College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

Jurisprudence Course Handbook

Important Principles Midwives Need to Know

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Introduction

The purpose of this handbook is to provide information on the ethical and legal framework within which midwives practise in Ontario.

This handbook will first discuss the concepts of professionalism and self-regulation. The *Midwifery Act, 1991* is based on these concepts. The handbook will then look at the requirements for midwives under the *Regulated Health Professions Act, 1991* and the *Midwifery Act, 1991*. The handbook will explore how proper communication with clients and colleagues is fundamental to a professional practice. For example, informed choice is not possible without it. The handbook will then review the role of the College in the regulation of the profession, including the registration of midwives; complaints, discipline, and incapacity matters; and quality assurance activities. Finally, the handbook will set out the various additional laws that midwives are most likely to have to deal with in their practice.

In this handbook a number of Acts are referred to by their abbreviations, including the following:

- AODA - *Accessibility for Ontarians with Disability Act, 2005*
- HCCA - *Health Care Consent Act, 1996*
- HPPC – Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act, 1991*)
- PHIPA – *Personal Health Information Protection Act, 2004*
- PIPEDA – Personal Information Protection and Electronic Documents Act
- RHPA – *Regulated Health Professions Act, 1991*

Other abbreviations and short forms include the following:

- the College – the College of Midwives of Ontario
- CAS – Children's Aid Society
- CCB – Consent and Capacity Board
- ICRC – Inquiries, Complaints, and Reports Committee
- QA – Quality Assurance
- HPARB – Health Professions Appeal and Review Board

1. Professionalism And Self-Regulation

A profession is different from a business. Members of a profession believe that they, both individually and as a group, help clients. Midwives have a number of duties to their clients. For example, midwives have the duty to be honest with clients. Midwives also have a duty to provide high quality care to clients. In addition, midwives have a duty to collaborate with their clients on their care and to ask for their clients' agreement before providing care.

Being a member of a profession also means that midwives have a duty to other members of the profession. Midwives have a duty to be courteous and work with fellow midwives to serve the welfare of their clients. For example, midwives have to coordinate the continuity of care for clients they are treating as a team.

Midwives also have a duty to work with their regulatory College to protect the public from dishonest or incompetent midwives. As such, midwives are required to cooperate in an investigation of a complaint.

Professionals must also obey the laws that apply to their profession and there are many different laws that pertain to midwives. This handbook describes some of these laws in a general way so that midwives understand the basic principles. It does not cover all of the exceptions and special circumstances that arise in real life. If a midwife has a specific legal question about their own circumstances, they should seek advice from a lawyer.

a) The concept of self-regulation

The "regulation" of an activity means that the law imposes restrictions on it to ensure the public is, first, not harmed and, second, that the client actually benefits. There are many ways in which an activity or profession can be regulated. For example, the government could choose one of the following options:

1. No regulation at all. This allows the market to determine which activities or practitioners will be chosen.
2. Consumer protection legislation. For example, buying a membership with a fitness centre is governed by Ontario's *Consumer Protection Act, 2002*.
3. Direct government regulation. The government could have the Ministry of Health regulate the midwifery profession just like it regulates laboratories.
4. Self-regulation. The government can delegate to a profession under an Act the authority to regulate itself.

   In Ontario, most professions are self-regulated. In many other parts of the world, professions are regulated directly by the government or through general consumer protection laws.

   Being self-regulated means that the majority of the members of the College's governing Council are elected by the midwifery profession. In addition, the majority of the members of almost all College committees are members of the midwifery profession elected or appointed to those committees by the Council of the College.

The Council is the Board of Directors of the College. The Council establishes the policies of the College (e.g., it makes the professional misconduct regulation) and oversees the administration of the regulatory activities of the College (e.g., it establishes the budget for the quality assurance program of the College). The College operates through committees (e.g., the Registration Committee, the Discipline Committee).

Self-regulation ensures that the regulatory actions of the College are informed by the expertise and specialized knowledge of the midwifery profession. Self-regulation also helps to ensure that the profession accepts and supports the regulatory actions of the College because it has such a large say in them.

The mandate of the College is to serve the public interest. However, there is always a concern under the self-regulation model that the profession will look after its own interest rather than the public interest. To ensure that this does not occur, the *Regulated Health Professions Act, 1991* (RHPA) has numerous safeguards including the following:

i. The College has an explicit mandate under the RHPA to serve the public interest. This is found in the "objects" clause establishing the College.
ii. The College has a duty to report to the Minister of Health and to consider recommendations and implement directions from the Minister. The Minister has the right to audit the operations of the College. If the College is not acting in the public interest the Minister can appoint a supervisor to take over the role of the Council and senior College staff.
iii. The government has to approve any regulations proposed by the College before they take effect. Proposed regulations and many proposed by-laws have to undergo circulation and comment by the public and the profession before they are made.
iv. The government appoints individuals, who are not members of the midwifery profession, to the Council. These public members will also serve on College committees.
v. Decisions by the College in registration and complaints matters can be appealed to an independent body, the Health Professions Appeal and Review Board.
vi. Registration policies and procedures are reviewed by the Office of the Fairness Commissioner, an independent organization, to ensure that they are transparent, objective, impartial and fair.
vii. Decisions in discipline and fitness to practise matters can be appealed to the courts.
viii. Meetings of the Council of the College are open to the public. Discipline hearings are also public. There are rare exceptions to this rule such as where sensitive personal health information will be revealed.
ix. The College is required to publish its discipline decisions. That and other information about members of the midwifery profession must be placed on the public register which is available on the College's website.
x. The College must have a website setting out its roles, responsibilities, and regulatory activities.

These safeguards help ensure the College serves the public interest in a fair and open manner.

Given the public interest mandate of the College and the safeguards that are in place, professional members elected to the Council need to be careful about their role. Council members are like directors of a corporation who have a duty of loyalty and good faith to the mandate of their organization. Council members are not like politicians who represent and serve those who elected them. The only "constituent" of a Council member is the public as a whole.

In contrast to the College, professional associations advocate on behalf of the profession and in the interest of the members of the profession.

Sample Exam Question

What sentence best describes the respective roles of the College and a professional association?

i. The College serves the public interest, and a professional association serves the interests of the members of the profession.
ii. The College and a professional association both serve the public interest.
iii. The College and a professional association both serve the interests of the profession.
iv. A professional association directs the operations of the College.

The best answer is i. The College's mandate is to regulate the profession in order to serve and protect the public interest. Answer ii is not the best answer because a professional association is designed to serve the interests of their members. While a professional association cares about the public interest and often takes actions that assist the public interest, it is under no statutory duty to do so and is accountable only to its members. Answer iii is not the best answer because the College is not permitted to serve the interests of its members under its statute. While it tries to ensure it regulates its members sensitively and fairly and consults with its members, the College's mandate is the public interest. Answer iv is not correct. While the College consults with professional associations and considers seriously their views and respects their expertise, the College is not under the control of any professional association.

b) Ethics, professional standards, professional conduct, competence, and capacity

There are different categories of expectations on midwives. Each category guides the conduct and practice of midwives so that the public receives respectful and high-quality services. Each of the concepts of ethical behaviour, standards of practice, professional conduct, competence, and physical and mental capacity are slightly different. Midwives need to understand each of these concepts in order to meet their professional obligations.

Professional Standards

Professional standards describe the way midwives practise their profession. For example, it is a professional standard to assess a client before treating that client.

Sometimes the details of the professional standard are not formally outlined by the College. For example, the College may not have a document describing exactly how a midwife assesses a client. Often how the standard is applied changes with the circumstances (e.g., the answers the client gives to the midwife's questions will change how the assessment is done). Professional standards are learned through education, professional reading and learning, experience in practice and in discussions with other midwives. Professional standards are always changing.

However, to assist members, the College develops written publications discussing professional standards. These publications can have different names (e.g., Standards of Practice, Guidelines, Policies and Position Statements) depending on their context and purpose. The purpose of these publications is to remind midwives about the factors required to practise safely, ethically, and effectively. These publications are on the College's website and cover a wide variety of topics. While professional standards are not "law" in the same way a statute or regulation is, failing to comply with a published standard will often lead to a violation of the law or will result in professional misconduct.

An overview of midwifery professional standards is set out in the College document called the Professional Standards for Midwives.

Professional Misconduct

Professional misconduct is conduct that falls below the minimum expectations of a safe and ethical midwife. Professional misconduct is defined in either the statute or the regulations applying to midwives. The provisions in the statute and regulations are described in more detail below in the section on the Professional Misconduct Regulation. As noted above, many College publications will assist midwives to recognize how to avoid engaging in professional misconduct.

Engaging in professional misconduct can lead to disciplinary proceedings that could result in serious orders (e.g., a fine, suspension or even revocation of one's certificate of registration). It is very serious for a midwife to engage in professional misconduct.

Permitting Illegal Conduct Scenario

Deepika, a midwife, is registered with the College. Deepika's mother is no longer registered with the College. Deepika's mother sometimes drops into Deepika's midwifery practice to consult with clients (usually the children of her former clients) during the early stages of their pregnancy before Deepika takes over their care. The office assistant refers to Deepika's mother as "the grandma midwife" when booking clients. A client complains to the College when Deepika, rather than her mother, shows up at the delivery. Is Deepika at risk for her mother's conduct?

The answer is yes. It is professional misconduct to permit a person to hold themselves out as practising the profession when they are not registered. Deepika condoned the conduct occurring in her office. Deepika, by being registered, gave

credibility and status to the illegal conduct of her mother. Deepika could face a discipline hearing.

Incompetence

Incompetence is where a midwife shows a serious lack of knowledge, skill or judgment when assessing or treating a client. It is defined in the Health Professions Procedural Code (HPPC). Concern that a midwife is incompetent can be investigated by the College and can result in a discipline hearing. If the Discipline Committee finds a midwife to be incompetent, it can impose restrictions on the midwife's registration (e.g., prohibiting the midwife from doing certain things, such as being the primary midwife) or the Committee can suspend or revoke the midwife's registration.

In any investigation of incompetence, the College will usually look at the midwife's client's records. It will interview the client and the midwife and ask other midwives about their competence. Both the Committee investigating the concerns and the Discipline Committee will be comprised, in part, of midwives who know the difference between good and bad practice. The Committees will typically also have the benefit of independent expert opinions.

Incompetence Scenario

Donna, a midwife, does not really assess her clients. She just asks the client what is wrong and then gives all of them the same advice. A client, Paula, had a serious condition that Donna did not recognize. Paula's condition got worse. Donna still did not recognize it. After three months Paula went to the emergency department of the hospital and was immediately admitted for the remainder of her pregnancy. Paula complained to the College about Donna's incompetence. The Inquiries, Complaints and Reports Committee looked at Paula's health records and reviewed Donna's explanation for what she had done. It referred the case to the Discipline Committee. The Discipline Committee agreed that Donna showed a lack of knowledge, skill, and judgment. It ordered Donna to undergo significant remediation and to be closely monitored upon her return to practise.

Incapacity

Incapacity is defined in the Health Professions Procedural Code (HPPC). A midwife is incapable when they have a health condition that prevents them from practising safely. Usually, the health condition is one that prevents the midwife from thinking clearly. Even a midwife with a severe disability can practise safely so long as the midwife understands their limits and gets the necessary help. Most incapable midwives suffer from addictions or certain mental illnesses that impair the midwife's professional judgment. For example, a midwife who is addicted to alcohol or drugs may try to see clients when the midwife is impaired.

Incapable midwives are not treated as if they have engaged in professional misconduct or are incompetent. The investigation looks at the midwife's health

condition and the treatment they are receiving. The College can require the midwife to go for a specialist examination. If the concern is justified, the midwife is referred to the Fitness to Practise Committee for a hearing. The Fitness to Practise Committee can order the midwife to undergo medical treatment, have medical monitoring and/or restrict their practice. In an extreme case (e.g., where the midwife continues to see clients while impaired) the Fitness to Practise Committee can suspend or revoke the midwife's registration in order to protect the public.

Incapacity Scenario

Deepika, a midwife, has been drinking a lot more alcohol the last few months and has been hung-over while on-call and during clinic appointments. More recently she has been drinking during lunch breaks. One day Deepika comes back after lunch, drunk. Paula, a client, notices Deepika smells of alcohol and that Deepika is stumbling around the clinic. Paula tells the College. At first Deepika denies she has a problem. However, during the investigation, the College learns that some of Deepika's colleagues have noticed a significant change in Deepika's behaviour in recent months. The College also learned Deepika has been charged with impaired driving. The College sends Deepika to a medical specialist who diagnoses Deepika with a serious substance abuse disorder. The College encourages Deepika to go for treatment at the Homewood Health Centre and Deepika agrees. The matter is referred to the Fitness to Practise Committee. Deepika and the College agree to an order requiring Deepika to stop drinking, attend group meetings, see her new substance abuse specialist regularly, have a colleague monitor Deepika at work and send regular reports to the College.

Conclusion

Each of the above sections looks at different aspects of professional practice. Each section also serves a different purpose. Professional standards deal with ways to practise safely, effectively, and professionally. Professional misconduct deals with the minimum conduct necessary to avoid discipline. Incompetence deals with having an adequate level of knowledge, skill and judgment in the assessment and treatment of a client. Incapacity deals with health conditions that prevent a midwife from thinking clearly.

2. Requirements for Midwives under the Regulated Health Professions Act, 1991

There are a number of sources of law. They include:

- **Statutes.** Most often when one thinks of law, one thinks of statutes (also called Acts). In addition to regular statutes there are overriding statutes that take priority over other statutes such as the Canadian Charter of Rights and Freedoms. The statutes midwives need to be most aware of are the *Regulated Health Professions Act, 1991* and the *Midwifery Act, 1991*. In Ontario, statutes are made by the Legislative Assembly (in Ontario, the Legislative Assembly is often called Queen's Park).
- **Regulations**. Regulations are made by the government when permitted by a statute. Under the *Regulated Health Professions Act, 1991* regulations can be proposed by the College (e.g., Registration Regulation, Professional Misconduct Regulation, Quality Assurance Regulation, General Regulation, Designated Drugs Regulation) or by the Minister of Health (e.g., Controlled Acts Regulation, regulations dealing with professional corporations).
- **By-laws.** By-laws are made by the Council of the College. They deal primarily with the internal operations of the College. Some by-laws affect members (e.g., fees, professional liability insurance, information that must be provided by midwives to the College, additional information that could be put on the public register, election of midwives to the Council of the College).
- **Case Law**. Court decisions are used as a guide by lawyers and judges when similar issues arise in the future. Courts try to be consistent, so long as the result is not unfair. Court decisions are particularly important on guiding the procedure of College committees (e.g., investigations by the Inquiries, Complaints and Reports Committee, hearings by the Discipline Committee).
- **Guiding documents.** While they are not binding laws themselves, the College publishes official documents, usually called Standards of Practice, Policies or Guidelines. Written Standards of Practice set out the general expectations for the safe, legal, and ethical practice of the profession. Policies and Guidelines help Midwives and College committees understand and interpret the laws that govern the profession. Midwives should read and understand the College's guiding documents.

  The *Regulated Health Professions Act, 1991* is the statute that governs all of the regulated health Colleges in Ontario. Together with the Health Professions Procedural Code (which is a schedule to the RHPA), the RHPA sets out the duties and responsibilities of the Minister of Health, the Colleges and each of the Colleges' committees. The RHPA also imposes a number of obligations on the members of regulated health professions, including midwives.

c) Mandatory reports

Part of being a member of a regulated health profession is that one cannot remain silent when another health care practitioner is harming a client. Practitioners must speak up when client health and safety is at risk. The RHPA carefully balances the need to protect clients by requiring practitioners to make a report against the need to avoid disrupting the health care system with many unnecessary reports. The statute also recognizes that if

practitioners unnecessarily report on their colleagues, it will harm the supportive atmosphere necessary for interprofessional collaboration.

Both the RHPA and case law provide immunity (i.e., legal protections) to practitioners who make a mandatory report in good faith. For example, they cannot be successfully sued for damages. Retaliation against people making mandatory reports is prohibited and any such retaliation would likely constitute professional misconduct.

The mandatory reporting requirements also create an exception to the practitioner's usual duty of confidentiality. In addition, *the Personal Health Information Protection Act, 2004* permits a report to the College to be made as an exception to the privacy duties under that statute.

Sexual Abuse

A midwife must report sexual abuse of a client by another health care practitioner. The duty arises if the midwife has reasonable grounds to believe the sexual abuse occurred and the midwife obtained this information in the course of practising the profession or while operating a health facility (which probably includes an office or clinic). The reasonable grounds could arise even if the midwife did not personally observe the sexual abuse. For example, if a client tells the midwife details of the abuse, it would likely constitute reasonable grounds. A midwife does not have to investigate the events first nor does the midwife have to actually believe that the information is true (e.g., the midwife might know the alleged abuser and cannot believe that they would do such a thing). If the information constitutes reasonable grounds, the report must be made. Reasonable grounds means information that would cause a reasonable person who does not know the individual involved to conclude that it is more likely than not that the information is correct.

The report must be made in writing to the Registrar of the College to whom the alleged sexual abuser belongs. The report has to contain the reporting midwife's name and the grounds of the report. However, the report cannot contain the client's name unless the client agrees in writing that the name can be included. This limitation is intended to protect the privacy of clients who may be in a vulnerable position. The report must be made within 30 days of receiving the information. If it appears that clients are continuing to be harmed and there is an urgent need for intervention, the report must be made right away.

Sexual Abuse Mandatory Report Scenario

Donna, a midwife, is told by Paula, a client, that Paula had an affair with her family doctor. Donna asks Paula if her family doctor was treating her while the affair was ongoing. Paula says yes. Donna tells Paula that she is required by law to report this information to the Registrar of the College of Physicians and Surgeons of Ontario (CPSO). Donna explains that the CPSO will want to investigate the report. It will be very difficult for the CPSO to investigate the report if Paula's name and contact information are not included in the report. The CPSO will likely want to interview Paula about the affair. The investigation could lead to a discipline hearing. However, the law is clear that Donna cannot include Paula's name and contact information

unless Paula is prepared to sign a written consent permitting Donna to do so. Donna says that they can call the CPSO right now, on an anonymous basis, to see what the process would be like. Paula agrees to the telephone call. After the call is completed, Paula says that she will not give her consent to include her name and contact information. Donna then provides the report in writing without identifying Paula.

Incompetence, Incapacity and Professional Misconduct

A midwife must make a report where they restrict the practise or ends a business relationship with another health care practitioner on the basis that the other health care practitioner is incompetent or incapacitated or engaged in professional misconduct. Examples of business relationships include employer-employee, partners, partner-associate, and shareholders in a professional corporation or space-sharing arrangements. The report must be made even if the person quit or resigned first; if the midwife was going to make a report it must still be made.

The report must be made in writing to the Registrar of the College that regulates the other health care practitioner. The report must be made within thirty days of ending (or proposing to end) the business relationship. Under this mandatory reporting obligation, the name of any client involved can be included without the client's consent.

In addition, if a midwife operates a health facility (which probably includes an office or clinic), the midwife must report any reasonable grounds to believe that another health care practitioner is incompetent or incapacitated.[1] This report must be made even if the business relationship with the other health care practitioner has not ended. For example, if a health care practitioner at the facility is found to have a drug addiction and goes into a treatment program while the job is kept for them, the report would still have to be made.

Again, the report must be made in writing to the Registrar of the College to whom the alleged incompetent or incapacitated health care practitioner belongs. The report has to contain the reporting midwife's name and the grounds of the report. Under this mandatory reporting obligation, the name of any client involved can be included without the client's consent. The report must be made within 30 days of receiving the information. If it appears that clients are continuing to be harmed, the report must be made right away.

In addition, midwives are also required to self-report any finding of professional misconduct or incompetence made against them by another regulatory body, in or outside of Ontario.

[1] This duty to report, unlike the termination reports discussed above, does not apply if the person just committed professional misconduct but is not incompetent or incapable (e.g., the health care practitioner published a misleading advertisement).

Incompetence, Incapacity and Professional Misconduct Mandatory Report Scenario

Deepika, a midwife, learns that her practice partner, is an alcoholic. Deepika tries to help her partner get treatment, but the partner keeps relapsing. Yesterday the partner came back after lunch impaired, and Deepika had to call her partner's spouse to pick her up and take her home. As a result, Deepika had to cover for her partner with the clients. What scared Deepika the most was that her partner saw three clients after lunch before Deepika found out about her condition. Deepika wants to end her professional relationship with her partner. She consults a lawyer about how to dissolve the partnership. Deepika's lawyer advises her that Deepika must make a written report to the Registrar of the College.

Offences – Self Report

Midwives have to report themselves when they have been criminally charged or have charges laid against them under the *Health Insurance Act, 1990* or the *Controlled Drugs and Substances Act*. Current conditions or restrictions imposed by a court or other lawful authority to a midwife's custody or release must be reported. Midwives must also report themselves when they have been found guilty of an offence. All offences are supposed to be reported. Therefore, criminal offences, offences under federal drug or other legislation and provincial offences (including highway traffic offences) need to be reported. Only courts can make offence findings. Thus, any findings by a body that is not a court (often called "tribunals") do not have to be reported under this provision. All findings of guilt must be reported even if they did not result in a conviction (i.e., a finding of guilt that leads to an absolute or conditional discharge is not a conviction).

Reports are to be made to the Registrar of the College as soon as possible after the finding and should contain the following information:

- the name of the midwife filing the report;
- the nature of, and a description of the offence;
- the date the charges were laid against the midwife, or the midwife was found guilty of the offence;
- the name and location of the court in which charges were laid or that the midwife was found guilty of the offence; and
- the status of any appeal initiated respecting the finding of guilt.

The report will be reviewed by the College and may result in an investigation. However, the report is not automatically put on the public register (see the discussion of the register below).

If there is an appeal that alters the information reported, an updated report must be made.

