

approved December 2, 1999
effective June 15, 2000

INDICATIONS FOR MANDATORY DISCUSSION, CONSULTATION AND TRANSFER OF CARE

As a primary caregiver, the midwife together with the client is fully responsible for decision-making. The midwife is responsible for writing orders and carrying them out or delegating them in accordance with the standards of the College of Midwives.

The midwife discusses care of a client, consults, or transfers primary care responsibility according to the Indications for Mandatory Discussion, Consultation and Transfer of Care.¹ The responsibility to consult with a family physician/general practitioner, obstetrician and/or specialist physician lies with the midwife. It is also the midwife's responsibility to initiate a consultation within an appropriate time after detection of an indication for consultation. The severity of the condition and the availability of a physician(s) will influence these decisions.

The informed choice agreement between the midwife and client should outline the extent of midwifery care, in order to make clients aware of the scope and limitations of midwifery care. The midwife should review the Indications for Mandatory Discussion, Consultation and Transfer of Care with the client.

DEFINITIONS

Category 1: Discuss with another midwife or with a physician

It is the midwife's responsibility to initiate a discussion with or provide information to another midwife or physician, with whom the care is shared, in order to plan care appropriately.

¹ For a discussion of how this document is used to guide decisions about choice of birth place, see Indications for Planned Place of Birth.

Category 2: Consult with a physician

It is the midwife's responsibility to initiate a consultation and to clearly communicate to the consultant that she is seeking a consultation. A consultation refers to the situation where a midwife, in light of her professional knowledge of the client and in accord with the standards of practice of the College of Midwives, or where another opinion is requested by the client, requests the opinion of a physician competent to give advice in this field. The midwife should expect that:

The consultation involves addressing the problem that led to the referral, an in-person assessment of the patient, and the prompt communication of the findings and recommendations to the patient and the referring professional.

Following the assessment of the patient by the consultant(s), discussion can occur between the health professional and consultant regarding future patient care.²

The consultation can involve the physician providing advice and information and/or providing therapy to the woman/newborn or prescribing therapy to the midwife for the woman/newborn.

Consultation must be documented by the midwife in her records in accord with the regulations of the College of Midwives.

After consultation with a physician, primary care of the client and responsibility for decision-making together with the client either:

- a) continues with the midwife, or
- b) is transferred to a physician.

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

² "Clinical Practice Parameters and Standards for Consultation and Transfer of a Woman/Newborn in or from a Birth Centre Where Only Midwives Provide Primary Care, to a Physician/Health Facility," College of Physicians and Surgeons of Ontario, December 23, 1993.

Where urgency, distance or climatic conditions make an in-person consultation with a physician not possible, the midwife should seek advice from the physician by phone or other similar means. The midwife should document this request for advice, in her records, in accord with the requirement of the College of Midwives and discuss with the client the advice received.

The consultant may be involved in, and responsible for, a discrete area of the client's care, with the midwife maintaining overall responsibility within her scope of practice. Areas of involvement in client care must be clearly agreed upon and documented by the midwife and the consultant.

The College of Midwives has agreed that:

One health professional has overall responsibility for a patient at any one time and the patient's care should be co-ordinated by that health professional whose identity should be clearly known to all of those involved and documented in the records of the referring health professional and consultant. Responsibility could be transferred temporarily to another health professional, or be shared between health professionals according to the patient's best interests and optimal care; however, transfer or sharing of care should only occur after discussion and agreement among patients, referring health professionals, and consultants.³

Category 3: Transfer to a physician for primary care

When primary care is transferred, permanently or temporarily, from the midwife to a physician, the physician, together with the client, assumes full responsibility for subsequent decision-making. When primary care is transferred to a physician, the midwife may provide supportive care⁴ within her scope of practice, in collaboration with the physician and the client.

³ *"Clinical Practice Parameters and Standards for Consultation and Transfer of a Woman/Newborn in or from a Birth Centre Where Only Midwives Provide Primary Care, to a Physician/Health Facility," College of Physicians and Surgeons of Ontario, December 23, 1993.*

⁴ *Supportive care is defined in the Standard on Supportive Care.*

INDICATIONS: Initial History and Physical Examination

- Category 1:**
- adverse socio-economic conditions
 - age less than 17 years or over 35 years
 - cigarette smoking
 - grand multipara (para 5)
 - history of infant over 4500 g
 - history of one late miscarriage (after 14 completed weeks) or preterm birth
 - history of one low birth weight infant
 - history of serious psychological problems
 - less than 12 months from last delivery to present due date
 - obesity
 - poor nutrition
 - previous antepartum hemorrhage
 - previous postpartum hemorrhage
 - one documented previous low segment cesarean section
 - history of essential or gestational hypertension
 - known uterine malformations or fibroids
- Category 2:**
- current medical conditions for example:⁵ cardiovascular disease, pulmonary disease, endocrine disorders, hepatic disease, neurologic disorders
 - family history of genetic disorders
 - family history of significant congenital anomalies
 - history of cervical cerclage
 - history of repeated spontaneous abortions
 - history of more than one late miscarriage or preterm birth
 - history of more than one low birth weight infant
 - history of gestational hypertension with proteinuria and adverse sequelae
 - history of significant medical illness
 - previous myomectomy, hysterotomy or cesarean section other than one documented previous low segment cesarean section
 - previous neonatal mortality or stillbirth
 - rubella during first trimester of pregnancy

⁵ Refer to *Guidelines to Antepartum Consultations for Clients of Midwives to Anaesthesia*, July 1996.

