspected teratogenicity
- prolonged PPV or significant resuscitation
- infant weight less than 2500g
- Infant at or less than 5th percentile in weight for gestational age
- fewer than 3 vessels in umbilical cord
- excessive bruising, abrasions, unusual pigmentation and/or lesions
- birth injury requiring investigation
- congenital abnormalities, for example: cleft lip or palate, developmental dysplasia of the hip, ambiguous genitalia
- abnormal heart rate pattern or persistent/symptomatic murmur
- any other abnormal findings on physical exam
- persistent poor suck, poor feeding, lethargy, hypotonia or abnormal cry
- persistent abnormal respiratory rate and/or pattern
- persistent cyanosis, pallor or jitteriness
- jaundice in first 24 hours
- failure to pass urine or meconium within 36 hours of birth
- suspected pathological jaundice after 24 hours
- temperature less than 36°C unresponsive to therapy
- temperature of 38°C or more unresponsive to therapy
- temperature instability
- vomiting or diarrhea[18]
- infection of umbilical stump site[18]
- persistent weight loss unresponsive to therapy
- failure to regain birth weight in 3 weeks
- failure to thrive

Transfer:

- Apgar score lower than 7 at 10 minutes
- suspected seizure activity
- significant congenital anomaly requiring immediate medical intervention, for example: omphalocele, myelomeningocele