Offence Mandatory Report Scenario

Donna, a midwife, is found guilty of failing to wear a seatbelt under the *Highway Traffic Act*. Six months later, on the College's annual renewal form she sees a question asking if she has been found guilty of any offence. She cannot believe that this question is meant to include her seatbelt charge. She calls the College for clarification. Donna is told that the *Regulated Health Professions Act, 1991* requires all

offences to be reported. The intent of requiring such reports was to prevent midwives from determining whether the findings were relevant or not. That decision is to be made by the College. In fact, Donna should have reported the finding when it occurred and not waited six months for the annual renewal form. Donna makes the report. A few weeks later she receives a letter from the College thanking her for her report, stating that the College does not believe that this finding is worth investigating further and reminding her that in future such findings need to be reported right away.

Professional Negligence – Self-Report

Midwives have to report themselves when they have been sued and found to have engaged in professional negligence or malpractice. Findings of professional negligence or malpractice are only made by the courts. Thus, any findings by a tribunal do not have to be reported under this provision. If a lawsuit is settled, it does not have to be reported unless the settlement involved a court finding of professional negligence or malpractice.

Reports are to be made to the Registrar of the College as soon as possible after the finding and should contain the following information:

- the name of the midwife filing the report;
- the nature of, and a description of the finding;
- the date of the finding;
- the name and location of the court that made the finding; and
- the status of any appeal initiated respecting the finding.

The report will be reviewed by the College and may result in an investigation. The report is automatically put on the public register (see the discussion of the register below).

If there is an appeal that alters the information reported, an updated report must be made.

Professional Negligence Mandatory Report Scenario

Deepika, a midwife, is sued in Small Claims Court by a client, Paula. Paula claims that she told Deepika about pain in her lower abdomen, but that Deepika attributed those symptoms to stress associated with Paula's pregnancy. After two weeks of supportive treatment for the stress, despite increasing pain, Paula went to the emergency department. Paula was rushed into surgery for appendicitis and stayed in the hospital for almost a week. Paula claims Deepika should have referred Deepika to another health care practitioner to rule out appendicitis before assuming the symptoms were purely stress related. The Small Claims Court judge agreed and ordered Deepika to pay Paula $10,000 for her malpractice. Deepika reports the finding to the College. The College places a note about the finding on the public register.

Duty to Warn

Under case law, a midwife who has reasonable grounds to believe that another person is likely going to cause severe bodily harm has to warn the appropriate people of the risk. This duty applies even if the person who will likely cause the harm

is the client of the midwife. For example, if a client threatens to kill someone and has the means to do so (e.g., is believed to have a gun), the midwife should advise the police and, where feasible, the subject of the threat.

Duty to Warn Mandatory Report Scenario

Donna, a midwife, has a client, Paula, who is having serious difficulties with her spouse, Peter. Paula reports that Peter can be violent. So far, the reports have been vague. One day Peter comes storming into the office demanding to know where Paula is. Peter is yelling profanities that are violent and says "Don't expect Paula to come back here, or anywhere else ever again." He storms out shouting "I am going to kill that b----." Donna calls the police and leaves a message for Paula on her cell phone.

Sample Exam Question

Is a mandatory report required where a midwife overhears a physician at a hospital tell two male clients a sexually explicit joke that causes the clients to laugh loudly?

i. No. Sexually explicit jokes are not sexual abuse.
ii. Yes. This is sexual harassment. The report should be made to the Human Rights Tribunal.
iii. No. The clients liked the joke and would not have been harmed by it.
iv. Yes. This constitutes sexual abuse and should be reported to the physician's regulatory College.

The best answer is iv. Sexual abuse includes comments of a sexual nature to a client. Reporting sexual abuse is mandatory. While it is unlikely that punitive action will be taken by the College (perhaps the physician will receive a caution or be asked to complete a sensitivity course), it is still important that health care practitioners learn that such conduct can be harmful to clients. One never knows what experiences clients have had in their past that might make even a sexually explicit joke harmful. Answer i is incorrect because sexually explicit jokes are sexual abuse as that term is defined in the *Regulated Health Professions Act, 1991.* Answer ii is not the best answer because there are no mandatory reporting requirements under the Human Rights Code. Also, the *Regulated Health Professions Act, 1991* uses the term sexual abuse rather than sexual harassment and gives that term a unique meaning. Answer iii is not the best answer because whether the client was a willing participant or not is irrelevant. The comment still should not have been made. In addition, sexualizing the practice of the profession is inherently confusing to clients who assume that there is not a sexual aspect to their relationship with their health care practitioner.

For additional information regarding mandatory reports, refer to the College's Guide on Mandatory and Permissive Reporting. Its content will be part of the jurisprudence exam.

d) Public register

The *Regulated Health Professions Act, 1991*requires that the public have access to certain information about midwives through the College's register.

The register is a complete listing of midwives that have been registered with the College. Its purpose is to provide clients and the public with information about Ontario midwives, which may assist them in deciding who to choose for their care. In addition, the register assists in ensuring that midwives practise only as they are permitted to. For example, if a midwife is suspended for three months, people can more easily report to the College if the midwife is still working during the suspension period when the suspension shows on the public register.

The register must contain the following information about each midwife:

- Name;
- Business address and telephone number;
- Name and business address and telephone number of each professional corporation
- Class of registration;
- Any terms, conditions, and limitations on the registration;
- Every caution that the midwife has received from a panel of the Inquiries, Complaints and Reports Committee
- Referrals to the Discipline Committee for a discipline hearing;
- Specified allegations against the midwife for every matter that has been referred to the Discipline Committee and that has not been finally resolved;
- Any acknowledgements and undertakings in relation to matters involving allegations of professional misconduct or incompetence that the midwife has entered into with the College and that are in effect;
- A summary of every finding of professional misconduct, incompetence or incapacity;
- Findings by a court of professional negligence or malpractice;
- Every suspension of registration;
- Every revocation of registration;
- Any agreement to resign and never reapply for registration; and
- Any other information that the by-laws say should go on the register.

The College's by-laws provide that additional information must also be placed on the public register, including hospitals, birth centres and facilities at which midwives hold privileges and the results of discipline proceeding made in other provinces. These by-laws are constantly changing as society's expectations about what information should be available to the public evolve. In fact, in 2014 the Minister of Health wrote to all regulated health Colleges urging them to put more information about the complaints process on the public register. In response, the College's by-laws were updated providing further information on the public register, particularly with respect to the complaints process.

There are only a few circumstances where the College can choose not to put this information on the register or to remove information from the register. It can do so in the following circumstances:

- The information (e.g., contact information) would jeopardize the safety of a midwife (e.g., if a midwife is being stalked).

- The information is obsolete or no longer relevant (e.g., the finding of professional misconduct related to conduct that is now acceptable, for example if a midwife was prosecuted for misleading advertising but the advertising rules happen to change).
- Unnecessary information about the personal health of a midwife (e.g., in incapacity matters).
- After six years, where there was only a reprimand, a fine or a finding of professional misconduct or incapacity and the Discipline Committee or Fitness to Practise Committee agrees that there is no public interest in keeping the information on the register.

The register is available to the public in a number of ways. It is on the College's website. It is available at the College's office. A paper copy can be requested. The College can also give information available on the register over the telephone. Where a person asks about a midwife, the College must help the person find whatever information that person wants that is on the register.

Public Register Scenario

Donna, a midwife, has separated from her partner. Donna's partner hit her a number of times. Since the separation, Donna's partner has been following her. The police have not been able to stop him. Donna moves to another city. She asks the Registrar not to put her business address or telephone number on the public register so that Donna's partner cannot find her. Donna provides documents from the police and the courts about her partner's behaviour. The Registrar removes Donna's contact information from the register.

e) Professional corporations

Midwives can choose to practise personally (i.e., in their own names), through a partnership or through a professional corporation (i.e., a special type of corporation for regulated health professionals). Midwives cannot practise through regular business corporations; they can only practise through a professional corporation.

Professional corporations have a number of conditions and restrictions. These include the following:

- only midwives can hold shares;
- the officers and directors of the professional corporation must be shareholders;
- the name of the professional corporation must include the words "Professional Corporation";
- the professional corporation cannot be a numbered company (e.g., 1234567 Ontario Inc.); and
- the professional corporation can only practise the profession or provide related or ancillary services. It cannot, for example, practise another profession like registered massage therapy.

Midwives cannot avoid professional liability through a professional corporation. Clients who are injured can sue the midwife personally. However, midwives working through a professional corporation do have protection against trade creditors. For example, if

suppliers or other creditors of a midwifery professional corporation are not paid by the professional corporation, they cannot sue the midwife personally.

A number of provisions have been made to prevent midwives from hiding behind the professional corporation when facing questions from the College. These include the following:

- the RHPA applies to midwives despite their practising through a professional corporation;
- a midwife's fiduciary (i.e., loyalty and good faith) and ethical obligations to clients remain in place and now apply equally to the professional corporation as well;
- during investigations and other proceedings involving midwives, the College has the same powers over the professional corporation (e.g., access to premises and documents) as it does over the midwife;
- any monetary orders against midwives are also payable by the professional corporation;
- any duty to a client, the public or the College takes precedence over the duties of the midwife as an officer or director of the professional corporation;
- any terms, conditions and limitations against a midwife apply to the professional corporation as well; and
- any knowingly false representation made to obtain a certificate of authorization is an offence.

Professional corporations have to obtain from the College a "certificate of authorization," similar to a certificate of registration, for individual midwives. To obtain a certificate of authorization, a midwife goes through the following process:

- Select a name for the professional corporation. Ministry regulations require that the name must contain the surname of at least one shareholder (as set out in the College register). The name can also include the person's given name and initials. The name of the corporation must also indicate the name of the member's health profession (i.e., "Midwifery"). The name must also include the words "professional corporation". The name cannot include anything else.
- The professional corporation must then be incorporated with the government. This involves preparing articles of incorporation, corporate by-laws, paying a fee and submitting an application form with the government. If the paperwork is acceptable the government will issue a corporation profile report and a certificate of incorporation.
- Within 30 days of obtaining one's corporation profile report, the professional corporation must apply to the College for a certificate of authorization. Such an application will require the following:
    - Completing the application form that can be obtained from the College. The application form will require the name, registration numbers and addresses of each shareholder. The application form will require the applicants to specify which shareholders hold which positions with the corporation. The business premises or practice locations of the corporation will have to be identified.
    - Paying the fee required by the College in its by-laws.

- Enclosing a copy of the corporation profile report issued by the Ministry that is no more than 30 days old.
- Enclosing a copy of the certificate of incorporation issued by the government.
- Providing a written declaration from a director of the corporation that was completed not more than 15 days before the application date that certifies the accuracy of the documents submitted with the application and that the corporation will only practice the profession or related or ancillary activities.

Once incorporated, the corporation must notify the College immediately if its name or articles of incorporation change. Also, the College needs to be notified promptly of any change in shareholder, officer, or director of the professional corporation or if the corporation changes its location or locations of practice. Each year the professional corporation must renew its certificate of authorization. The renewal process involves completing the same sort of paperwork as was involved in the initial application. The renewal process updates the information about the corporation and its shareholders.

A certificate of authorization can be revoked if it does not follow the rules.

> The College cannot give advice to midwives as to whether a professional corporation is good for them. Midwives will need to obtain advice from their own accountants or lawyers.

Professional Corporation Scenario

> Deepika, a midwife, wants to set up a professional corporation. As part of her practice, she works with a number of nurse practitioners. She asks the nurses if they want to become shareholders of her professional corporation. They say yes. Deepika also wants family members to be non-voting shareholders so she can split her income for tax purposes. She goes to her lawyer who says that only registered midwives can be shareholders, officers, or directors of a Midwifery professional corporation. Even non-voting shareholders must be registered with the College.

3. Professional boundaries and Sexual abuse

In order to understand the nature of professional boundaries and the harm that can result from crossing boundaries, including sexual abuse, it is useful to consider the applicable core concepts.

Trust

The professional relationship between a midwife and a client is based on trust. The client must feel safe with the midwife in order for the midwife to provide the best possible care. Safety is not limited to physical safety. A fear, no matter how misguided, that a midwife may disclose the client's personal health information means that the client will not provide the information needed by the midwife. Similarly, a concern that the midwife is judging the client may result in the client answering questions incompletely or inaccurately.

Power

The midwife-client relationship involves a power imbalance in favour of the midwife. The client comes to the midwife in a position of need. In large part, the client chooses a midwife to ensure that they and their baby are kept safe. As such the client is highly dependent on the expertise and judgment of the midwife. The client has to disclose personal information about themselves to the midwife. (In contrast, the midwife is not expected to – and indeed usually should not – disclose personal information about themselves to the client). The midwife will usually have to touch the client's body, which involves a high degree of intimacy and vulnerability. The client may feel under scrutiny as the midwife examines their body. The client may have a sense that their body, values, or beliefs are unusual.

Pregnancy, birth, and the postpartum period are emotional experiences, which can increase the power imbalance. This may be further increased if the client is in discomfort or pain or does not speak the same language as the midwife.

This is not to say that the power differential between the midwife and the client is always significant. Some clients will feel quite comfortable and in control of the interactions. However, the clients that feel most vulnerable are at risk of significant harm from any boundary crossing or sexual abuse.

Choice

A fundamental concept of both our legal and health care systems is that clients should have control over their bodies and their healthcare. In part, this balances the power of the midwife. The authority of the client to control their body and their healthcare requires that they be provided informed choice for all care decisions.

Principles

As a result of these foundational concepts, the following principles apply:

1. The midwife must always act in the client's best interests.
2. It is the midwife's responsibility to maintain professional boundaries. The client is not co-responsible.
3. Failing to maintain boundaries can affect the quality of the outcome for the client.
4. Crossing boundaries can harm clients and can compromise the public's trust in the profession.
5. Clients must be protected from sexual abuse.

Boundaries

During each visit, midwives must be careful to act as a professional health care practitioner and not as a friend. Becoming too personal or too familiar with a client is confusing to clients and can make them feel uncomfortable. Clients will be uncertain as to whether the professional advice or services are motivated by something else other than the best interests of the client. It is also easier for a midwife to provide care when there is a "professional distance" between them (e.g., telling the client the truth about the client's options and limitations).

It is a delicate balance between maintaining a suitable professional distance and being engaged with the client. Being too distant or too close can compromise the client's care.

Maintaining professional boundaries is, however, also about being reasonable in the circumstances. For example, one should be careful about accepting gifts from clients, but there are some circumstances in which it is appropriate to do so (e.g., a token New Year's gift from a client). In other areas, however, crossing professional boundaries is never appropriate. For example, it is always professional misconduct to engage in any form of sexual behaviour with a client.

The following are some of the areas where midwives need to be careful to maintain professional boundaries.

Self-Disclosure

When a midwife shares personal details about their private life, it can confuse clients. Clients might assume the midwife wants to have more than a professional relationship. Self-disclosure often suggests the professional relationship is serving a personal need for the midwife rather than serving the client's best interests. Self-disclosure can result in the midwife becoming dependent on the client to serve the midwife's own emotional or relationship needs, which is damaging to the relationship.

Self-Disclosure Scenario

Paula is having difficulty deciding whether to marry her boyfriend and talks to Donna, her midwife, about this issue a lot during their visits. To help Paula, Donna decides to tell Paula details of her own doubts about accepting the proposal from her first husband. Donna tells of how those doubts had long-term consequences, gradually ruining her first marriage as both she and her husband had affairs. Paula is offended by Donna's behaviour and decides to go elsewhere for care, which is not the best option for Paula given the advanced stage of her pregnancy.

Giving or Receiving of Gifts

Giving and receiving gifts is potentially dangerous to the professional relationship. A small token of appreciation by the client purchased while on a holiday or given at the end of the midwifery course of care is not unusual. In addition, one must be sensitive to the client's culture where refusing a gift could be considered to be a serious insult. However, anything beyond small gifts can indicate the client is developing a personal relationship with the midwife. The client may even expect something in return. Gift giving by a midwife will often confuse a client. Even small gifts of emotional value can confuse the client even though the financial value is small. While many clients would find a holiday card from a midwife to be a kind gesture, some clients might feel obliged to send one in return. So even here, thought should be given to the type of clients in one's practice (e.g., some clients might be unfamiliar with the tradition).

Gift Giving Scenario

Donna, a midwife, has a client with a large family, many of whom need Donna's services. The client brings food on every visit. Donna thanks her but tries not to treat it as an expectation. On one visit Donna happens to mention her home-made pizza recipe. The client insists that Donna bring it over to her house for Thanksgiving. Donna politely declines, giving the client a written recipe instead. The client stops bringing in food, is less friendly during visits and starts missing appointments. Donna did not do anything wrong in this scenario, but this shows the confusion that can occur with a client when boundaries start to be crossed.

Dual Relationships

Midwives may be asked to provide care to persons with whom they have an existing relationship, such as family members, colleagues, or friends. In such cases, there would be a dual relationship between the midwife and the client (e.g., midwife and friend; midwife and practice partner; midwife and cousin).

Before providing care to a person with whom the midwife has a dual relationship, the midwife must consider the potential conflicts and risks that may arise. Both the midwife and the client should consider how the personal relationship might affect the midwife's quality of care and interfere with their professional role.

It should be noted that midwives are prohibited from providing midwifery care to persons with whom the midwife has a sexual relationship (including spouses). This is discussed below in the section entitled "Sexual Abuse".

Where a midwife does provide care to a person with whom the midwife has a dual relationship, special safeguards are essential (e.g., discussing the dual relationship with the client and agreeing with the client to be formal during visits and never talk about health issues outside of the office). Should the midwife or client believe that the personal relationship compromises the midwife's judgment or ability to provide quality care, the midwife must have mechanisms in place to be able to transfer the client's care.

The College has a document on Mediating Risk in Caring for Related Persons and Others Close to Midwives which helps midwives decide when and how to provide care to individuals whom they have a pre-existing relationship with. It is linked on the last page of this handbook and will form part of the jurisprudence exam, along with the College's other written Standards of Practice.

Dual Relationship Scenario

Donna, a midwife, has Paula as a client. Paula is self-employed as a house cleaner. Donna decides to hire Paula to clean Donna's house. Donna also recommends Paula to some of Donna's friends who also hire Paula. Paula is extremely grateful. Donna has a large family gathering for a wedding and asks Paula to clean her house on a specific date. Paula, who was planning to visit family in the United States then, feels that she cannot say no or else she will lose her job cleaning the houses of Donna's friends. Paula is also trying to get pregnant again and needs to be able to use Donna's services. The dual relationship may have contributed to Paula's concerns.

Becoming Friends

Becoming a personal friend with a client is a form of a dual relationship. Clients should not be placed in a position where they feel they must become a friend of the midwife in order to receive ongoing care. Midwives bear the sole responsibility to not allow a personal friendship to develop during professional visits. It is difficult for all but the most assertive of clients to communicate that they do not want to be friends.

Ignoring Established Customs

Established customs usually exist for a reason. Ignoring an established custom confuses the nature of the professional relationship. For example, appointments are usually held during regular business hours at the midwife's clinic or proposed place of birth. Meeting the client after hours or at an unusual location (e.g., a restaurant) is outside of the usual practice approach. By ignoring this custom, the client might begin thinking the meeting is a social visit. Or the client might feel they have to pay for the meal. Treating clients as special, or different from other clients, can be easily misinterpreted.

Personal Opinions

Everyone has personal opinions, and midwives are no exception. However, midwives should not use their position to promote their personal opinions (e.g., religion, politics or even lifestyle) on clients. Similarly, strongly held personal reactions (e.g., that a client is unpleasant and obnoxious) should not be shared. Disclosing personal reactions does not help the professional relationship.

Personal Opinions Scenario

A client named Paula is discussing world events. She pushes her midwife Donna for her views on immigration. At first Donna resists, but eventually says she has some concerns about the abuses of the immigration system. Donna says she has heard, often directly from clients, about how they have lied to the immigration authorities. Paula responds by loudly criticizing the immigration authorities for allowing too many immigrants into the country. Paula is overheard by other clients in the clinic at the time, including some who are new Canadians. The other clients tell other staff at the clinic they feel uncomfortable with either Donna or Paula around.

Touching and Disrobing

Touching can be easily misinterpreted. A client can view an act of encouragement by a midwife (e.g., a hug) as an invasion of space or even a sexual gesture. Extreme care must be taken in any touching of clients. The nature and purpose of any clinical touching must always be explained first, and the client should always give consent before the touching begins. The client can withdraw consent at any time.

The most common clinical touching in midwifery is of the breasts, abdomen, and genital areas of the client, which are inherently sensitive. The degree of discomfort of such touching varies with the personality, age, gender, and culture of the client. Such touching should never be a surprise to the client. While this advice applies to all clients, it is important to keep in mind that some clients have suffered physical or sexual abuse. Any sudden or unexpected touching of the client could be startling and upsetting. The midwife should ensure that the client consents to all touching at the time.

In addition, draping of clients for examinations is important. Midwives should also consider discussing the client's privacy expectations during labour at a prenatal appointment to avoid misunderstandings.

Managing boundaries is important for both midwives and clients.

Sexual Abuse

The *Regulated Health Professions Act, 1991* (RHPA) is designed to eliminate any form of sexual contact between midwives and clients. Because of the status and influence of midwives there is potential for any sexual behaviour to cause serious harm to the client. Even if the client consents to the sexual behaviour, it is prohibited for the midwife.

The term "sexual abuse" is intended to convey how seriously the conduct is taken. However, it should not be thought that only deliberatively exploitative conduct is captured by the phrase. In fact, sexual abuse includes conduct that might, on the surface, appear to be genuine and sincere.

The term "sexual abuse" is defined broadly in the RHPA. It includes the following:

- sexual intercourse or other forms of physical sexual relations between a midwife and a client;
- touching, of a sexual nature, of the client by a midwife; or
- behaviour or remarks of a sexual nature by a midwife towards the client.

There is an exception for touching, behaviour, or remarks of a clinical nature (e.g., an appropriate internal examination). To safely fall within the exception the client should clearly understand and consent to the nature and reason for the touching or comment before it occurs.

