

College of Midwives of British Columbia

Indications for Discussion, Consultation and Transfer of Care

As a primary caregiver, the midwife is fully responsible for decision-making, together with the client. 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, 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 and/or specialist physician lies with the midwife. It is also the midwife'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.

The College of Midwives expects members to use their professional judgment in making decisions to consult or transfer care. The following list is not exhaustive. Other circumstances may arise where the midwife believes consultation or transfer of care is necessary.

The informed choice agreement between the midwife and client should outline the extent of midwifery care, so that the client is aware of the scope and limitations of midwifery care. The midwife should review the Indications For Discussion, Consultation And Transfer Of Care with the client.

DEFINITIONS

Discussion with Another Midwife or a Physician¹

It is the midwife's responsibility to initiate a discussion with, or provide information to, another midwife or a physician in order to plan care appropriately. It is also expected that the midwife will conduct regularly scheduled reviews of client charts to assist

in planning care. Discussion should be documented by the midwife in her records.

Consultation with a Physician²

It is the midwife's responsibility to initiate a consultation and to communicate clearly to the consultant that she is seeking a consultation. A consultation refers to the situation where a midwife, using her professional knowledge of the client and in accordance with the standards of the College of Midwives, requests the opinion of a physician competent to give advice in the relevant field. A midwife may also seek a consultation when another opinion is requested by the client. Consultation must be documented by the midwife in her records in accordance with the standards of the College of Midwives.

The midwife should expect that the consultant will address the problem that led to the referral, conduct an in-person assessment(s) of the client, and promptly communicate findings and recommendations to the client and to the referring midwife. Discussion may then occur between the midwife and the consultant regarding the future care of the client.

Where urgency, distance or climatic conditions do not allow an in-person consultation with a physician, 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 accordance with the standards of the College of Midwives, and discuss the advice received with the client.

A 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.

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

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

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

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.

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

Transfer to a physician for primary care

When primary care is transferred permanently or temporarily from the midwife 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 midwife may provide supportive care within her scope of practice, in collaboration with the physician and the client.

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INDICATIONS : Initial History and Physical**Discussion**

- adverse socio-economic conditions
- age less than 17 years or over 40 years
- cigarette smoking
- grand multipara (5 or more previous births)
- history of infant over 4,500 g
- history of one late miscarriage (after 14 weeks) or pre-term 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 caesarean section
- history of essential or pregnancy-induced hypertension
- known uterine malformations or fibroids

Consultation

- current medical conditions, for example: cardiovascular disease, pulmonary disease, endocrine disorders, hepatic disease, neurologic disorders, severe gastrointestinal disease
- family history of genetic disorders, hereditary disease or significant congenital anomalies
- history of cervical cerclage or incompetent cervix
- history of repeated spontaneous abortions
- history of more than one late miscarriage or pre-term birth
- history of more than one low-birth-weight infant
- history of eclampsia
- history of significant medical illness
- previous myomectomy, hysterotomy or caesarean section other than one documented previous low-segment caesarean section
- previous neonatal mortality or stillbirth
- rubella during first trimester of pregnancy
- significant use of drugs, alcohol or other toxic substances
- age less than 14 years
- history of postpartum haemorrhage requiring transfusion

Transfer

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

INDICATIONS : Prenatal Care**Discussion**

- presentation other than cephalic at 4 weeks prior to due date
- no prenatal care before 28 weeks gestation

- uncertain expected date of delivery

Consultation

- anaemia (unresponsive to therapy)³
- documented post-term pregnancy (42 completed weeks)
- suspected or diagnosed fetal anomaly that may require physician management during or immediately after delivery
- 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
- pregnancy-induced hypertension
- isoimmunization, hemoglobinopathies, blood dyscrasia
- serious psychological problems⁴
- sexually transmitted disease⁵
- twins⁶
- repeated vaginal bleeding other than transient spotting
- presentation other than cephalic at 37 weeks

Transfer

- cardiac or renal disease with failure
- insulin-dependent diabetes
- multiple pregnancy (other than twins)
- proteinuric pre-eclampsia or eclampsia
- symptomatic placental abruption

