COLLEGE OF MIDWIVES OF BRITISH COLUMBIA

SHARED PRIMARY CARE POLICY

In order to provide continuity of care and choice of birth place in a midwifery practice, primary care is normally shared by a small group of two to three (no more than four) midwives. In limited circumstances, such as where there is a solo practice or a small practice serving a large geographic area, or where the practice is serving a population with special needs, the College of Midwives may approve an arrangement where primary care may be shared by a midwife and a physician, or a midwife and a nurse practitioner.

Shared primary care shall be provided in accordance with the *Philosophy of Care* of the College of Midwives of British Columbia. Midwives entering approved shared care arrangements with physicians or nurse-practitioners must share this document with those practitioners and discuss its practical implications for sharing care[1].

Minimally, both the midwife and the physician, or other shared care provider[2], involved in a woman's care must plan to see the woman for at least two antenatal visits[3], ideally at least one of which is a visit in the third trimester of pregnancy, in order to be on call as the primary care provider for her birth. Only a midwife or a physician can assume the role of primary care during the intrapartum period.

All primary care providers involved in a woman's care must offer care consistent with the College's *Continuity of Care Policy* and the *Midwifery Model of Practice.* If a group of shared care providers wishes to provide care in an alternative model, they must apply and be approved to provide care in this alternative model under the policy *Midwifery Pilot Projects to Serve Women with Diverse Needs.*

A shared care system as described in the *Midwifery Model of Practice* must be in place to ensure the coordination of each woman's and newborn's care.

College approval of shared primary care arrangements will be made based on the following criteria:

1. Demonstrated need for a shared primary care arrangement, for example:
    a) insufficient number of midwives in an area to provide on-call coverage for clients;
    b) geographically remote location;
    c) practice covers a large geographical area;
    d) practice serves a community with special needs.

[1] For example, whether or not physicians will be involved in attending home births, and if not, how choice of birth place will be supported. Note: In order to attend a home birth with a physician as a part of an approved shared care arrangement, a midwife must confirm that the physician is currently trained in NRP and CPR.

[2] A nurse practitioner cannot take on the primary care role in the intrapartum period, but may act in the role of an approved second birth attendant.

[3] Or have equivalent one-to-one contact with the woman (e.g. through a centering pregnancy model of care) to have the opportunity to develop a relationship of trust

2. Evidence that the shared care arrangements are consistent with the College's *Philosophy of Care* and the *Midwifery Model of Practice.*
3. Demonstrated support from the community.

Midwives must apply to the College for approval of any shared care arrangements where the care of the woman and/or newborn is within the scope of practice of the midwife and the shared care is not a result of consultation or transfer of care consistent with the College's *Indications for Discussion, Consultation and Transfer of Care.*

A midwife who is working with a physician in an approved shared care arrangement may work with that physician as a second birth attendant without additional second attendant approval from the College.