For example, telling a client a sexual joke is sexual abuse. Hanging a calendar on the wall with sexually suggestive pictures (e.g., a provocative "fire fighters" calendar) is sexual abuse. Non-clinical comments about a client's physical appearance (e.g., "guys won't be able to keep their hands off of you") are sexual abuse. Dating a client is sexual abuse. Unnecessary or inappropriate comments about a client's sexual orientation, gender identity or gender expression is sexual abuse. For example, insisting that a client who identifies himself as male use the women's washroom because the client is "really" a woman while he is pregnant is sexual abuse.

This definition of sexual abuse includes treating one's spouse as a client. While some Colleges, like the one that regulates dentistry, have made regulations permitting their members to treat their spouses, the College of Midwives of Ontario (like many other health Colleges) has not done so.

However, a midwife can treat their spouse or sexual partner and it will not be considered to be sexual abuse, if all of the following conditions are satisfied:

- At the time the midwife provides the health care service(s), a sexual relationship exists between the individual and the midwife.

- The midwife provided the health care service to the individual in emergency circumstances or in circumstances where the service is minor in nature.
- The midwife has taken reasonable steps to transfer the care of the individual to another regulated midwife or regulated health care professional or there is no reasonable opportunity to transfer care.

In these circumstances, the sexual partner to whom care is being provided is not considered to be a client of the midwife.

While sexual abuse only relates to clients, sexual misconduct towards other persons can constitute disgraceful, dishonourable, and unprofessional conduct. For example, flirting with the relative of a client would generally be unprofessional. So would sexual harassment of a colleague or employee.

It is always the responsibility of the midwife to prevent sexual abuse from occurring. If a client begins to tell a sexual joke, the midwife must stop it. If the client makes comments about the appearance or romantic life of the midwife, the midwife must stop it. If the client asks for a date, the midwife must say no (and explain why it would be inappropriate). If the client initiates sexual touching (e.g., a kiss), the midwife must stop it.

Sexual Abuse Scenario No. 1

Donna, a midwife, tells a colleague about her romantic weekend with her husband at Niagara-on-the-Lake for their anniversary. Donna makes a joke about how wine has the opposite effect on the libido of men and women. Paula, a client, is sitting in a waiting area and overhears. When being treated by Donna, Paula mentions that she overheard the remark and is curious as to what Donna meant by this, as in her experience, wine helps the libido of both partners. Has Donna engaged in sexual abuse?

Donna clearly has crossed boundaries by making the comment in a place where a client could overhear it. However, the initial comment was not directed towards Paula and was not meant to be heard by her. It would be sexual abuse for Donna to continue the discussion with Paula. Donna should apologize for making the comment in a place where Paula could hear it and state that Donna needs to focus on Paula's treatment.

Because sexual abuse is such an important issue, Colleges take it very seriously. The College has a Zero Tolerance policy towards sexual abuse. This means that all complaints or reports are taken seriously, investigated thoroughly, and acted upon responsibly. They are not resolved through an alternate dispute resolution process. A referral to discipline is likely where a substantiated complaint of sexual touching of a client is made. At the discipline hearing the identity of the client can be protected. The client may even be given a role at the discipline hearing (e.g., to make a statement on the impact of the sexual abuse on the client if a finding is made). Where the Discipline Committee finds that sexual abuse of a client has been proved, comprehensive orders are made. While the order made varies with the type of sexual abuse that occurred, where the sexual abuse involved frank sexual acts with clients (e.g., intercourse, masturbation), the order must include revocation for a minimum period of five years. All findings of sexual abuse are posted, permanently, on the College's public website register. In addition, in all cases where a finding of sexual abuse has been made, the midwife will be reprimanded.

Where an allegation of sexual abuse is made, the College is also responsible to pay for at least some of the costs of any counselling or therapy needed by the client. The Client Relations Committee administers the funding program. In the event the midwife is found to have sexually abused the client, the midwife can be required to reimburse the College for the funding.

The College is responsible for taking steps to prevent sexual abuse from occurring. For example, the Client Relations Committee of the College has developed resources that educate midwives and the public about the nature of sexual abuse, the harm that it causes, the expectations on midwives and how sexual abuse can be avoided.

For further information, refer to the College's Sexual Abuse Prevention Policy, Guideline on Appropriate Professional Behaviour with Clients, and Guideline for Reporting Sexual Abuse.

As discussed in the section on mandatory reports, midwives are required to make a report where they have reasonable grounds to believe that another health care practitioner has engaged in sexual abuse. The report is made to the Registrar of any health College where the other health provider is a member. For example, if a client tells a midwife that their physiotherapist fondled them, the midwife must make a written report to the Registrar of the College of Physiotherapists of Ontario.

Tips for Preventing Sexual Abuse Concerns

All midwives should consider ways of preventing sexual abuse (or even the perception of sexual abuse) from arising. Experience indicates that most sexual abuse is not done by predators. Rather, in most cases a midwife and the client develop romantic feelings for each other, and the midwife fails to respond appropriately.

Where any romantic feelings develop, the midwife has two choices:

- put a stop to them immediately, or
- transfer the care of the client to another midwife immediately.

Other suggestions for preventing even the perception of sexual abuse include the following:

- Do not engage in any form of sexual behaviour or comments around a client.
- Intervene when others, such as colleagues and other clients, initiate sexual behaviour or comments.
- Do not display sexually suggestive or offensive pictures or materials. Monitor the advertising posters, calendars and magazines used in the clinic.
- If a client initiates sexual behaviour, respectfully but firmly discourage it.
- Do not date clients.
- Monitor warning signs. For example, avoid the temptation to afford special treatment to clients one likes, such as engaging in excessive telephone conversations or scheduling visits outside of clinic hours. Be cautious about connecting with clients on social media.

- Unless there is a very good reason for doing so, avoid meetings outside of the clinic or proposed place of birth.
- Avoid self-disclosure.
- Similarly, avoid comments about a client's appearance, clothing, or body unless clinically necessary.
- Do not touch a client except when clinically necessary or appropriate and acceptable to client. If clinically necessary, first explain the nature of the touching, the reason for the touching and be clinical in one's approach (e.g., use of gloves for vaginal examinations).
- Use the informed choice principle before touching a client.
- Be sensitive when offering physical assistance to clients who may not be mobile. Ask both whether and how best to help them before doing so.
- Avoid hugging and kissing clients.
- Be aware and mindful of cultural, religious, age, gender, and other areas of differences. If in doubt, ask if one's proposed action is acceptable to the client.
- Do not comment on a client's romantic life.
- Ensure any incidents or misunderstandings are fully and immediately documented.

The Beginning and Termination of a Midwife-Client Relationship
A midwife-client relationship begins when there is a direct interaction between a midwife and an individual at the earliest occurrence of the following events:

- The midwife has, in respect of a health care service provided by the midwife to the individual, charged or received payment from the individual or a third party on behalf of the individual.
- The midwife has contributed to a health record or file for that individual.
- The individual has consented to the health care service recommended by the midwife.
- The midwife prescribed a drug for which a prescription is needed to the individual.

A midwife-client relationship ends at the latest occurrence of the preceding events.

Sexual Relationship Following Termination of the Midwife-Client Relationship
Developing a sexual relationship with a former client is a sensitive issue. Pursuant to the RHPA, a former client is deemed to remain a client for a period of one year from when the former client would otherwise cease to be a client. If one year has passed since the end of the midwife-client relationship, the former client will no longer be considered a client and a sexual relationship with the former client would not be prohibited. In the event that the former client requires midwifery care while engaged in a sexual relationship with the midwife, the midwife is not authorized to provide any midwifery services to the former client as the individual would then become a client again and the midwife will be considered to be in violation of the RHPA. The only exception to this is providing care in an emergency circumstance or providing minor care and reasonable steps have been taken to transfer the individual's care to another regulated midwife or regulated health professional or there is no reasonable opportunity to transfer care.

Sexual Abuse Scenario No. 2

Donna, a midwife, is attracted to her client Paula. Donna notices she is looking forward to Paula's visits. Donna extends the visits a few minutes in order to chat informally with

Paula. Donna thinks Paula might be interested as well by the way that she makes eye contact. Donna notices she is touching Paula on the back and the arm more often. Donna decides to ask Paula to join her for a coffee after her next visit to discuss whether Paula is interested in her. If Paula is interested, Donna will transfer Paula's care to a colleague. If Paula is not interested, then Donna will make the relationship purely professional. Donna decides to ask a colleague, Vanessa, for advice.

Vanessa, correctly, tells Donna she has already engaged in sexual abuse by letting the attraction develop while continuing to treat Paula. Vanessa also says that it is important for Donna to transfer the care of Paula right away and certainly before they get together for coffee.

Sample Exam Question

Which of the following is sexual abuse:

i. Performing a clinically indicated abdominal and internal examination.
ii. Using glamour shots of scantily dressed Hollywood stars as your interior design theme in order to attract younger clients.
iii. Making repeated passes at the clinic's receptionist.
iv. Dating a former client.

The best answer is ii. These pictures sexualize the atmosphere at the clinic, which is inappropriate in a health care setting. Answer i is not the best answer because the examination is clinically relevant and will affect the care decisions to be made for the client. Answer iii is not the best answer because the sexual abuse rules only apply to clients. Sexual harassment of an employee may be both unprofessional under another definition of professional misconduct and a breach of the Human Rights Code, but it is not sexual abuse (unless the receptionist was also a client). Answer iv is not the best answer because the person is not a client at the time of dating. However, it might still be unprofessional to date a former client soon after they stop being a client.

Conclusion

Professional boundaries are established to protect both midwives and clients from inappropriate behaviour. A professional boundary demarks the point where the professional relationship has crossed over to another sort of relationship. Sexual abuse is a particularly serious example of a boundary crossing.

Midwives need to understand what kinds of conduct amount to sexual abuse, the harm that can result from such behaviour, the need to participate in the province-wide effort to eliminate sexual abuse and take reasonable measures to avoid even the perception of sexual abuse. A midwife found to have engaged in sexual abuse will face serious consequences including, in some cases, revocation of their registration for at least five years.

> See the College's Sexual Abuse Prevention Policy and Guideline on Appropriate Professional Behaviour with Clients. Its content will be part of the jurisprudence exam.

4. Scope of Practice, Use of Titles, and Controlled Acts

Each College has a profession-specific statute which establishes that College under the RHPA. The *Midwifery Act, 1991* is the profession-specific statute of the College of Midwives of Ontario. The *Midwifery Act, 1991* works together with the *Regulated Health Professions Act, 1991* so that they can be treated as if they were one Act.

a) Scope of practice

Each regulated health profession has a scope of practice statement in its statute. However, no profession has an exclusive scope of practice. Members of other professions can do the same things that midwives can do. There are two exceptions:

- As noted above, people cannot perform a controlled act unless they have legal authority to do so.
- There is a "risk of harm" provision that prevents people from performing potentially dangerous procedures even if they are not controlled acts.

Risk of Harm Provision

The risk of harm provision in the RHPA prohibits a person from treating or advising a person "with respect to his or her health in circumstances in which it is reasonably foreseeable that serious bodily harm may result from the treatment or advice or from an omission from them". This provision is designed to prevent individuals from taking advantage of vulnerable clients, in ways other than performing a controlled act. For example, encouraging a client with cancer to try a diet as the only means of treatment might fall within this risk of harm provision.

However, the risk of harm provision does not apply to midwives practising within their scope of practice. Thus, it is not an offence for a midwife to provide treatment within the scope of practice of midwifery even if there is an inherent risk to the treatment. If the midwife provides incompetent care, the midwife would be accountable to the College (not provincial offences court) for their conduct. However, if a midwife provides treatment outside of the scope of practice of the profession, the risk of harm provision does apply. For example, if a midwife treated a client's cancer, then the midwife could face prosecution under the risk of harm provision.

Thus, it is important for midwives to know their scope of practice.

Scope of Practice Statement

A profession's "scope of practice" is a description of what that profession does. Under the *Midwifery Act*, the scope of practice statement reads as follows:

3. The practice of midwifery is the assessment and monitoring of women during pregnancy, labour, and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries.

While fairly broadly worded, this scope of practice statement does not authorize a midwife to provide treatments that are outside of the usual practices of midwives. For example, caesarean surgery is not included in this scope of practice.

Midwives are permitted to perform procedures that are not inherently dangerous that lie outside of their scope of practice. For example, a midwife could perform relaxation massage. However, clients need to know if the midwife is acting as a midwife or as another health care practitioner. This policy applies whether the midwife is registered with another College or not. The client must be told which professional role the midwife is engaged in (e.g., Midwife, Registered Massage Therapist, Esthetician). In fact, to ensure that a client is not misled, separate appointments, records and billings should be made.

Scope of Practice Scenario

Donna, a midwife, is seeing Paula who wants to become pregnant. Donna recommends a combination of exercises and natural remedies. Paula is unable to conceive and after spending $10,000 and losing out on two years to try more conventional treatment she approaches Donna who suggests a 40-day complete fast (only drinking water). Paula goes to the police alleging fraud.

In this case, Donna has clearly provided treatment that is outside of the scope of practice of midwifery. Donna's treatment also appears to have no evidence to support it. Paula appears to have lost out on other opportunities to receive help in conceiving. In addition, there was an inherent risk of harm in advising the client to fast completely for 40 days.

The College has a document called the Midwifery Scope of Practice that describes the midwifery scope of practice set out in the *Midwifery Act, 1991* its regulations and other legislation that govern the midwifery profession in Ontario. It is linked on the last page of this handbook.

b) Use of titles

There are a number of rules about the use of professional titles and designations by midwives.

The first general rule is that only certain regulated health professionals[2] can use any form of the title "Doctor" when providing or offering to provide health care services in Ontario. A midwife may not use the title "Doctor" in a clinical setting even if they have earned a doctoral degree (i.e., they have a Ph.D.). Allowing a staff person to call a midwife "Doctor" would constitute an offence. Under this provision, midwives can use the title "Doctor" in other settings, such as socially or in a purely teaching setting, where there are no clients.

The second rule is that each profession-specific statute regulates the use of titles relating to their profession. Each profession has specific titles that only persons

[2] Chiropractors, optometrists, physicians, psychologists, and dentists.

registered with their College can use as a professional title. For example, only midwives can use the title "Midwife" or any variation of that title. In addition, people who are not registered midwives cannot hold themselves out as midwives. This prevents people from pretending that they are midwives when they are not. The College can take legal action to stop illegal practitioners from practising midwifery. The only exception is an Indigenous person who provides midwifery services. They may use the title "Aboriginal midwife" or a variation, abbreviation or an equivalent in another language and may hold themselves out as a person who is qualified to practise in Ontario as an Indigenous midwife.

Thus, midwives need to be careful not to use a professional title or designation that is restricted to members of other Colleges. For example, unless a person is registered with the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario, they cannot call themselves a TCM practitioner or acupuncturist.

Finally, there are general professional misconduct regulations preventing the use of misleading titles or designations or engaging in false or misleading advertising. For example, it would be professional misconduct for a midwife to refer to an educational degree that they had not actually obtained.

Use of Titles Scenario

Deepika, a midwife with a PhD, teaches at a Midwifery Education Program. She also supervises students at her clinic. The students refer to her as "Doctor Deepika" at the clinic. A colleague pulls Deepika aside and tells her to ask her students to stop calling her "doctor" in the clinic where there are clients. It is acceptable in the classroom, but not in the clinic. Deepika reviews the *Regulated Health Professions Act, 1991* and realizes that her colleague is correct.

c) Controlled Acts

There are certain health care procedures that are potentially dangerous and should only be done by a properly qualified person. These potentially dangerous procedures have been listed in the *Regulated Health Professions Act*. They are called "controlled acts". No one can perform controlled acts without legal authority.

The fourteen controlled acts are as follows:

1. Communicating to the individual or their personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or their personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.

5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand, or finger,
    i. beyond the external ear canal,
    ii. beyond the point in the nasal passages where they normally narrow,
    iii. beyond the larynx,
    iv. beyond the opening of the urethra,
    v. beyond the labia majora,
    vi. beyond the anal verge, or
    vii. into an artificial opening into the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.
8. Prescribing, dispensing, selling, or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing-impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.
14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception, or memory that may seriously impair the individual's judgement, insight, behaviour, communication, or social functioning.

The seventh controlled act refers to forms of energy set out in the Minister's regulation. That regulation lists the following forms of energy that cannot be used:

1. Electricity for,
    i. aversive conditioning,
    ii. cardiac pacemaker therapy,
    iii. cardioversion,
    iv. defibrillation,
    v. electrocoagulation,
    vi. electroconvulsive shock therapy,
    vii. electromyography,
    viii. fulguration,
    ix. nerve conduction studies, or
    x. transcutaneous cardiac pacing.
2. Electromagnetism for magnetic resonance imaging.
3. Soundwaves for,
    i. diagnostic ultrasound, or
    ii. lithotripsy.

Since only diagnostic ultrasound is prohibited, that means that therapeutic ultrasound is not a controlled act.

The eighth controlled act refers to the definition of a drug in the *Drug and Pharmacies Regulation Act.* It reads as follows:

> "drug" means any substance or preparation containing any substance,
>
> (a) manufactured, sold, or represented for use in,
>
> (i) the diagnosis, treatment, mitigation or prevention of a disease, disorder, abnormal physical or mental state or the symptoms thereof, in humans, animals or fowl, or
>
> (ii) restoring, correcting, or modifying functions in humans, animals, or fowl,
>
> (b) referred to in Schedule I, II or III,
>
> (c) listed in a publication named by the regulations, or
>
> (d) named in the regulations,
>
> but does not include,
>
> (e) any substance or preparation referred to in clause (a), (b), (c) or (d) manufactured, offered for sale, or sold as, or as part of, a food, drink or cosmetic,
>
> (f) any "natural health product" as defined from time to time by the *Natural Health Products Regulations* under the *Food and Drugs Act* (Canada), unless the product is a substance that is identified in the regulations as being a drug for the purposes of this Act despite this clause, either specifically or by its membership in a class or its listing or identification in a publication,
>
> (g) a substance or preparation named in Schedule U,
>
> (h) a substance or preparation listed in a publication named by the regulations, or
>
> (i) a substance or preparation that the regulations provide is not a drug;

Unfortunately, this definition refers to a number of other provisions. Midwives may need to do some research or obtain advice when dealing with a specific substance. A general rule is that if a substance has a DIN (drug identification number) it is usually considered to be a drug.[3]

It is important for midwives to be familiar with the above list of controlled acts.

There are four ways in which a health care practitioner can receive legal permission to perform a controlled act:

- Authorization. Being authorized to perform the controlled act by the health care practitioner's enabling statute. The *Midwifery Act, 1991* authorizes midwives to perform the following controlled acts:

    1. Communicating a diagnosis identifying, as the cause of a woman's or newborn's symptoms, a disease or disorder that may be identified from the results of a laboratory or other test or investigation that a member is authorized to order or perform on a woman or a newborn during normal pregnancy, labour, and delivery and for up to six weeks post-partum.

    2. Managing labour and conducting spontaneous normal vaginal deliveries.

[3] Some non-drug substances have different kinds of drug numberings, for example, a Natural Product Number (NPN) or Homeopathic Medicine Number (DIN-HM).

3. Inserting urinary catheters into women.

4. Performing episiotomies and amniotomies and repairing episiotomies and lacerations, not involving the anus, anal sphincter, rectum, urethra and periurethral area.

5. Administering, by injection or inhalation, a substance designated in the regulations.[4]

6. Prescribing drugs designated in the regulations.[5]

7. Putting an instrument, hand, or finger beyond the labia majora or anal verge during pregnancy, labour, and the post-partum period.

8. Administering suppository drugs designated in the regulations beyond the anal verge during pregnancy, labour, and the post-partum period.

9. Taking blood samples from newborns by skin pricking or from persons from veins or by skin pricking.

10. Intubation beyond the larynx of a newborn [in accordance with the regulations[6]].

11. Administering a substance by injection or inhalation as provided for in subsection 4.1 (2) [i.e., where ordered by a physician].

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[4] The Designated Drugs Regulation under the *Midwifery Act, 1991* lists the substances Midwives may administer by injection and inhalation on their own responsibility.

[5] The Designated Drugs Regulation under the *Midwifery Act, 1991* lists the drugs Midwives may prescribe on their own responsibility. The Regulation also states that Midwives may use any drug or administer any substance by injection or inhalation on the order of a physician. Midwives may also administer, prescribe, or order any non-prescription drug or substance.

[6] The regulation reads as follows:
Requirements for intubation beyond the larynx of a newborn
15.1 A member is authorized to perform a procedure under paragraph 10 of section 4 of the Act if the procedure is performed in accordance with the following requirements:
1. The member has the knowledge, skill, and judgment to perform the procedure safely, effectively, and ethically.
2. Before performing the procedure, the member determines that the newborn's condition warrants performance of the procedure, having considered,
i. whether the procedure is necessary to preserve or restore the health of the newborn,
ii. the known risks and benefits to the newborn of performing the procedure,
iii. the predictability of the outcome of performing the procedure,
iv. the safeguards and resources available in all the circumstances to safely manage the outcome of performing the procedure, and
v. other relevant factors specific to the situation.
3. The member has successfully completed an intubation training program approved by the Council.

- **Exceptions**. The *Regulated Health Professions Act, 1991* creates a number of exceptions permitting people to perform controlled acts in certain circumstances. These exceptions include the following:
    - Helping someone in an emergency.
    - While in formal training to become a member of a College authorized to perform the controlled act, as long as the act is performed under supervision or direction of a member of the profession.
    - Treatment by prayer or spiritual means pursuant to one's religion.
    - When done for a member of one's household. This applies only to communicating a diagnosis (e.g., telling one's child that they have a cold), administering a substance by injection or inhalation or putting an instrument, hand, or finger in a bodily orifice.
    - Helping a person with their routine activities of daily living where it includes administering a substance by injection or inhalation or putting an instrument, hand, or finger in a bodily orifice (e.g., on a home visit helping a client with their insulin injection).
    - Counselling a person. In many ways the counselling exception provision is simply intended to convey the point that counselling, itself, does not normally fall within any of the controlled acts. It is not really a true exception.
    - Providing aboriginal healing within the aboriginal community.