INDICATIONS : During Labour and Delivery**Discussion**

- no prenatal care
- thin, non-particulate meconium⁷

Consultation

- breech presentation⁸
- pre-term labour (34-37 completed weeks)
- prolonged active phase
- prolonged rupture of membranes
- prolonged second stage
- suspected placenta abruption and/or previa
- retained placenta
- third or fourth degree tear
- twins⁹
- unengaged head in active labour in primipara
- thick or particulate meconium¹⁰

Transfer

- temperature over 38°C on more than one occasion
- active genital herpes at time of labour
- pre-term labour (less than 34 weeks)
- abnormal presentation (other than breech)
- multiple pregnancy (other than twins)
- pre-eclampsia or eclampsia
- prolapsed cord
- placenta abruption and/or previa
- severe hypertension

- abnormal fetal heart rate patterns unresponsive to therapy
- uterine rupture
- uterine inversion
- hemorrhage unresponsive to therapy
- obstetric shock

INDICATIONS : Postpartum (Maternal)**Consultation**

- breast infection unresponsive to therapy¹¹
- wound infection¹²
- uterine infection¹³
- signs of urinary tract infection unresponsive to therapy¹⁴
- temperature over 38°C on more than one occasion¹⁵
- persistent hypertension
- serious psychological problems¹⁶

Transfer

- hemorrhage unresponsive to therapy
- eclampsia
- thrombophlebitis or thromboembolism
- uterine prolapse

INDICATIONS : Postpartum (Infant)**Discussion**

- feeding problems¹⁷

Consultation

- suspicion of or significant risk of neonatal infection
- 34 to 37 weeks gestational age¹⁸
- infant less than 2,500 g
- less than 3 vessels in umbilical cord
- excessive moulding and cephalohaematoma
- abnormal findings on physical exam
- 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
- persistent poor suck, 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 24 hours of birth
- suspected pathological jaundice after 24 hours
- temperature less than 36°C unresponsive to therapy
- temperature more than 37.9°C unresponsive to therapy
- vomiting or diarrhea¹⁹
- infection of umbilical stump site²⁰
- significant weight loss (more than 10% of body weight)
- 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
- temperature instability

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

2 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.

3 Consultation may be with a physician or a nurse-practitioner

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

5 Consultation may be with a physician, or a nurse-practitioner.

6 In many settings the management of a twin pregnancy will involve transfer of care to an obstetrician. The midwife may continue to provide supportive care and whatever care is within her scope of practice and is agreed to by the physician who is in the role of most responsible care provider.

7 Whenever meconium is present the midwife in attendance must be prepared to intubate any non-vigorous newborn.

8 While many of these deliveries may become transfers of care, breech presentation and twins are listed as indications for consultation to allow an obstetrical consultant discretion in deciding if a midwife may manage such a delivery, where a spontaneous birth is reasonably anticipated. Usually a midwife would 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 her obstetrical colleagues can prevent a woman from having to leave her family and community. Midwives may also gain important hands-on experience under obstetrical supervision.

9 See footnote #8 above

10 Where thick or particulate meconium is identified, delivery in hospital is indicated unless the membranes rupture so close to the time of birth that transport to hospital would be unsafe. The midwife should initiate appropriate surveillance of fetal well-being (see *Guideline for Fetal Health Surveillance in Labour*) and consult with a physician in hospital. Indicators such as a reassuring or non-reassuring fetal heart rate pattern will affect whether or not transfer of care during labour is indicated. With thick or particulate meconium, it is important to have a midwife or physician in attendance who is both skilled and prepared to intubate any nonvigorous newborn. In hospitals where pediatricians are available on-call, it is recommended that a pediatrician be consulted and in attendance at the birth.

11 Consultation may be with a physician or a nurse-practitioner

12 Consultation may be with a physician or a nurse-practitioner

13 Consultation may be with a physician or a nurse-practitioner

14 Consultation may be with a physician or a nurse-practitioner

15 Consultation may be with a physician or a nurse-practitioner

16 See footnote #4 on page 4

17 Discussion may be with another midwife, a physician, a nurse-practitioner or a lactation consultant.

18 Consultation may be with a physician or a nurse-practitioner.

19 Consultation may be with a physician or a nurse-practitioner

20 Consultation may be with a physician or a nurse-practitioner