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Laboratories and Diagnostics Branch
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The Ontario Medical Association (OMA) appreciates the opportunity to participate in Ministry consultations regarding the proposed update of the list of laboratory tests and point of care test that midwives can order and administer within their scope of practice.

The content of this submission is composed of two parts. The first will focus on general recommendations and the second provides specific comments.

- The OMA recognizes the important role of midwifery in the assessment and monitoring of women during normal pregnancy, labour, and the post-partum period and of their newborn babies. We are supportive of a collaborative, team-based health care delivery model where every professional can work to their full scope of practice and be appreciated for their unique skills and experience. We support that midwives can order necessary tests that align with their scope of practice.

- Based on extensive member consultations with physicians specializing in Obstetrics, Lab Medicine, Infectious Diseases, Pediatrics, and Family Medicine, as well as the OMA's Health Policy Committee, we strongly recommend the Ministry not to proceed with the proposed changes as outlined.

- The ordering of lab tests should be consistent with the knowledge, skill and training of the professional involved. The midwifery program does not include the depths of training in pharmacology, microbiology, infectious disease and biochemistry which is necessary to order and manage tests. Several of the proposed tests give rise to patient safety concerns, are inappropriate or outdated, and are not even routinely done by a physician or obstetrician.

- The panel of midwifery lab testing should be selected only for the purposes of supporting routine patient assessment and monitoring or rule out diseases or disorders that require physician consultation. The tests should not be performed for the purposes of making a

diagnosis that would otherwise be made or require management by a consultant physician. It is unclear how the tests will be used in midwifery practice, and we strongly recommend that standards for test ordering and usage (including when to order, how to administer and when to consult a physician or specialist, including for example genetic specialists) are developed prior to expanding the lists of tests.

- Concerns have been raised regarding the specific tests within the list and who was consulted in its development. In general, and for all future scope proposals, we recommend that the Ministry establishes a clinical reference group which can help evaluate proposals in terms of appropriateness, safety, alignment with scope of practice and cost efficiency. The OMA would like to be engaged in the establishment of a clinical reference group and could recommend physicians with relevant clinical expertise.

We have summarized concerns with specific tests below:

Proposed Schedule 2 Lab Tests

- **6. Aspartate Transaminase (AST).** AST is only covered by OHIP in specific circumstances. Choosing Wisely guidelines says that AST should only be ordered by physicians with experience in treating liver disorders. For this reason, it would not be appropriate for midwives to order AST.
- **7. Bile Acid Breath Test.** The Bile Acid Breath Test is performed in the scenario of bacterial overgrowth. This is an inappropriate test as by the time the test is considered, the patient should be under the care of a physician specialist.
- **12. Blood culture (including aerobic, anaerobic, subcultures, smears).** Blood culture testing should not be ordered as a routine outpatient test. Assessment and management of patients suspected of bacteremia/sepsis are outside the midwifery scope of practice and should be immediately transferred to an appropriate facility.
- **15. Carrier screening (hemoglobinopathy, Tay-Sachs, Ashkenazi Jewish screening panel).** Given midwifery scope of practice this is not an appropriate test. Carrier testing requires consultation and testing of both mother and father to assess the probability of disease/carrier status in a potential child. In light of the midwifery scope of practice, it would be inadequate and insufficient for midwives to only order carrier testing on the mother. Carrier testing is most ideally done during the preconception stage (for reproductive decision-making), outside the scope of midwifery practice.
- **21. Crossmatch per unit of blood.** Crossmatching should not be ordered as a routine outpatient test. Due to the potential for patient harm, all activities around blood transfusions (assessment of patients requiring blood transfusions; ordering of blood products; monitoring for transfusion reactions) should be managed by physicians and fall outside of the scope of midwifery practice.
- **25. Cytomegalovirus (CMV).** Unclear if this is a PCR or serological test.
- **35. Hepatitis associated antigen or antibody immunoassay (for a specific marker)** Unclear what is meant by this.
- **40. Fetal Scalp Lactate & and 45. & 46 Placental Growth Factor – A &B.** These tests are not appropriate for midwives to order. Fetal Scalp Lactate is conducted in labour for a fetus with an abnormal heart rate pattern and would require immediate physician consultation. Placental growth factor A & B are associated with pre-eclampsia and intrauterine grow

restriction. These tests should not be used indiscriminately and not prior to referral to OB or Maternal Fetal Medicine for evaluation & treatment.

- **43. pCO2, pO2 and pH in combination.** Cord blood gas testing performed in facilities (hospitals or birthing units) for concerns of neonatal asphyxia are typically emergent situations requiring immediate consultation and would no longer be considered "normal" births. Cord blood samples submitted from home births for testing would not yield accurate results. Reliable blood gas results require samples to be analyzed promptly, and delays in time from sample collection to analysis may result in falsely decreased pH/increased CO2. There may be limited situations where midwife ordering of blood gases may be useful in a facility (i.e. in remote settings where there is limited/no access to obstetrical/neonatal pediatric care), but this would have to be carefully balanced with risks.
- **61**. **T4 total.** This test is no longer considered useful.

Laboratory Tests to consider

There are two relevant tests that the College of Midwives should consider adding:

- **T-cell Receptor Antibody**, which should be ordered on any pregnant with hyperthyroidism
- **Parvovirus B19 serology** to determine acute/recent infection, during pregnancy.

Proposed Point of Care Tests

- **1. Amniotic swab.** Amniotic Swab is indicated only for culture. It is not a validated diagnostic tool for determining whether membranes are ruptured.
- **2. Blood Group — ABO and RhD.** Point-of-care blood grouping is not currently a routine test or used as standard of care in pregnancy. The rationale for allowing midwives to perform this POC test has not been explained.
- **3. Ferning test.** The Ferning test is not a validated test for determining whether amniotic membranes have been ruptured and is no longer consistent with the standard of care.
- **5. Hemoglobin test.** Hemoglobin POC tests are not reliably accurate and as a result, most physicians stopped relying on them many years ago in favour of validated tests through hospitals or labs.
- **7. Strep B rapid screen.** Group B Streptococcal rapid screening has been shown to have greater failure rates and does not provide sensitivities for patients with penicillin allergies. Furthermore, Strep B rapid screen testing is not currently a routine test. These are not typically performed by obstetricians in out of hospital setting.
- **8. Urine dipstick.** Urine dipstick in pregnancy is usually done for protein or glucose in the urine. It is not useful for determining "infection". Most pregnant women have "leukorrhea" (vaginal discharge). A broad dipstick (to diagnose a presumptive urinary tract infection) is unreliable in pregnancy because of leukorrhea, and relying on it may lead to increased numbers of women being treated inappropriately with antibiotics**.**

In closing, we propose the following three recommendations:

1. **Pause this proposal.** We recommend the Ministry not to proceed with the proposed list in its current form due to patient safety concerns and inconsistences with standard of care. We ask that the list undergoes a thorough review to ensure it aligns with the knowledge, training and scope of midwives. Furthermore, we also recommend that standards are developed for test ordering and usage, including when a physician or other expert should be consulted.

2. **Strike a clinical advisory group.** This group can help evaluate scope expansion proposals in terms of appropriateness, safety, alignment with scope of practice and cost efficiency.
3. **Don't add extra administrative burden on physicians**. Ensure that the proposed changes do not add to the administrative burden of physicians, e.g. by providing infrastructure that support effective interprofessional communication.

We would welcome the opportunity to discuss this matter further.

Sincerely,

Adam Farber
Interim Executive Vice-President, Economics,
Policy and Research, and General Counsel