- **Exemptions**. In addition to the exceptions listed in the Regulated Health Professions Act, the Minister of Health has provided a number of exemptions in a Minister's regulation. Most of those exemptions are limited in scope (e.g., dentists are permitted to apply electricity for electro coagulation). A few of the exemptions have broader application, including the following:
    - Anyone can perform cosmetic body piercings and tattooing.
    - Anyone can perform electrolysis.
    - Members of some health Colleges, but not Midwives, can perform acupuncture under exemption.[7]
    - Anyone can perform male circumcision.

- **Delegation**. A person can perform a controlled act if another health care practitioner who is authorized to perform that controlled act has delegated it. Delegation can be made to another health care practitioner or to an unregistered person. For example, a physician can delegate a controlled act, such as placing an instrument, hand, or finger into an artificial opening into the body, to a midwife. Similarly, a midwife could delegate the insertion of a catheter into a client during labour to an unregistered second birth attendant. However, delegation is subject to a number of rules, including the following:

    - The person giving the delegation is limited by any regulations or professional standards of their College. Before delegating a controlled act, a delegating

[7] They are: chiropody, chiropractic, massage therapy, nursing, occupational therapy, physiotherapy, and dentistry. Naturopathy will be added to the list. There are members of other Colleges, such as traditional Chinese medicine and physicians, who can perform acupuncture under the authorization of their profession-specific Acts.

midwife must ensure that they have the authority to perform the controlled act in the first place; that they are competent to perform the controlled act safely and ethically; and that the person accepting the delegation is adequately trained and competent to perform the controlled act. The delegating midwife should also document the delegation appropriately.
- The person accepting a delegation is limited by any regulations or professional standards of their College (if the person is a member of a regulated College).
- The person delegating the procedure is responsible for the actions of the person receiving the delegation. For example, if a physician delegated to a midwife the controlled act of casting a fracture and the cast is put on too tightly, the physician could be held accountable by their own College and the courts.

An order is an authorization to perform a procedure on a client. An order has an authorizer and an implementer. The implementer is given the authority under legislation to perform the procedure when the client has an order authorizing it. For example, under the 11th controlled act listed above, a physician can issue an order that a client receive an injection of a substance even though the Designated Drugs Regulation does not authorize a midwife to inject it on their own authority.

A direct order relates to a specific client who has been assessed, whereas a directive is an order that applies to any client who meets the criteria specified in the directive. For example, a facility could have a medical directive authorizing the performance of bilirubin tests on newborns that present with jaundice within 24 hours of birth.

The College's Professional Standards for Midwives provides more detailed guidance regarding delegation, orders, and directives. The content of this standard will be part of the jurisprudence exam.

Controlled Acts Scenario No. 1

Deepika, a midwife, sees her client, Paula. Paula has a sore arm. Deepika realizes that it is fractured and tries to stabilize it with a splint. Deepika recommends that Paula should go to the emergency department of a hospital, but Paula indicates she will not go. Deepika therefore applies a cast to the fracture. Later Deepika wonders if she was permitted to apply the cast.

Applying a cast to a fracture is a controlled act. Midwives are not authorized to perform that controlled act by the *Midwifery Act, 1991*. From the facts described above, it does not appear that any other authority exists to apply the cast. While this could be viewed as an emergency, the appropriate response to the emergency is to stabilize the fracture and arrange for the client to go to the emergency department of a hospital. A client's reluctance to go to the hospital does not provide legal authority to perform a controlled act.

Controlled Acts Scenario No. 2

Donna, a midwife, performs an episiotomy on her client Paula. An episiotomy is a controlled act authorized to midwives under the *Midwifery Act, 1991*. Donna is authorized to perform that controlled act.

Controlled Acts Scenario No. 3

Deepika, a midwife, discovers that her client Paula has gone into diabetic shock. Deepika looks in Paula's briefcase and finds a syringe and insulin. Deepika injects the insulin into Paula's muscle and calls 911. Paula recovers. While Deepika did perform a controlled act not authorized to her (injecting insulin, a drug not authorized to be injected by midwives), she did so in an emergency, which is a recognized exception to the controlled acts rule. The "routine activities of daily living" exception probably does not apply here unless Deepika was asked by Paula or a substitute decision-maker to help with a regular injection of insulin.

Controlled Acts Scenario No. 4

Donna, a midwife, only works part time. Her other job is to perform artistic body piercings. Even though such piercings go beyond the dermis, this procedure is exempted under the Minister's regulation on controlled acts.

Controlled Acts Scenario No. 5

Deepika, a midwife, works with a physician. Because of Deepika's knowledge of anatomy, deliveries and caesarean sections, the physician asks Deepika to be her first assistant for caesarean sections. This is an example of a delegation. However, both Deepika and the physician will be responsible if something goes wrong.

Sample Exam Question

Which of the following is a controlled act:

i. Removing broken glass that has been deeply embedded in a child's leg.
ii. Cleaning a scrape on a child's elbow with soap and water.
iii. Applying alcohol to a scrape on a child's elbow.
iv. Wrapping a child's wounds.

The best answer is i. Deeply embedded glass almost certainly has gone beyond the dermis and is sitting in deeper tissue. There may be an issue as to whether this is an emergency (likely not as in most cases it would be possible to take the child to a hospital or physician's clinic for treatment), but that does not change the fact that removing the glass is a controlled act. Similarly, the household exemption does not apply to these sorts of procedures. Answer ii is not the best answer because a scrape on the skin implies that it has not gone beneath the dermis. Answer iii is not the best answer because applying a substance to the skin is not administering a substance by inhalation or injection. Answer iv is not the best answer because the procedure is above the skin and does not fall within any of the other controlled acts.

5. Regulations and By-laws

Together, the *Regulated Health Professions Act, 1991* and *Midwifery Act, 1991* authorize the College to develop regulations and by-laws to regulate the profession.

Regulations and by-laws are both forms of law. The major difference between a by-law and a regulation is that a by-law is made directly by the Council of the College, while a regulation must be approved by the government of Ontario. By-laws typically relate to the administration and internal affairs of the College. Regulations generally deal with matters of broader public concern. There are currently five regulations that have been passed under the *Midwifery Act*:

1. The Registration Regulation;
2. The Professional Misconduct Regulation;
3. The General Regulation (dealing with intubation of a newborn);
4. The Quality Assurance Regulation; and
5. The Designated Drugs Regulation.

a) Registration Regulation

The Registration Regulation sets out the requirements for obtaining and maintaining registration with the College. It is intended to make sure that members of the College are competent and have good character.

The Registration Regulation establishes four classes of members:

1. General for midwives practising independently;
2. Supervised practice for midwives obtaining clinical experience required for a General class of registration;
3. Inactive for midwives who are not practising; and
4. Transitional for midwives who are awaiting the results of the qualifying registration examination.

General Requirements

There are certain requirements that must be met by all applicants for registration with the profession. All applicants must fully complete an application form and pay applicable fees. The applicant must also inform the College of any criminal or other findings or regulatory proceedings or findings against them. The application form requires applicants to provide information regarding the applicant's training and experience, as well as past professional experiences (including previous registration with another regulatory body). The applicant must also provide other information that may affect their ability to practise effectively and safely (i.e., proof of competency in neonatal resuscitation, cardiopulmonary resuscitation, emergency skills). The applicant must have adequate fluency in either English or French. The applicant must not be incapacitated (i.e., have an illness that prevents them from practising safely, like a drug addiction that is not under control).

Specific Requirements

There are specific requirements for each class of registration. For example, applicants for General class registration must have completed an acceptable educational program, successfully completed the clinical experience requirements

and passed the registration examinations. Applicants for Supervised practice class registration must meet the same requirements as the General class other than meeting the clinical experience requirements.

Transitional class applicants must have taken the qualifying registration examination and be waiting for their marks.

Applicants must have completed a jurisprudence course on the laws and regulations that apply to the practice of midwifery in Ontario.

There are provisions in the Registration Regulation to promote the mobility of registered midwives across Canada. The College of Midwives of Ontario will not require qualified applicants registered elsewhere in Canada to once again prove that they have adequate education, experience, and examination credentials.

Conditions of Registration

Once a midwife is registered with the College, they must continue to meet certain general terms, conditions, and limitations. For example, they must carry appropriate professional liability insurance. Competency in neonatal resuscitation, cardiopulmonary resuscitation and emergency skills must be kept current for practising midwives. If a midwife is found guilty of a criminal or other offence, the member must tell the College. If a midwife is disciplined by another professional regulator, the member must tell the College.

Midwives in the General class of registration are required to maintain an active practice. If a midwife falls short on their active practice requirements, they can be required to comply with a plan (and related terms, conditions, and limitations) proposed by the Registration Committee.

It is a condition for Supervised and Transitional class midwives to practise under the supervision of a midwife registered in the General class.

Inactive class midwives must not engage in the practice of midwifery. They must be registered in the General class of registration prior to switching to the Inactive class. In addition, before resuming General class status, an inactive midwife may be required to successfully complete a requalification program that is tailored to their circumstances.

The following chart summarizes the various conditions of registration and the classes to which they apply:

Condition	General	Supervised	Inactive	Transitional
Must disclose information to the College, including, among other things, findings of misconduct, civil judgments and settlements, criminal findings, and	☒	☒	☒	☒

Condition	General	Supervised	Inactive	Transitional
actions taken by other regulatory bodies				
Must not make false or misleading statements to the College	☒	☒	☒	☒
Must display certificate of registration and make registration card available	☒	☒	☒	☒
Must continue to be legally authorized to work in Canada	☒	☒	☒	☒
Must have professional liability insurance	☒	☒		☒
Must comply with active practice requirements	☒			
Must provide evidence of continuing competency in neonatal resuscitation (every year)[8]	☒			
Must provide evidence of continuing competency in emergency skills and cardiopulmonary resuscitation (every two years)	☒			
New Registrants must only work within an established practice, and must attend a minimum of 30 births as primary midwife and 30 births as secondary midwife	☒ (New Registrants Only)			
Must only practise in accordance with approved supervision plan		☒		
Must only practise under supervision of approved supervisor		☒		☒
Must file any required agreements and undertakings		☒		
Must not engage in the practice of midwifery			☒	

[8] Although applicants to the Supervised and Transitional classes of registration are required to provide satisfactory evidence of competency in neonatal resuscitation, cardiopulmonary resuscitation, and emergency skills, these are not continuing conditions of registration due to the time-limited nature of these classes of registration.

Registration Regulation Scenario

Donna is a registered midwife in the General class of registration. She has been practising for 10 years. In the last five years, she has not met the active practice requirements because she reduced her client caseload to be able to complete a part-time master's degree in public health. The Registrar notifies Donna that she has not met the active practice requirements and the matter is referred to the Registration Committee. Donna explains that she is returning to full time practice now that her program is complete. Donna agrees to comply with a plan proposed by the Registration Committee, which includes recertifying in an emergency skills workshop with a home birth component.

b) Professional Misconduct Regulation

Some types of professional misconduct are contained in the RHPA itself. For instance, the RHPA makes breaking the law professional misconduct (e.g., to be found guilty of an offence relevant to a midwife's suitability to practise the profession). Being found guilty of professional misconduct outside of Ontario can lead to disciplinary action in Ontario as well. Sexual abuse of a client is also specified in the RHPA as being professional misconduct. So is failing to cooperate with the Quality Assurance Program.

However, the College's Professional Misconduct Regulation defines additional types of professional misconduct. Some provisions found in the Professional Misconduct Regulation are common to many of the professions under the RHPA, while others are more specific to this profession.

The following are the main topics found in the Professional Misconduct Regulation. However, midwives should be familiar with all of the types of professional misconduct listed in the Professional Misconduct Regulation.

Standards of Practice

The Professional Misconduct Regulation makes failing to maintain the standards of practice of the profession professional misconduct. Usually, this relates to the care of clients by the midwife. The standards of practice may be written or unwritten. They reflect a shared understanding of the profession and how it should be practised effectively and safely. This is based on what would be reasonably expected of the ordinary competent midwife in their field of practice. Expert witnesses are often used to describe a standard of practice and how it applies to the particular circumstances of the case.

Inappropriate Behaviour Towards Clients or the Public

Many provisions in the Professional Misconduct Regulation relate to inappropriate behaviour towards clients or the public. For example, in addition to sexual abuse, it is professional misconduct to abuse a client, verbally, physically, psychologically, or emotionally, or to take unfair advantage of a client. This includes rude or unbecoming behaviour towards a client. In addition, it is professional misconduct to influence a client or the client's authorized representative to change the client's will. Mistreatment of members of the public or professional colleagues can also constitute professional misconduct.

Record Keeping

Failing to make and keep appropriate and adequate records is professional misconduct. This is an important area to understand for midwives, so it is discussed in depth in its own section.

Informed Choice

Informed choice will be discussed in more detail in a separate section and is also mentioned in regard to record keeping. The regulation makes it professional misconduct to fail to obtain consent when caring for a client.

Controlled Acts, Delegation and Supervision

Midwives must ensure that any person to whom they delegate a controlled act has the knowledge, skill, and judgment to perform it. In addition, midwives must be careful only to accept a delegation for tasks for which they have the knowledge, skill, and judgment to perform.

In addition, failing to adequately mentor a New Registrant or supervise a midwife of the Supervised or Transitional class of registration can amount to professional misconduct.

Confidentiality

Midwives must keep all client information confidential. Failing to maintain confidentiality can be considered professional misconduct. There may be exceptions depending on the circumstances. For example, clients can consent to the midwife disclosing information. Also, where a midwife is required (e.g., by a court summons) or permitted (e.g., when selling one's practice) by law to disclose client information, it can then be disclosed. The concept of confidentiality is discussed in its own section along with privacy.

Conflict of Interest

A midwife cannot engage in a conflict of interest. In order to avoid a conflict of interest, midwives must put the interests of their clients first and not allow personal or other interests to interfere. A conflict of interest arises where a midwife does not take reasonable steps to separate their own personal interests from the interest of clients. Where the personal interest would reasonably affect the midwife's professional judgment, a conflict of interest exists. For example, if a midwife refers a client to a baby store owned by the midwife's spouse to buy products, a reasonable person would question whether the midwife recommended that product because the client needed it or in order to help their spouse.

Midwives have a duty to act in the best interests of their clients. For example, a midwife has a duty to only refer clients to others where it is in the best interest of the client. Where a health care practitioner pays a midwife for referrals, the midwife has a conflicting interest (i.e., referring the client to the practitioner who will do the best job or to the practitioner who is paying the midwife) that is unprofessional.

To determine whether a situation amounts to an unprofessional conflict of interest, one looks to what a reasonable person would likely conclude from the circumstances. A conflict of interest can be actual, potential, or perceived.

A conflict of interest can be direct or indirect. For instance, an improper benefit conferred on a close relative (i.e., parent, grandparent, child, spouse, or sibling) of a midwife can put the midwife in a conflict of interest.

Some common examples of conflicts of interest are as follows:

- Receiving benefits from suppliers or persons receiving referrals from the midwife;
- Giving gifts or other inducements to clients who use the midwife's services where the service is paid for by a third party (e.g., like the government);
- Using or referring a client to a business in which the midwife has a financial interest; and
- Selling a drug to a client for a profit.

Whether a conflict exists will always depend on the circumstances. The midwife should always ask themselves: would another objective and reasonable person think that there is a conflict of interest, given the circumstances? For example, it probably would be appropriate to give a client a small calendar to record their future appointments even if a third party pays for the treatment. However, giving the client an expensive stroller is unreasonable in the circumstances.

Most conflicts of interest are prohibited outright. However, there are certain circumstances where taking certain safeguards could remove the concern. In the example above about referring a client to a baby store owned by the midwife's spouse to buy a product, such a referral would not raise concerns if the midwife did the following:

- Disclose the nature of the relationship with the store (e.g., "my spouse owns the store");
- Provide alternative options (e.g., "here are three other places you could get the product I am recommending for you"); and
- Reassure the client that choosing another store will not affect the client's care (e.g., "You are free to choose any of the places to get the product; you will still be welcome here as my client").

Midwives may be asked to provide the College with any documents, explanations, or information regarding a suspected conflict of interest. This is to enable the College to assess whether a conflict of interest is a concern. For example, if the College receives information that a midwife is receiving payments from a provider of Registered Education Savings Plans, then the College could ask for an explanation of those payments, and any financial records related to them, to determine whether there is a conflict of interest.

Conflict of Interest Scenario

Deepika is a midwife who has a busy and successful practice. Recently, she began buying a new brand of bread that is fortified with iron. Clients eating it have maintained good iron levels during pregnancy. Deepika calls the company to tell them her feedback from her clients and that she likes eating and recommending the bread. The company asks her if she would like to be in a new advertising campaign they are going to put into some magazines targeted at young women where she would provide similar statements. They plan to put a picture of her within the advertisement and identify her by name and qualifications. They say they cannot pay her because they are still a small company and don't have the budget for it. She thinks, why not? She likes the bread and since she is not getting paid she is not inappropriately benefiting from the relationship.

Unfortunately, this would still likely be a conflict of interest and would be professional misconduct. A midwife cannot use their professional status to promote a product commercially. This is so even though they have not been paid for the endorsement. It can also be assumed that they will benefit from the advertisement in some indirect manner (for example, they may have increased client influx from those people who see the advertisement). Also, without making any observations or assessments of an individual, a midwife should not be making any sort of clinical recommendations. Deepika can, however, give advice on proper nutrition during pregnancy provided it is within a midwife-client relationship and it is based on professional judgment regarding a client's individual needs through proper assessment.

Misrepresentation

It is professional misconduct to be dishonest in one's dealings with clients, colleagues, third party payers or the College. Dishonesty with other members of the public is also unacceptable (even if the intent is to help a client). Members of the public often assume that midwives are honest because of their professional status and rely upon their integrity. For example, it would be professional misconduct to issue a letter or certificate saying that a client was too sick to work when the midwife does not know this to be true or to sign a blank form for a client. Misrepresentations can occur by using a misleading title or designation (e.g., Paediatric Midwife) or providing inaccurate information about one's training, qualifications, or experience.

Improper Billing and Fees

Midwifery services are free for all residents in Ontario, regardless of whether they are insured by OHIP. Midwives are typically paid on a "per client" basis through a contract with a Transfer Payment Agency of Ontario's Ministry of Health. This means that midwives are paid for a complete course of care as a package; they are not paid separately for each visit. In fact, the College's Professional Misconduct Regulation prohibits midwives from charging for midwifery services on a fee for service basis. One of the rationales behind this model is to avoid providing incentive for unnecessary interventions.

There may be services or products that midwives offer to their clients that are not covered by government funding. For example, a midwife might sell certain home birth supplies at their clinic (e.g., a birthing tub) or offer group prenatal classes. In those instances, the midwife must ensure that their accounts are accurate and that the fees charged are reasonable.

In addition, midwives should be aware that uninsured clients may have to pay for other health care services that are not funded by the government, including lab tests, consultations by physicians and hospital stays.

Establishing fees and administering payment to midwives are not part of the mandate of the College. However, the College does regulate unprofessional conduct related to billing, including:

- Submitting false or misleading accounts;
- Charging a fee or accepting payment from a client for services that have been paid by the Ministry of Health;
- Charging excessive fees; and
- Failing to inform the client of the fee to be charged for services before the commencement of the services.

Midwives can direct funding and billing questions to their Transfer Payment Agency, the Association of Ontario Midwives, or their lawyer.

Improper Advertising

Advertising of midwifery services should be factual, accurate, objectively verifiable, independent of personal opinion, comprehensible and professionally appropriate. It should not include any information that is misleading by either leaving out relevant information or including non-relevant, false, or unverifiable information. For example, suggesting that services can be provided at a hospital when one's privileges at that hospital are under suspension is misleading. Midwives should also take reasonable steps to ensure that the advertisements placed by others (e.g., employees) meet these standards.

Important information such as office hours and days of operation, telephone numbers, languages spoken, website address, and location are acceptable inclusions in advertising.

Although the College does not have a specific provision in its Professional Misconduct Regulation that deals with advertising, if a midwife engaged in false or misleading advertising it could amount to professional misconduct under the "catch all" provisions of unprofessional conduct or conduct unbecoming a midwife (discussed further below).

Conduct Towards Colleagues

Midwives must treat their colleagues with courtesy and civility. For example, if a client goes to another midwife or another health care practitioner and that midwife asks for a copy of the record (with client consent), one cannot simply ignore the letter. If a midwife disagrees with the care being provided by another health care

practitioner, the midwife must express themselves professionally and not make insulting comments about the other health care practitioner to the client.

Conduct Towards the College

Obligations come with the privileges of self-regulation. One obligation is that midwives must accept the regulatory authority of the College. Examples of conduct towards the College, which can constitute professional misconduct, include:

- Publicly challenging the integrity of the College's role or actions;
- Breaching an undertaking given to the College;
- Failing to cooperate in, or obstructing, an investigation by the College;
- Failing to participate in the Quality Assurance Program;
- Failing to comply with an order or direction of a Committee of the College (e.g., ICRC, Discipline Committee, QA Committee, or Registration Committee);
- Failing to respond appropriately and promptly to correspondence from the College;
- Failing to make a mandatory report; and
- Practising while suspended.

Disregarding Restrictions on Certificate of Registration

A midwife must confine their practice to what is legally permissible. If the *Act* or a committee of the College restricts a midwife in certain areas (e.g., the midwife's certificate of registration is subject to terms, conditions, or limitations), it would be professional misconduct to exceed those restrictions. For example, a midwife who is required to practise under supervision must always do so.

General "Catch-all' Provisions

The College has two general "catch-all" provisions for professional misconduct. These cover types of conduct that are not specifically dealt with elsewhere. One provision prohibits conduct that would be reasonably regarded as dishonourable, disgraceful, or unprofessional. This provision assumes that there is a general consensus in the profession of conduct or behaviour that would be considered unacceptable. For example, there is no specific provision that says that a midwife cannot abuse a client's mother during a visit. However, no one doubts that this conduct would be unprofessional.

The second "catch-all" provision makes it professional misconduct to engage in conduct unbecoming a member of the profession. This provision refers to conduct in a midwife's private life that brings discredit to the profession. For example, the College could discipline a midwife who engaged in fraud outside of work or who possessed child pornography at home.