- significant use of drugs or alcohol
- age less than 14 years

Category 3: • any serious medical condition, for example: cardiac or renal disease with failure or insulin dependent diabetes mellitus

INDICATIONS: Prenatal Care

Category 1:

- presentation other than cephalic at 36 completed weeks
- no prenatal care before 28 completed weeks
- uncertain expected date of delivery
- uncomplicated spontaneous abortion less than 12 completed weeks

Category 2:

- anemia (unresponsive to therapy)
- documented post term pregnancy (42 completed weeks)
- fetal anomaly
- inappropriate uterine growth
- medical conditions arising during prenatal care, for example: endocrine disorders, hypertension, renal disease, suspected significant infection, hyperemesis
- placenta previa without bleeding
- polyhydramnios or oligohydramnios
- gestational hypertension
- isoimmunization
- serious psychological problems⁶
- sexually transmitted disease
- twins
- vaginal bleeding other than transient spotting
- presentation other than cephalic, unresponsive to therapy, at 38 completed weeks

⁶ Notwithstanding the requirement for consultation with a physician, consultation may be with another appropriate health care professional; for example, a mental health worker.

- Category 3:**
- cardiac or renal disease with failure
 - insulin dependent diabetes
 - multiple pregnancy (other than twins)
 - gestational hypertension with proteinuria and/or adverse sequelae
 - symptomatic placental abruption
 - vaginal bleeding, continuing or repeated
 - placenta previa after 28 completed weeks

INDICATIONS: During Labour and Birth

- Category 1:**
- no prenatal care
 - non-particulate meconium

- Category 2:**
- breech presentation
 - preterm labour (34 - 37 completed weeks)
 - prolonged active phase
 - prolonged rupture of membranes
 - prolonged second stage
 - retained placenta
 - suspected placenta abruption and/or previa
 - third or fourth degree tear
 - twins
 - unengaged head in active labour in primipara
 - preterm prelabour rupture of membranes (PPROM) between 34 and 37 completed weeks
 - particulate meconium
 - gestational hypertension

- Category 3:**
- active genital herpes at time of labour
 - preterm labour (less than 34 completed weeks)
 - abnormal presentation (other than breech)
 - multiple pregnancy (other than twins)
 - gestational hypertension with proteinuria and/or adverse sequelae
 - prolapsed cord or cord presentation
 - placenta abruption and/or previa
 - severe hypertension

- confirmed non-reassuring fetal heart patterns, unresponsive to therapy
- uterine rupture
- uterine inversion
- hemorrhage unresponsive to therapy
- obstetric shock
- vasa previa

INDICATIONS: Post Partum (Maternal)

- Category 2:**
- suspected maternal infection e.g. breast, abdomen, wound, uterine, urinary tract, perineum
 - temperature over 38° C (100.4° F) on more than one occasion
 - persistent hypertension
 - serious psychological problems⁷

- Category 3:**
- hemorrhage unresponsive to therapy
 - postpartum eclampsia
 - thrombophlebitis or thromboembolism
 - uterine prolapse

INDICATIONS: Post Partum (Infant)

- Category 1:**
- feeding problems⁸
 - failure to pass urine or meconium within 24 hours of birth

- Category 2:**
- 34 to 37 weeks gestational age
 - infant less than 2,500 g
 - less than 3 vessels in umbilical cord
 - excessive moulding and cephalhematoma

 - abnormal findings on physical exam

⁷ Notwithstanding the requirement for consultation with a physician, consultation may be with another appropriate health care professional; for example, a mental health worker.

⁸ Notwithstanding the requirement for discussion with a physician or midwife, discussion may be with another appropriate health care professional; for example, a lactation consultant.

- excessive bruising, abrasions, unusual pigmentation and/or lesions
- birth injury requiring investigation
- congenital abnormalities, for example: cleft lip or palate, congenital dislocation of hip, ambiguous genitalia
- abnormal heart rate or pattern
- abnormal cry
- persistent abnormal respiratory rate and/or pattern
- persistent cyanosis or pallor
- jaundice in first 24 hours
- suspected pathological jaundice after 24 hours
- temperature less than 36° C, unresponsive to therapy
- temperature more than 37.4° C, axillary, unresponsive to non-pharmaceutical therapy
- vomiting or diarrhea
- infection of umbilical stump site
- significant weight loss (more than 10% of body weight)
- failure to regain birth weight in three weeks
- failure to thrive
- failure to pass urine or meconium within 36 hours of birth
- suspected clinical dehydration

Category 3:

- APGAR lower than 7 at 5 minutes
- suspected seizure activity
- major congenital anomaly requiring immediate intervention, for example: omphalocele, myelomeningocele
- temperature instability