Professional Misconduct Regulation Scenario

Donna, a midwife, has recently been told by her colleague, Wendy, who works in the same practice as her, that sometimes Donna is too loud with her clients. Wendy mentions that in speaking loudly she is disrupting other midwives in the office. Donna tells Wendy that she is sorry for disrupting her and any of her clients and that she will try to keep her voice down or lower it out of respect for the rest of the practice. But Wendy feels this is a serious problem and that Donna should be reported to the College for professional misconduct because she cannot stand loud

noise during her visits with her clients. She wants the very best atmosphere created for her clients and thinks loud talking is completely unprofessional. Is Wendy correct in saying this would be professional misconduct according to the regulations?

Probably not. Wendy holds a particular view about Donna's noise level that may not be consistent with the rest of the profession. Unless the conduct persists and unless it is so loud that most neutral observers would agree that Donna is inappropriately disrupting the rest of the office, it is not professional misconduct. While it is courteous for Wendy to raise the issue with Donna so that they can come to a reasonable resolution, professional misconduct is not meant to apply to uniquely personal views of unacceptable behaviour. Instead, it is intended to be based on conduct that is considered unacceptable by a general consensus of the profession.

Sample Exam Question

Which of the following situations is possible professional misconduct according to the Professional Misconduct Regulation?

i. Failing to maintain client confidentiality.
ii. Using verbal threats and insults to a client in an email to them when they do not show up for an appointment.
iii. Accepting a fee from a physician for a referral.
iv. All of the above.

The best answer is iv. The regulation describes many types of professional misconduct. All of the situations described involve conduct that is specifically prohibited in the Professional Misconduct Regulation. Answer i, ii and iii are not the best answers because all of the situations listed in the question are clear examples of professional misconduct.

c) General Regulation

The General Regulation deals with intubation of a newborn. Midwives are authorized to perform the controlled act of intubation beyond the larynx of a newborn if it is done in compliance with the regulations. The General Regulation establishes the standards that midwives must meet in order to perform this controlled act. This is referred to above under the section on Controlled Acts.

d) Quality Assurance Regulation

The Quality Assurance Regulation establishes the College's Quality Assurance Program, including the various components of the program and midwives' obligations under those components.

e) Designated Drugs Regulation

As noted in the section discussing authorized acts, midwives are authorized to perform the controlled acts of administering, by injection or inhalation, a substance designated in the regulations and prescribing drugs designated in the regulations. The Designated Drugs

Regulation lists the specific drugs that midwives may prescribe on their own initiative, as well as the substances midwives may administer, by injection or inhalation, on their own initiative. The Designated Drugs Regulation also states that midwives may use any drug or administer any substance by injection or inhalation on the order of a physician in the course of providing midwifery services. Midwives may also administer, prescribe, or order any non-prescription drug or substance.

f) College By-Laws

As noted above, the By-Laws are made by the College Council and relate primarily to the administration and internal affairs of the College. The College currently has General By-Laws and Fees and Remuneration By-Laws. Among other things, the By-Laws establish rules and procedures relating to:

- Elections to Council;
- Governance at Council and Committee meetings;
- Duties, responsibilities, and appointments to Committees;
- Registration renewal;
- The Register, including information about midwives that is posted on the Public Register and information that midwives are required to provide to the College; and
- Fees to be paid by midwives.

6. Written Standard of Practice statements

The College has published Standard of Practice documents to guide midwives on generally accepted expectations in common situations. The College's written Standards of Practice are available on the College's website. All midwives should familiarize themselves with these documents. The College's written Standards of Practice will form part of the jurisprudence exam.

Professional Standards for Midwives
The Professional Standards for Midwives (Professional Standards) describes what is expected of all midwives registered with the College.

The Principles
Five (5) mandatory principles form the Professional Standards. These principles define the fundamental ethical and professional standards that the College expects all practices and individual midwives to meet when providing midwifery services. The standards are not negotiable or discretionary. Midwives must be able to demonstrate at all times that they work in accordance with the principles and standards set out in the Professional Standards. A failure to maintain a standard of practice of the profession may amount to professional misconduct.

Midwives must practise according to the standards expected of them by:

- Demonstrating professional knowledge and practice
- Providing person-centred care
- Demonstrating leadership and collaboration
- Acting with integrity
- Being committed to self-regulation

Structure of the Professional Standards
The Professional Standards is divided into five (5) principles. Each principle includes a definition of the principle and a set of standards. The standards describe what midwives must achieve for compliance with the relevant principle. For midwives who are practice owners, there are additional standards at the end of each section that apply to them.

i) Record Keeping

One important aspect of the standard of practice of midwifery is record keeping. Keeping records is essential for providing good client care; even midwives with excellent memories cannot recall all the details of their clients' health status and treatment. Records permit the monitoring of changes in clients. Records assist other midwives on the team involved in the care of the client. Records also enable a midwife to explain what they did for clients if any questions arise. Records help a midwife to defend themselves if a client recalls things differently than the midwife. Failure to make and keep adequate records can be a failure to maintain minimum professional standards and is professional misconduct.

The College's Record Keeping Standard covers matters such as:

- The information that must be recorded;
- What to document in a clinical encounter;
- How long the midwifery records must be kept; and
- Access and retention of the midwifery record.

The information that must be recorded

The client record is intended to record what was done and what was considered by the midwife. It acts as a communication aid to ensure that there is continuity of care for the client. Proper records also enhance client safety. The following is a list of some of the requirements for documenting in the client record:

- the reason for the clinical encounter and information that conveys the client's health status and any concerns
- every assessment, clinical finding, treatment, discussion, or other provision of care provided by the midwife to the client
- the client's response and outcomes to the interventions or care provided
- the client's care management plans and updates to the management plan
- important communication with other care providers, family members, and substitute decision-makers
- every recommendation or order made by the midwife for examinations, tests, and consultations, and all associated reports received by the midwife or attempts made to acquire such reports
- every informed choice discussion, including risk, benefits, alternatives, any recommendations made and the client's consent or refusal
- every transfer of, and discharge from care as well as the reason for the transfer or discharge

1.

The form in which records can be kept

Records must be legible. Failure to maintain a legible record would defeat the purpose of maintaining a complete and accurate record.

Records can be on paper or electronic. Electronic records should be printable and viewable and should have an audit trail of changes made. These requirements are discussed further in the section on the *Personal Health Information Protection Act, 2004* (PHIPA) below.

It should be clear who made each entry into the health record and when that entry was made. Any change or amendment to the record should be indicated, the date on which the change was made should be noted and who made the change should be recorded. Any changes to the record should still permit the reader to read all previous entries.

Midwives cannot falsify records; this means that if an error is made in a previous entry, it cannot be removed (e.g., 'whited-out' or deleted). The record should be maintained with the error corrected (usually, in a paper record, a simple line through the erroneous entry with the date and initial of the person correcting the error).

How long the information must be maintained

The midwife, or health information custodian for whom the midwife works (e.g., the midwifery practice group) needs to keep the record according to the following:

- For a client who is 18 years or older, the record must be retained for 10 years from the date of the last entry
- For a client (including a newborn) who is younger than 18 years, the record must be retained for 10 years after the day on which the client reached, or would have reached, 18 years of age

In many cases this will mean that the midwife will be responsible for retaining the record for 28 years (18 years until the newborn reaches the age of majority plus 10 years). An interaction can involve any contact with the client, including a phone call or an email.

The rule regarding keeping records for 10 years includes financial records, appointment, and attendance records, in addition to the health record.

Maintaining or transferring records upon leaving a practice or retiring

The entire original midwifery record should be kept by the midwife (or the health information custodian for whom the midwife works). The College recommends that practices have an agreement that when a midwife leaves a practice, the original client record is retained by the practice and that they retain or have access to a copy of all relevant client records for the retention period.

Even when a midwife retires and resigns as a member of the College, the original record should be kept for the 10-year retention period unless the record has been

transferred to another midwife or other suitable person who will maintain the record. The client should be notified of any transfer of the record. In those circumstances, the original record can be transferred to the new midwife or custodian. Another option, upon resigning from the College, is to transfer the original record to the client.

If the client has just been referred to another health care practitioner and the client record has not been transferred, then the retention period of the entire original record (i.e., 10 years from last contact or the newborn's eighteenth birthday) is still mandatory.

The only exception to this is if there is some legal obligation to provide the original record (i.e., in a police, Coroner's, or College investigation, or with a summons). Even in this instance, the midwife should keep a legible copy of the record for themselves.

When the time period for keeping the record has expired, the destruction of the records should be done in a secure manner that prevents anyone accessing, discovering or otherwise obtaining the information (i.e., shredding, complete electronic destruction). If a midwife destroys any records, a good practice would be to keep a list of the files that were destroyed and the date on which they were destroyed.

If transferring from paper records to electronic records and the original paper record has been scanned into an electronic form, then the original may be destroyed. The electronic version of the document becomes the original.

Confidentiality and privacy issues

Midwives should take reasonable steps to keep records safe and secure. In general, no one outside of the authorized circle of care of health professionals should be able to access the records. Privacy protections must be in place to ensure the records cannot be seen, altered, or removed by others. Paper records should be kept under lock and key. Computer records need to be password protected on computers that have firewall and virus protections and be backed up regularly. Particular privacy issues are discussed later in the section on the *Personal Health Information Protection Act, 2004* (PHIPA).

Client access to records

Generally, a client has the right to review and receive a copy of all clinical records kept by a midwife unless access would significantly jeopardize the health or safety of a person. Although the midwife may retain the health care record and be responsible for it, clients are authorized by the *Personal Health Information Protection Act, 2004* (PHIPA) to access the record. The information in the record belongs to the client. Also, the client has the right to correct any errors in the health record. If a client requests any relevant parts of the record, the midwife should provide the client with a copy and not the original. This topic is discussed later in the section on PHIPA.

Record Keeping Scenario 1

Donna, a midwife, provided midwifery care to her client, Paula, in 2009 and 2010. Paula's baby was born on June 1, 2010, and the last postpartum appointment for both Paula and her newborn was held on July 15, 2010. Donna had no involvement in her care after that. Paula was 17 at the time and turned 18 on January 2, 2011. Donna is required to keep the record until June 1, 2038, which is 10 years after the newborn's 18th birthday.

Record Keeping Scenario 2

Deepika, a midwife, has been practising for 25 years in the same practice and has built up a busy and successful practice. She decides she is ready for retirement but wonders what she is supposed to do with her client records. Does she have to keep them herself? Ordinarily, she would have to retain client records for 10 years from the last interaction with the client or the newborn's 18th birthday, whichever is later. However, Deepika may be transferring her practice over to another midwife. If this is the case, she does not have to retain the records herself but should notify the clients of the transfer of their client records. This can be done through a combination of direct notification of clients (e.g., mail or email) and placing a notice in the local newspaper.

Sample Exam Question

Which one of the following does not need to be recorded in the client's record?

i. The client's birth date.
ii. The person who recommended the client to you.
iii. The client's health concerns.
iv. The management plan for the client.

The best answer is ii. The way in which the client chose you as a midwife does not have to be recorded. Answer i is not the best answer because midwives need to record the client's birth date. It is relevant to many care decisions. Answer iii is not the best answer because midwives need to record the client's health concerns (which are part of the client's health history). It is relevant to many care decisions. Answer iv is not the best answer because midwives need to record the management plan for the client. It is relevant to following through with the client's care on future visits and for justifying one's actions should questions be raised later.

7. Informed Choice and Consent

Many complaints against midwives are the result of poor communication with clients, staff, and colleagues. Good communication begins with listening to others. Understanding the person's wishes, expectations, and values before doing anything is important. Asking questions to clarify and expand on what the person is saying also helps. Repeating back to a client what the client has said, in the midwife's own words, can help ensure understanding and reassures the client the midwife has been listening. Good communication also involves making sure the other person understands what the midwife is going to do, why they are going to do it and what is likely going to happen. When the other person is confused by what the midwife is doing or why they are doing it, there is miscommunication. Also, people do not like

to be surprised (e.g., by pain, an unexpected complication, etc.). Telling the person what will or may happen removes the surprise.

Clients have the right to control their bodies and their health care. Midwives do not have the right to assess or treat a client unless the client agrees to it (i.e., consents). A midwife who assesses or treats a client without the client's agreement can face various consequences, including: criminal (e.g., a charge of assault), civil (e.g., a lawsuit for damages) or professional (e.g., a discipline hearing). This section of the handbook deals with client choice during assessment and treatment of clients. Another part of the handbook deals with the need for consent when dealing with a client's personal health information.

General Principles

Informed choice is a fundamental principle in midwifery care in Ontario. It recognizes clients as the primary decision-makers and provide informed choice in all aspects of care by:

1. providing information so that clients are informed when making decisions about their care
2. advising clients about the nature of any proposed treatment, including the expected benefits, material risks and side effects, alternative courses of action, and likely consequences of not having the treatment
3. making efforts to understand and appreciate what is motivating clients' choices
4. allowing clients adequate time for decision-making
5. ensuring treatment is only provided with the client's informed and voluntary consent unless otherwise permitted by law
6. supporting clients' rights to accept or refuse treatment

Thus, the concept of informed choice includes, but goes beyond the traditional legal concept of informed consent. It is person-centred.

Under the traditional concept of informed consent, to be valid a client's consent must:

- Relate to the treatment. The midwife cannot receive consent for one procedure (e.g., taking a history of the client's health) and then use it to do a different procedure (e.g., physically examine the client). The client's consent must be for what is actually going to be done.
- Be specific. The midwife cannot ask for a vague consent. For example, one cannot ask for the client to consent to any treatment the midwife believes is appropriate. The midwife must explain the actual assessment or treatment procedure that is being proposed. This means the midwife often has to obtain the client's consent many times as changes in treatment become advisable. This also means a midwife cannot obtain "blanket consent" to cover every procedure, when the client first comes in.
- Be informed. It is necessary for the client to understand what they are agreeing to. The midwife must explain to the client everything the client needs to know before asking the client to give consent. For example, if someone asks for your consent to

drive your car without telling you that they intend to use it to race over rocky fields, your consent was not informed. To be informed choice, it must include the following:

- Nature of the assessment or treatment. The client must understand exactly what the midwife is proposing to do. For example, does the midwife intend to just ask questions or will the midwife also be touching the client? If the midwife is going to be touching the client (which is a routine part of most assessments), they should tell the client about it first.
- Who will be doing the procedure? Will the midwife be doing the procedure personally or will a colleague or student be doing it, or will the services be provided by a team?
- Reasons for the procedure. The midwife must explain why they are proposing that procedure. What are the expected benefits? How does the procedure fit in with the overall plan of care? How likely is it that the hopes for benefits will happen?
- Material risks and side-effects. The midwife must explain any "material" risks and side-effects. A risk or side-effect is material if a reasonable person would want to know about it. For example, if there is a high risk of a modest side-effect (e.g., discomfort), the client should be told. Similarly, if there is low risk of a serious side effect (e.g., death), the client needs to be told.
- Alternatives to the procedure. If there are reasonable alternatives to the procedure, the client must be told. Even if the midwife does not recommend the option (e.g., it is too aggressive and has a higher risk), the midwife should describe the option and tell the client why the midwife is not recommending it. Also, even if the midwife does not offer the alternative procedure (e.g., it is provided by a member of a different profession, such as a physician), the midwife must tell the client if it is a reasonable option.
- Consequences of not having the procedure. In some circumstances, one option for a client is to do nothing. The midwife should explain to the client what is likely to happen if the client does nothing. If it is not clear what will happen, the midwife should say so and provide some likely scenarios.
- Particular client concerns. If the individual client has a special interest in some aspect of the procedure (e.g., its nature, a side-effect), the client needs to be told (e.g., the procedure would violate the client's religious beliefs).

- Be voluntary. The midwife cannot force a client into consenting to a procedure. The midwife should discuss with the client that consent is their choice, and that the client should not let anyone pressure the client into doing something the client does not want to do.
- Not be based on misrepresentation or fraud. The midwife must not make claims about the assessment or treatment that are not true. For example, telling the client that the midwife will definitely be there at the birth is misleading. This situation would not result in true client choice. Clients must be given accurate factual information and honest opinions.

  Effective communication between the midwife and the client is required to obtain informed choice to treat the client. The midwife must make sure the client understands what they are agreeing to. Informed choice can often be obtained quickly and easily, and it is only when dealing with complex or particularly risky matters that a lot of time may be required.

Informed Choice Scenario No. 1

Donna, a midwife, meets a new client, Paula. Paula complains about feeling stressed and tired during the early stages of the pregnancy. Donna says: "I would like to fully understand your personal and family background and your medical history. There could be a lot of things making you feel tired and stressed and this information will help me try to figure out why. If you are uncomfortable with any of my questions, please let me know. OK?" If Paula agrees, Donna has probably just obtained informed choice for taking a full history.

Sample Exam Question

Obtaining a broad consent to cover all treatment in the course of care (often called "blanket consent") in writing from the client during their first midwifery appointment is probably a bad idea because:

i. The client may still be shopping around for a midwife.
ii. The client does not have confidence in the midwife yet.
iii. The client does not know what they are agreeing to.
iv. The client does not know if physical touching will be involved in this visit.

The best answer is iii. Informed choice requires the client to understand all of the relevant information including the nature, risks and side-effects of the available choices. It is impossible for the client to know these things upon their first visit at the office. Answer i is not the best answer because it focuses on only one aspect of what the client does not yet know. Answer ii is not the best answer because having confidence in the midwife is not enough for there to be informed choice. A client may trust the midwife and that may motivate the giving of consent, but the client still needs to know what treatment they are agreeing to. Answer iv is not the best answer because it focuses on only one aspect of what the client does not yet know.

Ways of Receiving Consent

There are three different ways a midwife can receive consent. Each has its advantages and disadvantages.

- Written consent. A client can give consent by signing a written document agreeing to the choices. A written consent provides some evidence the client gave consent. One disadvantage of written consent is that midwives may confuse a signature with consent. A client who signs a form without actually understanding the nature, risks and side-effects of the choice has not given true consent. Also, the use of written consent documents can discourage the asking of questions. In addition, the midwife might then not check with the client to make sure the client understands the information and is truly consenting.
- Verbal consent. A client can give consent by a verbal statement. A verbal consent is the best way for the midwife and the client to discuss the information and ensure the client really understands it. Making a brief note in the client record of the discussion is generally required.

- Implied consent. A client can give consent by their actions. For example, in Consent Scenario No. 1, above, the client Paula could just nod her head, implying consent for Donna to begin asking her questions. The main disadvantage of implied consent is the midwife has no opportunity to check with the client and make sure the client truly understands what is going to happen.

Health Care Consent Act (HCCA)

The *Health Care Consent Act, 1996* (HCCA) sets out rules about consent to care (referred to in the act as "assessment and treatment") especially where there is concern about the capacity of the client to consent to the care. In brief, except in cases of emergency, informed choice for any assessment or treatment must be obtained from the client. If the client is incapable, informed choice is obtained from the client's substitute decision-maker.

Consent Where the Client is Incapable

A client is not capable of informed choice if the client either:

- Does not understand the information, or
- Does not appreciate the reasonably foreseeable consequences of the decision.

For example, if the midwife recommends that a client take a supplement once a day for a month to improve their health, and the client insists on taking 30 supplements at once in order to obtain the maximum immediate benefit, it is pretty clear the client does not appreciate the consequences of the decision.

A midwife can assume a client is capable unless there is evidence to the contrary. A midwife does not need to conduct an assessment of the capacity of every client. However, if the client shows they may not be capable (e.g., the client simply cannot understand the explanation of the midwife) the midwife should assess the client's capacity. The midwife can assess the capacity of the client by discussing the proposed choices with the client to see if the client understands the information and appreciates its consequences.

The issue is whether the client is capable to give consent for the proposed choice. A client can be capable to give consent for one choice but not capable for another. For example, a client might be capable of consenting to an internal examination but not be capable of consenting to management of a major eating disorder during the pregnancy.

If a midwife concludes the client is not capable to give consent for a choice, the midwife should tell the client. The midwife should also tell the client who the substitute decision-maker could be. The midwife should still include the client in the discussions as much as possible. Of course, there are circumstances where involving the incapable client in the discussions will not be possible (e.g., if it will be quite upsetting to the client or where the client is unconscious).

Unless it is an emergency, the midwife must then obtain consent for the assessment or treatment from a substitute decision-maker. A substitute decision-maker must meet the following requirements:

- Be at least 16 years of age. There is an exception where the substitute is the parent of the client (for example, a 15-year-old mother can be the substitute decision-maker for the care of her child). However, there is no minimum age to be capable of consenting to health care treatment for oneself.
- Must, themselves, be capable. In other words, the substitute must understand the information and appreciate the consequences of the decision.
- Be able and willing to act.
- There must be no higher ranked substitute who wants to make the decision. The ranking of the substitute decision-maker is as follows (from highest ranked to lowest ranked):
    - A court appointed guardian of the person.
    - A person who has been appointed attorney for personal care. The client would have signed a document appointing the substitute to act on the client's behalf in health care matters if the client ever became incapable.
    - A person appointed by the Consent and Capacity Board (CCB) to make a health decision in a specific matter. The CCB is discussed in more detail below.
    - The spouse or partner of the client. A partner can include a same-sex partner. It can also include a non-sexual partner (e.g., two sisters who live together).
    - A child of the client or a parent of the client or the Children's Aid Society who has been given wardship of the client.
    - A parent of the client who does not have custody of the client.
    - A brother or sister of the client.
    - Any other relative.
    - The Public Guardian or Trustee if there is no one else.

Here is a scenario that shows how these rules work.

Consent Scenario No. 2

Donna, a midwife, proposes to her client Paula that because of the presentation of the baby, the location of the birth be changed to a hospital setting. Paula has developed a mental illness during pregnancy that prevents her from understanding the issue. She is clearly incapable. Donna knows that Paula, while she was still well, appointed her friend Pat to be her power of attorney for personal care. However, Pat is travelling outside of the country and cannot be reached. Therefore, Pat is not able to make the decision. Donna contacts Paula's elderly mother, but Paula's mother is frail herself and does not feel confident in making the decision. Thus, Paula's mother is not willing to act as a substitute decision-maker. Paula's sister is willing and able to make the decision on Paula's behalf and appears to understand the information and its consequences for Paula. Paula's sister is able to give the consent even though she is not the highest ranked substitute.

If there are two equally ranked substitute decision-makers (e.g., two sisters of the client), and they cannot agree, the Public Guardian and Trustee shall make the decision.

A substitute decision-maker must consent to treatment decisions on the following basis:

- The substitute must act in accordance with the last known capable wishes of the client. For example, if the client, while still thinking clearly, said: "Do not give me an epidural under any circumstances" the substitute needs to obey those wishes.
- The substitute must act in the best interests of the client if the substitute does not know the last known capable wishes of the client. For example, if a proposed treatment is simple and painless and would make the client more comfortable through delivery with little risk of harm, the substitute decision-maker should consent to it.

If it were to become clear that a substitute decision-maker is not following the above rules, the midwife should speak with the substitute decision-maker about it. If the substitute decision-maker is still not following the above rules, especially in a way that will harm the client, the midwife should call the office of the Public Guardian and Trustee. The contact information of the Public Guardian and Trustee of Ontario is available on the internet.

The above rules on informed choice when a client is incapable are set out in the *Health Care Consent Act.* All midwives should be familiar with this statute.

Sample Exam Question

Which of the following is the highest ranked substitute decision maker (assuming everyone was willing and able to give consent):

i. A power of attorney for personal care for the client.
ii. The client's live-in boyfriend.
iii. The client's mother.
iv. The client's son.

The best answer is i. Only a court appointed guardian is higher ranked than a power of attorney for personal care. Answer ii is not the best answer because the client's spouse or partner is a lower ranked substitute decision-maker. In addition, it is not clear if the live-in boyfriend is a spouse (under the *Health Care Consent Act*, they must have been living together for at least one year, have had a child together or have a written cohabitation agreement to be spouses). Answers iii and iv are not the best answers because they are lower ranked than both a power of attorney for personal care or a client's spouse. In addition, the client's mother and son are equally ranked so either they would have to give the same consent, or it would need to be determined which one would give consent.

Emergencies

One exception to the need for informed choice is in cases of emergencies. The *Health Care Consent Act, 1996* sets out two kinds of emergencies where treatment can be provided without consent:

- Where the client is incapable and a delay in care would cause suffering or serious bodily harm to the client.

- Where the client is capable, but there is a communication barrier (e.g., language or disability) that cannot be reasonably accommodated without delaying care and a delay would cause suffering or serious bodily harm to the client. However, if there is reason to believe the client does not want the treatment, it cannot be performed.

  In either case the midwife must attempt to obtain consent as soon as possible, either by finding a substitute decision-maker (in the first example) or by finding a means of communication with the client (in the second example). As soon as possible following the emergency event, the midwife should discuss with the client or substitute decision-maker the care that was provided and document it in the client's record.

Consent Scenario No. 3

Donna, a midwife, is seeing her client Paula at the office. Paula suddenly collapses in an apparent heart attack. Donna has a defibrillator in the office. Without trying to get consent from a substitute decision-maker, Donna uses the defibrillator. Donna was able to act without consent in these circumstances.

Consent and Capacity Board

Where there is a dispute about the care of incapable clients, the decision-making body responsible for making determinations in Ontario is the Consent and Capacity Board (CCB). A midwife, client or substitute decision-maker may apply to the CCB when a decision relating to a client's consent or capacity needs to be made. The powers of the CCB include the following:

- The CCB can consider a client's challenge to a midwife's decision that the client is incapable with respect to a treatment. The CCB may agree with the midwife or may overrule the midwife and find that the client is capable with respect to the treatment. If the CCB overrules the midwife, the midwife cannot administer the treatment unless the client consents.
- The CCB can provide direction to a substitute decision-maker with respect to an incapable person's wishes, e.g., whether the client's previously stated wishes apply to the circumstances or whether or not the wish was expressed when the person was capable.
- The CCB can also consider a request from a substitute decision-maker to depart from a person's wish that was expressed while the person was capable.
- The CCB can review decisions regarding a person's capacity to consent to treatment, admission to care facilities or the use of a personal assistive service.
- The CCB can appoint a substitute decision-maker to make decisions for an incapable person with respect to treatment, admission to a care facility or use of a personal assistance service.
- The CCB can amend or terminate the appointment of a substitute decision-maker.
- The CCB can review a decision to admit an incapable person to a hospital or other similar facility for the purpose of treatment.
- The CCB can review a substitute decision-maker's compliance with the rules for substitute decision-making.

Decisions of the CCB may be appealed to the courts.

8. Interprofessional collaboration

It is in the best interest of clients if all of their health care practitioners work with each other in collaboration. Such collaboration helps to ensure that care and treatment are coordinated, and as effective as possible. Collaboration also reduces the chances of clients receiving conflicting or inconsistent treatment and advice.

The *Regulated Health Professions Act, 1991* requires the College to promote interprofessional collaboration. The College models this collaboration by working together with other health Colleges (e.g., sharing information on investigations, developing standards together to promote their consistency). In addition, the College's Professional Standards for Midwives requires that midwives work both independently and together with other midwives and other regulated and unregulated health care providers in relationships of reciprocal trust. The standards require that midwives work with clearly defined roles and responsibilities in all health care settings and when in health care teams.

It must always be clear who has primary responsibility for the client and the newborn and the roles and responsibilities of each practitioner. These decisions and agreements must be clearly communicated and documented. Regardless of their role, midwives remain accountable for the care that they provide.

Ultimately, the client controls the extent of interprofessional collaboration. If a client is uncomfortable with it, the client can direct their midwife not to share the client's personal health information with others. The midwife must comply with such a direction unless one of the exceptions in the *Personal Health Information Protection Act, 2004* (which is discussed in more detail in the privacy and confidentiality section of this handbook) applies. However, where the limitation on sharing of client information would prevent effective collaboration, the client should be told that the proposed collaboration might not occur. In addition, a client cannot compel a midwife to act outside of their scope of practice.

Midwives should discuss any planned interprofessional collaboration with the client when possible and as early as possible. However, there are circumstances where prior client consent is not possible (e.g., when the client goes to the hospital in an emergency). In an emergency, midwives can disclose information needed for the care of the client without consent as long as the client has not previously prohibited the midwife from doing so.

Interprofessional collaboration only succeeds if midwives respect their colleagues. Even if the midwife does not agree with the approaches taken by a colleague, communications should be polite. Midwives should share information and cooperate with their colleagues whenever possible. Reasonable attempts to coordinate treatment should be made. Compromises may sometimes need to be made (e.g., as to which care approach to try first). Interprofessional rivalries should be set aside; the client's best interest should always come first. Attempts should be made to avoid forcing the client to choose which health care practitioner to use whenever possible (avoid saying: "either she goes, or I go").

Where interprofessional collaboration involves working in a multi-disciplinary setting (i.e., a place where members of different professions work together and where clients are often seen by multiple health care practitioners, such as a hospital), other issues arise, including the following:

- Will the setting have shared records, or will the midwife have separate records?
- If the records are shared, will the midwife keep any private notes outside of the shared record? If so, how will the midwife make sure other health care practitioners have access to the information they need?
- How does the setting deal with the wording used in the records? For example, will everyone use the same abbreviations?
- What happens to the records if the midwife leaves to practise elsewhere? Will the client be told where the midwife has gone? Will another midwife from the setting take over the client's care? Will the client be given a choice? It is preferable for the client to be given a choice although some settings will only do so if the client asks.
- Who is the health information custodian that owns the records?
- How will disagreements in the approach to the care of the client be dealt with? If it is the midwife who is in disagreement, when and how does the midwife tell the client?
- Is the client aware of all of the above?

Interprofessional collaboration, while challenging at times, is the inevitable direction of health care in Ontario.

Interprofessional Collaboration Scenario

Donna, a midwife, has a client named Paula. Paula's family doctor calls unexpectedly to say Paula is not responding to her thyroid medication as the doctor had expected. The doctor has just learned that Donna is also treating Paula. The doctor wonders if there's anything Donna is doing that might interfere with Paula's medication. Donna has hinted to Paula that Donna is not supportive of the medication Paula is on. Donna wonders if Paula has stopped taking the medication without telling either her or the doctor. What should Donna say?

In many respects, there has already been a failure of interprofessional collaboration in this scenario. Donna should have already discussed with Paula the benefits of interprofessional collaboration. Rather than hint at her concerns about the medication Paula is on, Donna should have discussed the concerns openly with Paula and requested permission to speak with Paula's doctor. At this point, however, Donna should probably speak to Paula first before talking to the doctor. It is not clear whether Paula would consent to such a discussion taking place and it is not an emergency. Donna should obtain Paula's permission to speak to the doctor.

9. The Role of the College

The College has a number of roles and responsibilities in order to protect the public. Under the *Midwifery Act, 1991*, the College has to set up various committees and

operate various programs. The following are some of the most important processes the College carries out in the regulation of the profession.

a) Registration process

Registration is the way for a person to enter into the profession and become a member of the College if they meet the requirements set out in the Registration Regulation. The process of registration itself is fairly structured.

To become a registrant of the College a person files an application form with the Registrar and pays the applicable fees. Through the application form the applicant provides the College with information about their training and experience, their past conduct, and other information that may affect their ability to practise effectively (e.g., language fluency, professional liability insurance, current experience, etc.). The applicant has to successfully pass the qualifying examination to become a general or supervised class midwife. The applicant should provide enough information to demonstrate that they meet the requirements for registration. The applicant must not make any false statements on the application.

Where the applicant meets the requirements, the Registrar's office will simply accept the application. In this case, a certificate of registration is issued to the new member of the College.

However, if it appears that the applicant does not meet the registration requirements (or even if the Registrar is not sure) the Registrar will refer the application to the Registration Committee. The applicant will be told of the concerns and be given an opportunity to provide a written response to them. The Registration Committee will consider the application further and determine the applicant's suitability to become a member. If the Registration Committee concludes that the applicant meets the requirements, a certificate of registration will be issued. If the Registration Committee concludes that the applicant does not meet the requirements it can make a number of decisions including:

1. Direct the applicant to complete further training or examinations;
2. Register the applicant with terms, conditions, and limitations (for example, if the missing requirement is exemptible under the regulation and the public can be protected in the circumstances);
3. Refuse the application.

If an unconditional certificate is not granted by the Registration Committee, the applicant has further options. The decision may be appealed to the Health Professions Appeal and Review Board (HPARB). HPARB is appointed by the government and is independent of the College. HPARB will review the file and, if the applicant wishes, hear from witnesses. HPARB can determine that an applicant meets the registration requirements or can require the Registration Committee to obtain additional information and make a new decision. HPARB's decision can be appealed to the courts.

To ensure that the College's registration process is fair, the registration system itself is audited and reviewed by the Office of the Fairness Commissioner of Ontario.

Further, the RHPA has provisions to ensure that the registration processes of Colleges are transparent, objective, impartial and fair.

Where an applicant is registered in another part of Canada, the College must, with rare exceptions, accept the applicant's education, experience, and examination credentials without further inquiry. The College can still review the other registration requirements (e.g., good character, professional liability insurance, jurisprudence requirements).

Registration Process Scenario 1 – Making False Statements

Deepika filled out her application form for registration, but when asked if she had any previous criminal findings, she did not want to put down the shoplifting conviction she received 20 years ago when she was a juvenile. She was worried it would affect her application. So, on her application she reported that she did not have any previous criminal findings. On the basis of the application form, the College registered Deepika. A few years later the College is told about Deepika's previous conviction. The College realizes that Deepika made a false statement. The College can revoke Deepika's registration because she made the false statement on the application form. Ironically, if Deepika had disclosed the conviction, the Registration Committee would probably have accepted Deepika for registration since she was a youth at the time and because she had no other difficulties in twenty years. However, making a false statement on the application form is serious and reflects current dishonesty, that now she may be removed from the profession.

An applicant who has received a pardon or who has received a conditional or absolute discharge from court must still report the offence.

b) Complaints and discipline process

In order to protect the public, investigating concerns about a midwife's professional conduct or competence is an essential element of self-regulation. Where a concern appears serious, disciplinary action must be taken. The College deals with professional misconduct and incompetence in an educational manner as often as possible. If a matter is referred for discipline, the College provides a fair procedure to the midwife.

The following outlines how the complaints and discipline processes work.

The ICRC

The Inquiries, Complaints and Reports Committee (ICRC) is the statutory committee of the College that handles member-specific concerns (e.g., professional misconduct, incompetence, and incapacity).

The ICRC can only handle concerns regarding members and some former members of the College; it does not deal with the conduct of unregistered persons (e.g., illegal practitioners). Furthermore, the ICRC is only involved in allegations regarding professional misconduct, incompetence, or incapacity. It does not handle claims about professional negligence, which are dealt with by the courts in civil lawsuits.

For professional misconduct and incompetence issues there are two ways to bring the concerns to the attention of the ICRC:

1. Formal complaints; and
2. Formal investigative reports (called Registrar's Reports).

Incapacity concerns are also dealt with by the ICRC but will be discussed separately because they are handled in a different way than complaints.

Intake of Complaints

For a concern to be a formal complaint the following requirements must be met:

- It must be in writing or recorded on tape, film, disk or other medium (as set out in the Health Professions Procedural Code);
- The complainant must be identified;
- The member must be identifiable (the ICRC may be able to assist in identifying the member based on the information provided by the complainant);
- The complaint must specify some conduct or actions that are of concern (i.e., not just the complaint that a member is "unprofessional", "incompetent" or "incapable", but including some level of detail about the actions of the midwife); and
- The complainant must intend the matter to be a complaint.

The Registrar must give the member notice of complaint. This must be done within 14 days of the receipt of the formal complaint.

Intake of Registrar's Reports investigations

As mentioned above, the ICRC process can be initiated by a Registrar's Report. In this method the following occurs:

- a concern arises that the Registrar believes warrants investigation and it is brought to the ICRC with the request for the ICRC to approve the appointment of an investigator;
- an investigator is appointed;
- the investigation is conducted, and the investigator makes a report to the Registrar; and
- the Registrar then makes a Registrar's Report to the ICRC.

Once a Registrar's Report is provided to the ICRC, the matter proceeds in much the same way as a complaint.

Investigations

The investigations by the ICRC are thorough but neutral, objective, and fair.

The following is a summary of the investigation process for both complaints and Registrar's Reports.

1. Complaints Investigations:
   - Frivolous or vexatious complaints: The ICRC investigates every complaint, with one exception. When the complaint is 'frivolous or vexatious', made in bad faith, is moot

or is otherwise an abuse of process, the ICRC can choose not to investigate it. This happens rarely. Generally, it must be fairly obvious that there is little merit to the complaint and that processing the complaint would be unfair in the circumstances. For example, a complaint repeating a previous complaint without any new evidence would be frivolous and vexatious. Notice is given to the member and complainant if the ICRC intends to take no action in these cases.

- Investigative steps: Both the complainant and the member are usually first asked to provide all documentation available to them. The ICRC staff gathers additional information until they determine it is likely that all reasonable and available information has been obtained. Information is gathered from a variety of sources including College files, the midwife's files, public databases (i.e., court files), other regulators, witnesses, and other midwives.
- ICRC decision: At the completion of the investigation the ICRC makes its decision about the complaint.
- Time limits: The goal is to complete a complaints investigation within 150 days of it being filed with the College. If not completed within 150 days, the parties must be notified regularly about the progress of the complaint. If the College takes too long, the complainant or the member can ask the Health Professions Appeal and Review Board to take action.

2. Registrar's Reports Investigations:

- The Registrar may appoint an investigator in three different situations:
    1) Concerns come to the attention of the Registrar: Any concern about the conduct or actions of a midwife that is not a formal complaint is generally brought to the attention of the Registrar. For example, the Registrar may receive information from a client, a colleague of the midwife or another health professional. If the Registrar is of the view that there are reasonable and probable grounds that the midwife engaged in significant professional misconduct or is incompetent, the Registrar brings the concerns to the attention of the ICRC. The ICRC is asked to approve the appointment of an investigator;
    2) A request is made by the ICRC to help investigate the concerns: If the ICRC cannot obtain important information about the concerns on its own (e.g., a person refuses to provide it), the ICRC can ask the Registrar to use their special powers to help; or
    3) A request is made by the ICRC to help investigate information received from the Quality Assurance Committee: Where a member does not co-operate with the quality assurance process, or the process has revealed significant concerns about the member, the Quality Assurance Committee can bring the concern to the ICRC. The ICRC can ask the Registrar to appoint an investigator.
- The investigation: The investigator appointed by the Registrar has special powers. For example, they can enter the office of the midwife and examine files, can summon documents, and can compel witnesses to answer questions.
- Time limits: There is no set deadline to complete a Registrar's Report Investigation and render a decision. However, they should be completed within a reasonable time.

If a complainant wishes to withdraw a complaint, the ICRC can still decide to proceed with the investigation. The ICRC has to decide whether to accept a withdrawal of a complaint.

ICRC Decision

Once the investigation is completed the ICRC makes a decision. There are many options for the ICRC. Referring concerns to discipline is not the only option. The ICRC is a 'screening' body directing the concern to the most reasonable resolution. The ICRC does not hold a hearing, make findings of credibility, find wrongdoing, or impose a disciplinary order (i.e., fine or suspension). Only the Discipline Committee can do these things. The following are some of the decisions that can be made by the ICRC:

- Referral to Discipline: Discipline is intended for serious concerns (e.g., dishonesty, breach of trust, wilful disregard of professional values, inability to practise competently). Even when there are serious concerns, the ICRC must ensure that there is reasonable evidence to support the concerns.
- Referral for Incapacity Proceedings: This is done where the conduct may be due to an illness or health condition. The procedure is described separately below.
- Appearance for a Caution: The midwife can be required to appear before the ICRC for a caution about the conduct. Often this is accompanied by a statement informing the midwife that, if changes do not occur, the midwife may face more formal action if there is a complaint or report of a similar nature in the future.
- Other Actions: The ICRC can require the midwife to undergo a specified continuing education or remediation program (e.g., a record keeping course).
- Taking No Action: If there is no basis for concern the ICRC can close (or dismiss) the complaint.

Review Before HPARB

After the ICRC has rendered a decision on a complaint, either the complainant or the midwife can seek a review of the decision before the Health Professions Appeal and Review Board (HPARB) (unless the decision was a referral for discipline proceedings or for incapacity proceedings). HPARB may confirm a decision of the ICRC or return the matter to the ICRC to make a new decision. HPARB can also make recommendations to the ICRC.

A decision based on a Registrar's Report cannot be appealed to HPARB, but the midwife may apply to the courts for judicial review in certain circumstances.

Discipline Proceedings

Where the ICRC views a complaint or other investigation as serious, it can refer specified allegations to the Discipline Committee for a hearing.

In very serious cases the ICRC may make an interim order to suspend the midwife's certificate of registration to protect the public while awaiting a discipline hearing. Interim orders are only made when there is a concern that the midwife's continued practice will or is likely to expose harm to clients.

Procedure Before the Discipline Hearing Starts:

- The College initiates discipline proceedings with a notice of hearing. The notice contains information necessary to ensure that the midwife can participate effectively in the hearing, including where and when the hearing will be held. The notice is usually accompanied by a statement of allegations outlining the facts that are alleged and the legal conclusions that the College seeks to be drawn from the facts (i.e., that the midwife's conduct amounts to incompetence or a category of professional misconduct).
- The College discloses all relevant information in the College's files to the midwife. Disclosure enables the midwife to present the best possible defence.
- The Chair of the Discipline Committee selects a panel from among the members of the Committee to hold the hearing. It can be between three to five people (two must be public members, and the remaining panel members are usually midwives). These decision makers must have no conflict of interest and be unbiased.
- Prehearing conferences may be held before the discipline hearings. This is to reach an agreement on as many issues as possible and to plan the hearing. Discussions at pre-hearing conference are 'off the record'. If a resolution is agreed upon (e.g., the matter is settled) it is presented to the panel of the Discipline Committee for acceptance.

Procedure at the Discipline Hearing:

- The procedure of a discipline hearing is formal and unlike most meetings non-lawyers have been exposed to. It is similar to a court trial in that there are two sides presenting their arguments and evidence to the panel. The Discipline Committee panel ensures that the cases are presented fairly, they listen impartially to the evidence and arguments, and after both parties have completed their presentations, the panel decides on the issues.
- The hearing is open to the public unless there is some compelling reason for privacy. Open hearings uphold transparency and fairness in the process. There are only a few limited exceptions where the hearing may be closed (e.g., a person's sensitive personal health information might be disclosed, outweighing the benefit of holding a public hearing).
- The burden is on the College to prove that the midwife engaged in professional misconduct. The College presents its witnesses first. Then the midwife is permitted to call their witnesses if any. The midwife may choose to testify. The College can then call witnesses to reply to what the midwife's witnesses said.
- The hearing is divided into the following stages:
    - First, the panel hears evidence and argument with respect to the alleged misconduct or incompetence and makes a decision regarding whether the midwife engaged in professional misconduct or was incompetent.
    - Second, if the panel concludes that the midwife engaged in professional misconduct or was incompetent, the panel hears evidence and argument regarding the appropriate penalty order that should be made. The panel then makes a penalty order.
    - Finally, if either the College or the midwife seeks its costs, the panel hears evidence and argument and makes a costs order.

Evidence at the Discipline hearing:

- Generally, rules of evidence that apply to civil court trials apply to discipline hearings. For example, hearsay (i.e., second hand) evidence is not admissible.
- Decisions are to be based exclusively on the evidence admitted before it. The Committee cannot rely on any personal knowledge that was not presented as evidence to make a finding.
- A record is kept compiling all the exhibits (i.e., documentary evidence) and the witnesses' testimony is recorded.

Findings of the Discipline Committee

- Once a Discipline Committee panel determines what a midwife has done, it must then decide whether or not that behaviour constitutes professional misconduct or incompetence.
- Professional misconduct is defined in the RHPA and the Professional Misconduct Regulation (as described below).
- Incompetence is different from professional misconduct. It generally does not involve unethical or dishonest conduct, but rather that the midwife does not have the knowledge, skill, and judgment to practise safely. A finding of incompetence is based on the care of one or more of the midwife's clients.
- A finding of incompetence can either be that the midwife is unfit to continue to practise at all, or that the midwife's practise should be restricted.

Decisions and Orders in Discipline Cases:

If a midwife has been found guilty of professional misconduct, the Discipline Committee panel can make one of more of the following orders:

- Revocation – the removal of the midwife from the profession. The midwife cannot re-apply to the College for at least one year, at which time they must satisfy the Discipline Committee that they ought to be permitted back into the profession.
- Suspension – the temporary removal of a midwife from the profession. Its duration can be fixed (e.g., three months) or flexible (e.g., dependent on an event occurring such as successful completion of a course).
- Terms, conditions, or limitations – can either be for a specified period (e.g., until the midwife successfully completes certain remedial training) or for an indefinite period (e.g., the midwife cannot consume any alcohol). The terms, conditions or limitations must relate to the finding made by the Discipline Committee panel. For example, if the midwife was dishonest because of a substance abuse problem, the condition cannot be to take remedial education courses because there was no finding the midwife lacked any basic knowledge.
- Reprimand – is a formal conversation between the Discipline Committee panel and the midwife where the panel tells the midwife its views of their conduct and how to avoid similar problems in the future.
- Fine – the Discipline Committee panel can impose a fine of up to $35,000.
- Reimbursement for funding in sexual abuse cases – where there is a finding of sexual abuse the Discipline Committee panel can require a midwife to reimburse the College for any funding for counselling or therapy provided to the client.
- Minimum order in sexual abuse cases – cases involving frank sexual acts with clients (e.g., intercourse, masturbation) have a mandatory minimum order of both a

reprimand and revocation. In these cases, no reinstatement can be made for five years after the revocation occurs.
- Costs can be ordered by the Discipline Committee panel to cover a portion of the expenses associated with the hearing.

In incompetence cases, the Discipline Committee panel can order revocation, suspension, or terms, conditions, and limitations.

The Discipline Committee panel must issue both a written decision and written reasons for their decision.

Appeals

Either the midwife or the College may appeal a decision of the Discipline Committee to the Divisional Court. The Divisional Court has the power to confirm, amend or reverse a decision of the Discipline Committee panel if it acted unreasonably or made an error of law.

When a party seeks an appeal, the Discipline Committee's order will not be enforced until the end of the appeal process, unless the Committee made a finding of incompetence, certain findings of sexual abuse or an interim suspension had been ordered.

Complaints and Discipline Scenario 1

A client sends a letter of complaint to the College saying that Donna, a midwife, was rude to her. The client says that Donna became angry when the client expressed concern that the care was unhelpful. The client says that Donna "threw her out of the office". The Registrar sends a letter notifying Donna of the complaint and asking for a response. Donna responds that the client was extremely challenging and after doing all that she could to explain the proposed care management plan to the client she became verbally abusive. Donna had to terminate the professional relationship. Donna's letter is sent to the client who replies that she was never verbally abusive to Donna and that Donna is making this up to defend herself. The Inquiries, Complaints and Reports Committee (ICRC) obtains statements from the client's spouse, Donna's receptionist and a couple of clients who were around at the time. It is difficult to reconcile the stories but the picture that emerges is that there was a verbal confrontation in which both parties may have used intemperate language. The ICRC decides that this is not a case for discipline, particularly since there have been no previous complaints about Donna. However, the ICRC requires Donna to meet with the panel to receive an oral caution reminding her of the need to be professional in her dealings with clients even in challenging circumstances.

Complaints and Discipline Scenario 2

Donna is a midwife. Her former practice partner, Rebecca, calls the Registrar to express her concerns about Donna's care. Rebecca's contract with Donna has just been terminated. Rebecca lists a number of concerns, including Donna's clinical skills (ability to suture, knowledge of fetal heart monitoring, knowledge about emergency procedures), and communication style (she is rude to colleagues and not receptive to feedback). Rebecca states that she is particularly concerned because there have been a number of bad client

outcomes, as well as many "close calls". The Registrar appoints an investigator who obtains five client charts and interviews Rebecca, other midwives that work with Donna and several clients. Donna has been the subject of one previous investigation where she received an oral caution for failing to consult with a physician for a repair of a third-degree laceration. The ICRC considers the investigation report as well as Donna's submissions and determines that the concerns are serious enough to refer allegations of professional misconduct and incompetence to discipline. The ICRC also concludes that there is sufficient evidence to refer the matter to a hearing.

c) Incapacity process

As noted above, incapacity has a particular definition under the *Regulated Health Professions Act.* It relates to a regulated health care professional who has a physical or mental condition that warrants restrictions on their registration.

The intent of the incapacity provisions is not to punish an ill health practitioner, but rather to ensure that they receive appropriate care and are supervised and monitored sufficiently so that they can continue to practise without undue risk to the public. Only on rare occasions will the health practitioner have their certificate of registration suspended or revoked by the Fitness to Practise Committee.

Concern of Incapacity Initiated

When incapacity concerns arise, they are brought to the Inquiries, Complaints and Reports Committee (ICRC). The information of possible incapacity can come from a number of sources including a law enforcement agency, a mandatory report by a midwifery practice or an expression of concern by another midwife or a member of the public.

ICRC Inquiry

Once an ICRC panel is selected, notice is given to the midwife that the ICRC panel intends to inquire into whether the midwife is incapacitated. The ICRC inquiries panel is an investigative body. Its role is to gather information and then determine if formal proceedings should be initiated. The inquiry may involve any (or all) of the following:

- a review of any relevant information that might be contained in the College's files;
- obtaining witness statements from clients, co-workers, colleagues, family members, and others who have observed the midwife's behaviour, particularly any unusual behaviour;
- obtaining hospital and health care practitioner office charts of relevant treatment of the midwife;
- obtaining a report from health care practitioners who have treated the midwife; and
- ordering an independent specialist examination of the midwife.

The ICRC must prepare a report of its inquiries and send a copy to the midwife for comment. The ICRC then determines if the concerns should be referred to the Fitness to Practise Committee for a hearing.

ICRC Decision to refer to the Fitness to Practise Committee for hearing (or not)

The matter is only sent to a hearing when the midwife's problem is serious. The decision to require a hearing before the Fitness to Practise Committee is not taken lightly. There must be sufficient evidence of incapacity. This usually occurs when there is some concern that the midwife's illness will, now or in the future, adversely affect their professional practice. Typically, the health condition involves a lack of insight by the midwife into the extent of their illness.

The ICRC can make an interim order that directs the Registrar to suspend the certificate of registration of the midwife or to impose terms, conditions, or limitations on the midwife's registration until the Fitness to Practise Committee addresses the matter.

Hearing before the Fitness to Practise Committee

The hearings before the Fitness to Practise Committee share many similarities with the hearings before the Discipline Committee. Generally, the procedure at a fitness to practise hearing is as follows:

- A panel is selected by the chair of the Fitness to Practise Committee – a panel consists of at least three people including at least one public member of College Council and at least two other persons (usually midwives).
- Disclosure of evidence – the College has the same disclosure obligations as in a discipline hearing. This ensures that the midwife knows the case against them and have available any supportive information in the College files.
- Closed hearing – ordinarily, fitness to practise hearings are closed to the public because of the sensitive personal nature of such a hearing (and because the hearing is not meant to be punishment to the midwife). Only the midwife can request that the hearing be opened to the public.
- Order of hearing – is similar to a discipline hearing. The College has the burden of proving that the midwife is incapacitated. The College presents its case first. The midwife then has an opportunity to present their evidence.

Decisions of Fitness to Practise Hearings

The Fitness to Practise Committee must determine if a midwife is indeed incapacitated. As mentioned, this requires that the midwife have a physical or mental condition that warrants, in the public interest, some restrictions on the midwife's registration (e.g., supervision and treatment). The order will be based upon the evidence presented at the hearing, usually involving expert opinions on the midwife's health. The Committee looks at the current status of the midwife's health.

If the Fitness to Practise Committee finds the midwife to be incapacitated, it must also decide what restriction to place on the midwife's certificate of registration. It can revoke their certificate of registration entirely, suspend their certificate of registration, or impose terms, conditions, or limitations on their certificate of

registration. Terms, conditions, or limitations on the certificate of registration are the most common outcome where a finding of incapacity has been made. A typical order is for treatment, followed by monitoring and supervision.

If circumstances change, the Committee can change an order it made in the past. For instance, if a midwife establishes that their illness has been in remission (i.e., sobriety) for a while, there can be a loosening of the restrictions on their certificate of registration.

Appeals

Either the midwife or the College may appeal decisions of the Fitness to Practise Committee to the Divisional Court. Despite an appeal being made, any order from the Fitness to Practise Committee takes effect while the appeal is pending. The Divisional Court can confirm, amend, or reverse a decision of the Fitness to Practise Committee.

Fitness to Practise Scenario – The Typical Case

Deepika is a midwife working with Jordan, another Midwife. Jordan reports to the College that she is terminating her partnership with Deepika because Deepika's drinking is beginning to affect her work. Jordan is tired of covering for Deepika when she comes to the midwifery clinic two hours late after a binge. The Registrar makes some inquiries that confirm Jordan's report. Deepika, however, denies she has any problems. The Registrar reports the matter to the ICRC. The ICRC asks Deepika for consent to obtain a copy of her medical records, which Deepika provides. Those records indicate that Deepika has separated from her spouse, who accuses her of drinking, and that Deepika has recently been charged with impaired driving. The ICRC directs that Deepika attend an assessment with a specialist in substance abuse disorders. The report from the specialist indicates that Deepika clearly has a substance abuse disorder.

The ICRC refers Deepika to the Fitness to Practise Committee for a hearing and suspends Deepika's certificate of registration until the hearing can be completed. Deepika enters and successfully completes a 30-day residential treatment program for substance abuse and is an active participant in the recommended after-care program. At the Fitness to Practise hearing Deepika's lawyer and the College's lawyer present a joint submission asking the Committee to find that Deepika is incapacitated, as defined in the Act, and order that Deepika's certificate of registration be restored on the condition that she continue in regular treatment, that she work with another Midwife who will monitor Deepika's performance at work, and that regular reports be made to the College of Deepika's progress. The Committee accepts the joint submission.

d) Quality Assurance Program

Purpose of the program

Every College must have a quality assurance program. The goal of the quality assurance program is to ensure that the knowledge, skill, and professional judgment of midwives

remain current throughout their careers; and that they continue to provide safe, effective, and ethical midwifery care to their clients.

Whereas the complaints and discipline processes of the College may be described as reactive to concerns raised about members, the quality assurance program is a proactive means to ensure registrants are meeting the standards of the profession and to identify and remediate any issues at an early stage. In fact, the College generally cannot use information it learns through the quality assurance program to discipline a registrant, nor can the information be used by any person in any legal proceeding. At most, the Quality Assurance Committee can report the midwife's name and alleged misconduct to the Inquiries, Complaints and Reports Committee. The only exception is where the registrant makes a false statement to the College or fails to cooperate with the program.

The quality assurance program is administered by the Quality Assurance Committee of the College (the QA Committee).

The College has established the following specific activities as its quality assurance program:

1. Continuing education or professional development designed to promote continuing competence and continuing quality improvement; address changes in practice environments, promote interprofessional collaboration, and incorporate standards of practice, advances in technology, changes made to entry to practice competencies and other relevant issues in the discretion of the Council.
2. Self, peer, and practice assessments.
3. A mechanism for the College to monitor registrants' participation in, and compliance with, the program.

Midwives are required to cooperate with the QA Committee and with any assessors appointed by the Committee. This includes allowing assessors to enter and inspect their practice and review client records. A failure to cooperate can constitute professional misconduct.

Details of the College's quality assurance program are set out in the Quality Assurance Regulation under the *Midwifery Act, 1991* and in College documents available on the College's website.

Role of the QA Committee

The QA Committee administers the quality assurance program by developing policies, educating midwives about completing the components, and monitoring and reviewing compliance with each component. Most components are done by midwives themselves (e.g., self-assessments). The Peer and Practice Assessment program, however, is administered by the QA Committee.

For a Peer and Practice Assessment program, the QA Committee selects midwives and appoints an assessor to evaluate them against midwifery competencies and standards of

practice. The assessor's role is simply to review and report on a midwife's practice and not to make any decisions or orders.

The QA Committee's role in a Peer and Practice Assessment program is to determine if the midwife's knowledge, skill, or judgment is satisfactory. If the QA Committee is of the opinion that the midwife's knowledge, skill, or judgment is not satisfactory, the QA Committee may do any of the following:

- Require a midwife to participate in specified continuing education or remediation programs;
- Direct the Registrar to impose terms, conditions, or limitations on the midwife's certificate of registration for a specified period of time; or
- If the QA Committee believes the midwife may have committed an act of professional misconduct or may be incompetent or incapacitated, the QA Committee may disclose only the name of the midwife and the allegations (but not the evidence) against the midwife to the Inquiries, Complaints and Reports Committee.

Since the quality assurance program is educational and supportive in nature, the QA Committee will most often direct an upgrading program for the midwife who has gaps in their knowledge, skill, or judgment (e.g., courses or seeing a mentor).

The QA Committee must consider any written submissions by the midwife before taking any action.

Quality Assurance Scenario No. 1

Donna, a midwife, is selected for an assessment. The assessor meets with Donna and prepares a report for the QA Committee. During the assessment, Donna demonstrates that she has the required knowledge, skills and judgment required to practice safely. The QA Committee recognizes that there is no reason to take any action.

Sample Exam Question

If a midwife is selected for an assessment, the midwife should:

i. Cooperate with the assessor, including permitting the assessor to inspect their office and provide any requested records.
ii. Permit the assessor to inspect their home.
iii. Give the assessor all records except those that are confidential.
iv. Complete all required professional development records and fill in gaps in client records before sending them to the team.

The best answer is i. Midwives have a duty to cooperate with an assessor. Answer ii is not the best answer because assessors are not permitted to enter private homes. Answer iii is not the best answer because an assessment team's right to access premises and records overrides client confidentiality. Answer iv is not the best answer because while an assessment is a good opportunity to improve record keeping and other practices, a midwife should always update client records immediately so that they are accurate. Midwives should never wait until they are selected for an assessment to update their records.

Additionally, if records are falsified, the QA Committee may report the midwife's name and this allegation to the Inquiries, Complaints and Reports Committee.

10. Privacy and Confidentiality

e) Personal Health Information Protection Act (PHIPA)

Personal Health Information

Midwives have a legal and professional duty to protect the privacy of clients' personal health information. The *Personal Health Information Protection Act, 2004* (PHIPA) governs midwives' use of personal health information, including its collection, use, disclosure, and access. PHIPA helps guide the general duty of confidentiality described above.

Personal health information refers to almost anything that would be in a midwife's records regarding a client. It is defined in PHIPA as identifying information, whether oral or written, about a person, where the information:

(a) Relates to the person's physical or mental health, including the person's family health history;
(b) Relates to the provision of health care to the person, including the identification of a person as someone who provided health care to the person;
(c) Is a plan of service within the meaning of the Home Care and Community Services Act, 1994 for the person;
(d) Relates to the person's payments or eligibility for health care, or eligibility for coverage for health care:
(e) Relates to the donation by the individual of any body part or bodily substance of the person or is derived from the testing or examination of any such body part or bodily substance;
(f) Is the person's health number; or
(g) Identifies a person's substitute decision-maker.

Health Information Custodians

A Health Information Custodian (Custodian) is the person or organization responsible for all health records. The Custodian must create, implement, and oversee a privacy policy that meets the requirements of PHIPA.

A midwife, who is a sole practitioner, is the Custodian over any health information and records that the midwife collects.

Two or more midwives who work together may decide to act as a single organization for the purposes of PHIPA. This may be helpful because the midwives can create a single privacy policy. This would allow for consistent health record-keeping practices. In this case the midwives will have shared responsibility for complying with PHIPA.
If a midwife works for a health organization such as a public hospital, the organization is usually the Custodian of health records.

Information Officers

PHIPA requires every individual practitioner or organization to appoint a contact person (often called an Information Officer). An Information Officer is the person who ensures compliance with the privacy policy and requirements of PHIPA. The Information Officer's duties include reviewing the organization's privacy practices, providing training and monitoring compliance. The Information Officer is also the contact person for requests for information from the public.

A midwife who is a sole practitioner usually acts as Information Officer. Midwives working together in a practice should designate someone (usually one of the midwives) as the practice's Information Officer. A health organization may appoint a person within the organization or may hire a person outside of the organization to be its Information Officer.

PHIPA Scenario

Three midwives work together in a clinic. They decide they will act as an organization for privacy purposes. Their organization, the midwifery practice group, is the Health Information Custodian. The midwives create a privacy policy together. The midwives decide to appoint the most senior midwife to be the Information Officer. The Information Officer creates a procedure to protect personal information, develops a privacy complaints procedure and ensures that all midwives comply with the privacy policy.

Protecting personal health information

Custodians must put in place practices to protect personal health information in the Custodian's custody or control.

Practitioners or organizations must take appropriate measures to protect personal health information from unauthorized access, disclosure, use or tampering. Those safeguards must include the following components:

- physical measures (e.g., restricted access areas, locked filing cabinets);
- organizational measures (e.g., need-to-know and other employee policies, staff training); and
- technological measures (e.g., passwords, encryption, virus protection, firewalls).

Practitioners or organizations need to systematically review all of the places where they may temporarily or permanently hold personal health information (including laptops, smartphones and other handheld devices) and assess the adequacy of the safeguards. Almost every organization that has not done this before will find that it needs to make changes.

Practitioners or organizations also need to securely retain, transfer, and dispose of records in accordance with the College's requirements. For example, the College requires that client records be kept for 10 years from the last contact with the client (or if the client was not an adult, such as a newborn, at the last contact, ten years from when the client turned 18).

A midwife's or organization's privacy policy should explain how health information will be protected.

Collection, use and disclosure of personal health information

A midwife or organization must only collect, use, or disclose a person's personal information if the person consents or if the collection, use, or disclosure is otherwise permitted by law. A midwife should collect, use, or disclose no more information than is reasonably required in the circumstances.

A midwife's or organization's privacy policy should clearly explain how and when personal health information will be collected, used, and disclosed.

Under PHIPA, collection, use and disclosure of personal health information is permitted without consent in limited circumstances.

Circle of Care

A midwife can share personal health information with other individuals within a client's "circle of care" for the purposes of providing health care without the client's express consent.

A circle of care may include other health professionals who provide care to the same client (e.g., family physician, naturopath). A midwife may assume that they have a client's implied consent to disclose personal health information to other health providers in the client's circle of care.

A midwife who is working in a multidisciplinary setting may, for the purpose of treatment, share personal health information with other health care professionals who are providing care to the same client because these other health care professionals are within the client's circle of care.

A midwife who refers a client to another health professional may consider that health professional to be within the client's circle of care.

The circle of care of a client of a sole practitioner midwife may also include other health care practitioners in other institutions, if it is necessary for providing health care to the individual, and it is not reasonably possible for consent to be obtained in a timely manner.

The exception to this principle is that if a client or client's substitute decision-maker say that they do not want the information to be shared. The information must then not be shared unless another provision in PHIPA permits it (this is often referred to as placing the information in a "lock box").

Despite the ability to share information within the client's "circle of care", many midwives do not share information with others on the health care team outside of their practice without the client's explicit consent unless it is an emergency. This can avoid misunderstandings, particularly if the information is sensitive.

Circle of Care Scenario

Donna, a midwife, receives a telephone call from a registered nurse at a local hospital. The nurse advises Donna that her client has just been admitted to the hospital in a diabetic coma. The nurse reports that she has been unable to contact the client's substitute decision-maker. The nurse wants to know about the care Donna has been providing to the client. Donna tells the nurse of the care she has provided and discloses the contact information she has for the substitute decision-maker. In this case, the "circle of care" principle allows Donna to disclose her client's personal health information without express consent and it would be inappropriate to insist on a signed consent form before making any disclosure in these circumstances.

Family and friends

Generally speaking, consent should be obtained before sharing personal health information with members of a client's family.

However, personal health information may be disclosed for the purposes of contacting family members, friends or other persons who may be potential substitute decision-makers, if the individual is injured, incapacitated or ill and cannot provide consent.

Disclosure related to risk

A midwife may disclose a person's personal health information if the midwife believes on reasonable grounds that the disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm to the person or anyone else.

For example, if a client has a serious and highly contagious illness and has been admitted to a hospital, a midwife does not require a client's consent to disclose this to the hospital. This is because the disclosure is necessary to reduce the risk of the illness spreading to other clients and hospital staff.

Other laws

PHIPA permits disclosure of personal health information that is permitted or required by many other acts, including the following:

- The *Health Care Consent Act, 1996* or *Substitute Decisions Act, 1992* for the purposes of determining, assessing, or confirming capacity;
- Disclosure to a College in accordance with the *Regulated Health Professions Act, 1991*; and
- Disclosure to an investigator or inspector who is authorized by a warrant or by any provincial or federal law, for the purposes of complying with the warrant or facilitating the investigation or inspection.

Additionally, as discussed above in the section on Mandatory Reports, there are some circumstances in which disclosure of personal health information is mandatory.

Access to personal health information

Every client has a right to access their own personal health information. One important exception is if granting access would likely result in a risk of serious harm to the client's treatment or recovery or a risk of serious bodily harm to the client or another person. Many believe that "bodily harm" includes mental or emotional harm.

If a person makes a request to access personal health information, the Custodian must either:

- permit the person to see the record and provide a copy at the person's request;
- determine after a reasonable search that the record is unavailable and notify the person of this in writing as well as their right to complain to the Information and Privacy Commissioner of Ontario; or
- determine that the person does not have a right of access and notify the person of this as well as their right to complain to the Information and Privacy Commissioner of Ontario.

The Information and Privacy Commissioner, a government appointed official administering PHIPA, may review the Custodian's refusal to provide a record and may overrule the Custodian's decision.

If disclosure can be refused, a midwife should black out (on a copy, not the original) those parts that should not be disclosed if it is reasonable to do so, so that the client may access the rest of the record.

Sample Exam Question

Which of the following best describes a client's right to look at their personal health information contained in their midwifery records?

i. A client has an unrestricted right to access their personal health information.
ii. A client generally has a right to access their health information and has a right to complain to the Information and Privacy Commissioner if access is refused for any reason.
iii. A client has a right to access their health information unless the midwife believes it is not in the client's best interests to see the information.
iv. A client can request a copy of a record containing their personal health information, but a midwife does not have to provide it.

The best answer is answer ii. A client's right to access their health information is broad but has some legal limits. However, even if access is refused, the client is entitled to bring a complaint to the Information and Privacy Commission. Answer i is not the best answer because the right to access personal health information may be restricted in some circumstances (e.g., where there is a serious risk of significant bodily harm). Answer iii is not the best answer because a midwife's opinion about whether it is good for the client to see the record is irrelevant. Access may only be refused in limited circumstances, including if the midwife believes there is a risk of serious harm to the client's treatment. Answer iv is not the best answer because a midwife does not have a general right to refuse a person access to their personal health information.

Correction of personal health information

Individuals generally have a right to request corrections to their own personal health information. A midwife or other Custodian who receives a written request must respond to it by either granting or refusing the request within 30 days. It is wise to respond to verbal requests as soon as possible as well. If the request cannot be fulfilled within 30 days, the person should be advised of this in writing.

Corrections to records must always be made in a way that allows the original record to be traced. The original record should never be destroyed, deleted, or blacked out. If the record cannot be corrected on its face, it should be possible for another person accessing the record to be informed of the correction and where to find the correct information (e.g., by means of a footnote or link in an electronic record). The person should also be notified of how the correction was made.

At the client's request, the midwife / custodian should notify anyone to whom the midwife has disclosed the information of the correction. The exception to this is if the correction will not impact the client's health care or otherwise benefit the client.

The midwife / custodian may refuse the request if the midwife believes the request is frivolous or vexatious; if the midwife / custodian did not create the record and does not have the knowledge, expertise, and authority to correct it; or if the information consists of a professional opinion made in good faith. In other words, corrections are limited to factual information, not professional opinions.

A midwife / custodian who refuses to make a correction must notify the person in writing, with reasons and advise the person that they may:

- prepare a concise statement of disagreement that sets out the correction that the midwife refused to make;
- require the midwife to attach the statement of disagreement to their clinical records and disclose the statement of disagreement whenever the midwife discloses related information;
- require the midwife to make all reasonable efforts to disclose the statement of disagreement to anyone to whom the midwife has previously disclosed the record; or
- make a complaint about the refusal to the Information and Privacy Commissioner.

Complaints

Every organization must have a system in place to deal with complaints regarding personal health information. Clients should also be aware of their right to complain to the College and/or to the Information and Privacy Commissioner.

The content of the College's Guide on Compliance with *Personal Health Information Protection Act, 2004* (PHIPA). will be part of the jurisprudence exam.

f) Personal Information Protection and Electronic Documents Act (PIPEDA)

Another privacy law that midwives should be aware of is the *Personal Information Protection and Electronic Documents Act* (PIPEDA). PIPEDA is a federal law that governs the collection, use, and disclosure of personal information in relation to commercial activity outside of health care.

PIPEDA applies only to commercial activities of midwives, such as the sale of products at midwives' offices and the offering of educational sessions (e.g., prenatal classes). Because many midwives do not engage in commercial activities outside of healthcare, PIPEDA does not apply to them. Unlike PHIPA, which governs personal health information, PIPEDA governs all types of non-health personal information. Examples of personal information include the person's name, date of birth and home address.

The following ten privacy principles apply to midwives' commercial activities:

1. Accountability: Someone in an organization (the "privacy officer", sometimes called an "information officer") must be accountable for the collection, use and disclosure of personal information. The privacy officer must develop privacy policies and procedures and ensure that staff receives privacy training.
2. Identifying Purposes: An organization must identify the purposes for which personal information will be used at the time that the information is collected.
3. Consent: Consent is required to collect, use, and disclose personal information except in limited circumstances, e.g., in emergencies or where the law otherwise permits this.
4. Limiting Collection: An organization must only collect the information that is necessary to collect for the identified purposes.
5. Limiting Use, Disclosure, and Retention: An organization must only use, disclose, and retain personal information that is necessary, for the identified purposes and is obtained with consent. It should be retained no longer than necessary.
6. Accuracy: An organization must make reasonable efforts to ensure that any personal information collected is accurate, complete and up-to-date.
7. Safeguards: An organization must protect personal information with appropriate safeguards in order to protect against loss, theft, unauthorized access, disclosure, copying, use or modification.
8. Openness: An organization must make its privacy policies readily available.
9. Individual Access: Upon request, an individual must be informed of the existence, use and disclosure of their personal information and be given access to it. An individual can request corrections to the information. Access may be prohibited in limited circumstances such as the privacy of other persons if there is a prohibitive cost to provide it or for other legal reasons.
10. Challenging Compliance: An organization must have a complaints procedure relating to personal information and must investigate all complaints.

As one can see, PHIPA and PIPEDA are based on the same principles. PHIPA simply provides more details about how to achieve those principles in the health care context.

11. Other laws

a) Child, Youth and Family Services Act

A midwife who suspects that any child is in need of protection must report this to a Children's Aid Society (CAS). This duty overrides all privacy and confidentiality duties and laws, including PHIPA. No legal action can be taken against a midwife for making a report, unless the report is made maliciously or without reasonable grounds. The College cannot discipline a midwife for making such a report in good faith and with reasonable grounds.

As a result of a report, a CAS worker may investigate the report further and, where action is needed, in many cases CAS will offer the family services such as counselling and foster parenting.

A midwife who is concerned that a 16 or 17-year-old is or may be in need of protection may, but is not required to, make a report to CAS. However, a midwife has a duty to report with respect to any child under the age of 16. This includes all children, including a child of a client or a child who is a client or any other child. However, a midwife has a special responsibility to report information about a child who is a client if the information was obtained while providing treatment or services to the child. A midwife may be fined up to $1,000 for failing to make a report in this circumstance.

The duty to report is ongoing (for new information) even if a previous report was made respecting a child. A midwife must make a report personally.

A midwife must make a report if they have reasonable grounds to suspect any of the following:

1. The child has been or is at risk of harm
A report is required if a child has been or is at risk of likely being physically harmed by a person having charge of the child (e.g., a parent or guardian), either directly or as a result of neglect or a pattern of neglect.

A report is also required if a child has been or is at risk of being sexually molested or sexually exploited, either by a person having charge of the child, or by another person, if the person having charge of the child knows or should know of the risk of this happening and fails to protect the child.

2. Failure to provide or consent to services or treatment
There are numerous circumstances where a report is required because the person having charge of a child does not or cannot provide services or treatment to a child or does not or cannot consent to services or treatment for a child.

A report is required where a child is not receiving services or treatment and:

- the child requires medical treatment to cure, prevent or alleviate physical harm or suffering;
- the child has suffered or is likely at risk of suffering emotional harm, demonstrated by serious anxiety, depression, withdrawal, self-destructive or aggressive behaviour

or delayed development believed to be caused by action or inaction of the person having charge of the child;
- the child has a mental, emotional, or developmental condition that, if not remedied, could seriously impair the child's development; or if
- the child is under the age of 12, has killed or seriously injured another person or has caused serious damage to another person's property and services or treatment are needed to prevent a recurrence.

3. Abandonment
A report is required if a child has been abandoned by a parent or guardian or is otherwise left without a caregiver. This includes the death of a child's parents.

4. Failure to supervise a child
A report is required if a child has injured another person or damaged another person's property more than once because a person having charge of a child encouraged the child to do so.

A report is also required if a child has injured another person or damaged another person's property more than once because a person having charge of a child has not or cannot supervise a child adequately.

CAS Reporting Scenario 1

Donna, a midwife, has a client who discloses that she has physically harmed her son. Donna has a duty to make a report, even if the client reported this in confidence or in the course of assessment or treatment. If two months later the client says something that makes Donna suspect that the client has physically harmed her son again, Donna has a duty to make another report.

CAS Reporting Scenario 2

Deepika, a midwife, has a client with an 11-year-old son who has been displaying signs of erratic and violent behaviour during visits. The son tells Deepika during one visit that he violently attacked a friend last week. Deepika believes that specialized health care services are necessary to prevent the son from causing serious injury to others again. Deepika is particularly concerned about the newborn who apparently is left alone with the son on occasion by the client. Deepika recommends to her client that she should seek care or treatment from a specialized health care practitioner for her 11-year-old son. The client does not believe that her 11-year-old son would hurt anybody and refuses to seek any treatment for him. In this case Deepika has a duty to make a report. This duty to report exists even if the client does not want anyone to know about the incident and is angry with the midwife.

b) Human Rights Code

Every person is entitled to access and receive health care services in a manner that respects their human rights. The Ontario Human Rights Code requires every midwife to treat clients,

potential clients, employees, and others equally, regardless of the person's race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability (known as the "prohibited grounds").

If a person feels that a midwife or practice they are affiliated with has violated the Human Rights Code, the person can complain to the Human Rights Tribunal of Ontario. If the Human Rights Tribunal finds that a midwife or practice has violated the Human Rights Code, it may order the midwife or practice to pay damages and require the midwife or practice to take corrective action, such as undergoing training or implementing a human rights policy.

Since the Human Rights Tribunal does not have the power to suspend or revoke a midwife's certificate of registration, a person who believes their human rights have been violated may also bring a complaint to the College.

Duty not to discriminate

A midwife must not discriminate against any person on any prohibited ground. Examples of discrimination may include the following:

- Refusing to accept a new client for a prohibited reason;
- Refusing to continue treating a client for a prohibited reason;
- Making a treatment decision for a prohibited reason;
- Insulting a client for a prohibited reason;
- Refusing to permit a client with a disability to meet with the midwife with a support person; and
- Making assumptions, not based on clinical observation or professional knowledge and experience, about a person's health or abilities because of their age or another prohibited reason.

It is not discrimination to make clinical decisions or to accept or refuse to continue seeing a client for reasons other than prohibited grounds. For example, if a midwife is not competent to care for a potential client with a particular condition (e.g., a client who has a heart condition that the midwife does not fully understand) or if the care required is not within the midwife's scope of practice (e.g., inserting a hormonal contraception for a former client 6 months postpartum), a midwife should not accept or continue to care for a client.

In order to meet the obligations of the College and to avoid a misunderstanding that could lead to a human rights complaint, midwives should always clearly communicate their reasons for proposed care plans, referrals and other decisions. Midwives should always make decisions to refuse or end care in good faith and should not use their own lack of competence as an excuse to refuse to provide services to a person if there is no real competence issue.

Midwives are similarly entitled to rely on professional knowledge, judgment, and experience to make comments upon clinically relevant matters that relate to a person's age or sex.

However, it is discrimination to treat someone unequally even if the midwife did not intend to do so. For example, a policy that does not permit any animals in a building discriminates against persons who rely on service animals, even if the policy was not intended to discriminate against anyone. The policy would have to make exceptions for "service animals".

Duty to accommodate

If a midwife's conduct or policy discriminates against a person based on a prohibited ground, the midwife has a duty to accommodate that person unless the accommodation would result in undue hardship (e.g., because of a real risk to health or safety or because of undue cost).

Accommodation must be individualized. For example, not all persons with the same disability will require or request the same accommodation. Individual accommodations should be discussed with the person where possible and must be provided in a manner that respects the person's dignity and autonomy. However, a midwife is not required to provide the exact accommodation that a person requests if another form of accommodation is reasonable and acceptable.

Examples of accommodation may include the following:

- Permitting a client who uses a wheelchair to reschedule an appointment with less than 24 hours' notice if the elevator in the midwife's office building is temporarily out of service;
- Offering an extended appointment time to a client with an intellectual, learning, or mental health disability who may need more time to understand their options;
- Permitting a person with a disability to enter the premises with a support person, service animal or assistive device;
- Communicating in writing if a person with a hearing impairment or other disability requests this; and
- Offering an interpreter when there is a language barrier.

The duty to accommodate applies to all of the prohibited grounds of discrimination.

Human Rights Code Scenario No. 1

Donna, a midwife, determines she is unable to continue to provide care to her client because the client moved just outside of the practice's catchment area. In some instances, Donna may consider continuing care when a client moves outside of the practice's catchment, but because this client is due in the winter months Donna is concerned that she won't be able to be there for this client or for her other clients in a timely way. The client is unhappy about Donna's decision and believes that Donna has always had a problem with her because of her race and religion. Donna should carefully communicate her reasons for terminating the midwife-client relationship, so that the client is not left with the misunderstanding that the decision was based on a prohibited reason such as the client's race or religion. Donna should also arrange for an appropriate alternative care provider that is acceptable to the client.

Human Rights Code Scenario 2

Deepika, a midwife, has a potential new client who has an intellectual disability. Deepika finds it difficult to communicate with the potential client. Deepika should ask how she could help communicate better with the client. If the client has a support person who sometimes provides assistance, the client may ask to bring their support person to Deepika's clinic. Deepika is required by law to permit a support person to accompany a client. However, Deepika should not assume that the client needs a support person and should discuss the issue with the client, if possible. Additionally, if the client does not have the capacity to make care decisions, the client may need a substitute decision-maker. In any of these circumstances, Deepika cannot refuse to accept the client because of their disability even if it will take Deepika more time for those visits.

Human Rights Code Scenario 3

Donna, a midwife, has a client who has been diagnosed with a mental illness. Donna has been having increasing difficulties interacting with her client. The client has also been rude towards Donna and staff. While no client has a right to be abusive towards midwives and their staff, Donna may consider whether the behaviour is caused or exacerbated by the person's mental illness. Donna cannot stop providing treatment or health services because of the client's mental illness, unless Donna concludes she is not competent to continue treating the client or unless there are health and safety concerns for Donna or her staff. If Donna believes a transfer to another health care practitioner with the appropriate competencies to manage the client's health care needs is necessary, Donna should clearly explain the reasons for the decision to the client. Donna should also consider whether any accommodations are possible. For example, a client who is uncomfortable in a crowded waiting room because of their mental health disability might be offered an alternative space to wait. There may be other practical measures that the client may be able to suggest that will help the client manage their disability-related symptoms.

c) Accessibility for Ontarians with Disabilities Act (AODA)

The *Accessibility for Ontarians with Disabilities Act, 2005* (AODA) provides for accessible customer service, information and communications, transportation, employment and built environment (i.e., physical facilities). The AODA applies to every person and organization in Ontario. The intention of the standards is to achieve accessibility for Ontarians with disabilities by 2025. A midwife or organization the midwife works with may be fined for not complying with the AODA.

The standards currently apply only to persons and organizations with at least one employee in Ontario. Different standards apply depending on the number of employees an organization has. A sole practitioner or a group of persons in a partnership are not considered "employers" of the practice's associate midwives. Therefore, the AODA standards currently do not apply to some midwives. However, if a midwife has incorporated as a business, the midwife may be considered an "employee" of the corporation along with any other employees the midwife has. In addition, if a sole practitioner or a group of persons in a partnership employ administrative staff, cleaning staff, second birth attendants, etc., within their practice, then they are required to comply with AODA.

Interaction between AODA and other laws

Accessibility standards are found in regulations and have the status of law. If a standard provided in the AODA is different from a standard required under a different law, the standard that provides the highest level of accessibility to persons with disabilities always prevails. However, the AODA will not necessarily prevail over other legal requirements such as occupational health and safety laws.

A breach of an AODA standard is not necessarily a breach of the Human Rights Code. However, it is possible that the AODA standards will be used as a reference point in Human Rights Tribunal hearings.

Customer Service Standard

Midwives with at least one employee in Ontario must comply with the accessible Customer Service standard as of January 2012. For organizations with fewer than 20 employees, the AODA requires the following:

- Implement policies, practices, and procedures regarding the provision of goods and services to persons with disabilities,
    - that are consistent with the principles of dignity, independence, integration, and equal opportunity, and
    - that deal with the use of assistive devices and the availability of any measures that make services accessible (e.g., TTY, elevator).
- Permit service animals and support persons in public areas of premises.
- Provide reasonable notice of any temporary disruptions to any accessibility features or services, including the reason for the disruption, the anticipated duration, and a description of any alternate services.
- Provide training to all employees and anyone else who deals with members of the public or third parties which must include the following:
    - Review of purposes of AODA and requirements of Customer Service standard;
    - How to interact with persons with disabilities who use assistive devices, use a service animal, or are assisted by a support person;
    - How to use available accessibility equipment and devices on premises or that are otherwise provided to the public; and
    - What to do if someone with a particular type of disability is having difficulty accessing the providers' goods or services.
- Establish a process for receiving and responding to feedback about accessibility and make information about the process readily available to the public,
    - People must be permitted to provide feedback in person, by telephone, in writing or electronically, and
    - The process must specify actions that will be taken if a complaint is received.

For organizations with 20 or more employees, there are additional requirements including putting its policies, practices and procedures in writing and making them available upon request, filing publicly-available accessibility reports and keeping records of the training that has been provided.

Information and Communications Standard

The Information and Communications Standard requires organizations to ensure that information available to the public and the organization's communications with the public are accessible or can be made accessible.

This includes making any feedback system accessible upon request, ensuring that any emergency or public safety information that is available to the public is made accessible upon request (which must be complied with as of January 1, 2012) and providing accessible information formats and communication supports upon request.

For example, this standard may require midwives with at least one employee to provide intake forms, charts, and other health information in an accessible format (e.g., large print, audio, or Braille). It may also require midwives to provide a person with sign language interpretation. The midwife must consult with the person making the request regarding the form of accessible format or communication support. The midwife must provide a requested accessible format or communication support in a timely manner and may charge no more than the regular cost that is charged to other persons.

For organizations with 50 or more employees, additional steps will be required, including ensuring that websites are compliant with web accessibility standards and filing accessibility reports.

Employment Standard

The employment standard requires employers to provide an accessible workplace. This includes the following:

- Providing public notice regarding accessibility practices in hiring employees;
- Providing accessible workplace information; and
- Providing, on request, any individualized emergency response information to employees who require this individualized information because of a disability.

Integrated Standard

The Integrated Standard includes standards on information and communications, transportation, and employment.[9]

For organizations with fewer than 50 employees, the general requirements under this standard include the creation and implementation of policies, practices, and procedures regarding how the organization will meet the Integrated Standard and training of all employees, volunteers and others on the Integrated Standard and the Human Rights Code.

Built Environment Standard

The standard on built environment has not yet been developed except for public spaces. However, it will apply to the construction of new buildings and to major renovations.

[9] Midwives employed in public hospitals should be aware that public hospitals must meet earlier deadlines and have additional legal requirements under the Integrated Standard. Additional legal requirements include reporting obligations.

AODA Scenario

Deepika, a midwife, has an office with one employee who provides administrative support. Under the AODA's customer service standard, Deepika must create an accessibility plan for providing accessible customer service and accessible information and communications. Deepika is not required to put these policies, practices, and procedures in writing, but must ensure that they are followed, including by her employee. Deepika is also responsible for ensuring that training is provided to her employee regarding the accessibility standards (e.g., that support persons, animals or devices are allowed on the premises). Deepika should also be aware of how the information and communications and employment standards will apply to her practice.

d) Municipal Licensing

In addition to being registered with the College, midwives may require a municipal licence. A municipal licence, such as a business licence, is granted and regulated by the municipality and not by the provincial government. A municipal licence does not give a midwife the right to be registered with the College. However, a midwife may be registered with the College and also hold a municipal licence.

Generally speaking, the purpose of municipal licensing is to set conditions for a midwife's premises in which a midwife operates, as well as public health matters such as sanitation. For example, a municipal inspector may inspect a midwife's office and ensure that protocols are in place to avoid the spread of disease. A municipal licensing body is generally not focused on professional qualifications or professional conduct.

If the College requires a higher standard or different standard than the municipality does, the College's standard must always be followed. The *Regulated Health Professions Act, 1991* is a provincial statute; it takes priority over a municipal by-law.

Municipal licensing scenario

Donna, a midwife, has a municipal licence to practise in her city and pays a fee every year to renew her licence. The municipal authority recently inspected Donna's practice and found no violations. While the municipal licensing authority did not require Donna to maintain accurate clinical records and did not look at Donna's client records during its inspection, the College does require this. Donna must understand and abide by the College's record keeping expectations.

Conclusion

If a legal issue arises, midwives are encouraged to discuss it with colleagues and their professional association and to check with the College as to its expectations. The College cannot provide legal advice (neither can one's colleagues or professional association). Thus, on many issues midwives may need to consult with their own lawyer.

Documents Referenced in the Handbook

1. Professional Standards for Midwives
2. Health Professions Procedural Code (HPPC)
3. *The Regulated Health Professions Act, 1991*
4. Midwifery Scope of Practice
5. Guide on Mandatory and Permissive Reporting
6. College's Sexual Abuse Prevention Policy
7. Guideline on Appropriate Professional Behaviour with Clients
8. Guideline for Reporting Sexual Abuse
9. Mediating Risk in Caring for Related Persons and Others Close to Midwives
10. *The Midwifery Act, 1991*
    a. The General Regulation
    b. The Registration Regulation
    c. The Designated Drugs Regulation
    d. The Professional Misconduct Regulation
    e. The Quality Assurance Regulation
11. General By-Law
12. Fees and Remuneration By-Law
13. *Personal Health Information Protection Act, 2004* (PHIPA)
14. Personal Information Protection and Electronic Documents Act (PIPEDA)
15. *Health Care Consent Act, 1996*
16. *Child, Youth and Family Services Act, 2017*
17. Ontario Human Rights Code
18. *The Accessibility for Ontarians with Disabilities Act, 2005* (AODA)

Additional Resources

The College has a resource library on its website that provides additional guidance and publications and lists policies and legislation.

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