BCCNP
British Columbia College of Nursing Professionals

COLLEGE OF MIDWIVES OF BRITISH COLUMBIA

BC COLLEGE OF NURSES & MIDWIVES

As of Sept. 1, 2020, the British Columbia College of Nursing Professionals (BCCNP) and the College of Midwives of British Columbia (CMBC) amalgamated to create a new regulatory body: British Columbia College of Nurses & Midwives (BCCNM).

The document you are about to access reflects our most current information about this topic, but you'll notice the content refers to the previous regulatory college that published this document prior to Sept. 1, 2020.

We appreciate your patience while we work towards updating all of our documents to reflect our new name and brand.

Contact us

GENERAL INQUIRIES

604.742.6200
1.866.880.7101 toll-free within Canada only

info@bccnm.ca

REGISTRATION

register@bccnm.ca
registermidwives@bccnm.ca

REGULATORY POLICY & PROGRAMS

practice@bccnm.ca

COMPLAINTS

complaints@bccnm.ca
Fax 604.899.0794

BC CN & M
British Columbia College of Nurses & Midwives

COLLEGE OF
MIDWIVES
OF BRITISH COLUMBIA

JURISPRUDENCE COURSE HANDBOOK

Essential Information on Midwifery Practice in British Columbia

March 2020

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INTRODUCTION

Midwifery has been a designated health profession under the *Health Professions Act* (*HPA*) since March 15, 1995 in the province of British Columbia (BC), Canada. Midwifery is regulated by the College of Midwives of British Columbia (CMBC) in accordance with the *HPA*, the *Midwives Regulation* and the bylaws of the College.

The purpose of this handbook is to provide essential information on the legal and ethical framework of midwifery practice in BC. CMBC provides this handbook to individuals who seek midwifery registration in BC to assist with self-orientation and for use as a resource when completing the online CMBC Jurisprudence Course. The information in this handbook intends to be useful to all potential new BC midwives, whether they are a soon-to-be graduate from a CMBC recognized midwifery education program, a registered midwife coming to BC from another Canadian province/territory, or an internationally-educated midwife who has completed a CMBC recognized midwifery bridging program.

This handbook will first discuss the concepts of professionalism and self-regulation. It will then look at the legal regulatory framework under which registered midwives are governed in BC and the role of CMBC in the regulation of the profession. The handbook will explain the scope and standards of practice and other important aspects of professional practice. Finally, the handbook will set out the various applicable laws and identify stakeholders that midwives will most likely interact with in their practice.

In this handbook several provincial and federal statutes may be referred to by their abbreviations, including but not limited to the following:

- ATI – Access to Information Act of Canada;
- CFCSA - Child, Family and Community Services Act;
- HCCA - Health Care (consent) and Care Facility (Admission) Act;
- HPA - Health Professions Act;
- PA - Privacy Act of British Columbia;
- PIPA - Personal Information Protection Act of British Columbia; and
- PIPEDA - Personal Information Protection and Electronic Documents Act of Canada.

Other possible abbreviations and short forms include the following:

- CMBC - College of Midwives of British Columbia;
- HPRB - Health Professions Review Board;
- IC - Inquiry Committee;
- MABC – Midwives Association of British Columbia;
- MPP - Midwives Protection Program; and
- QA - Quality Assurance.

1. PROFESSIONALISM AND SELF-REGULATION

In BC, midwives are regulated health professionals who provide safe and high-quality care to clients (also referred to as patients). As registrants of a profession, midwives believe that they, both individually and as a group, help clients. A profession is different from a business.

Midwives are independent primary care providers in BC. Midwives who received their midwifery education and training outside of BC or who have practiced outside of BC may notice that there are some differences in regulation and practice that compared to the country or province/territory where they received training or practiced.

Autonomous Primary Care

BC Midwives provide autonomous, community-based primary care. A midwife in BC is the most responsible caregiver during the antepartum period, labour, birth and postpartum period (up to 6 - 12 weeks) as long as the client remains low risk. A full-time midwife is generally involved in providing care for about 40-60 clients per year as the primary midwife. Midwives collaborate with other health professionals and transfer care to a physician when the client's risk status changes and as necessary.

Continuity of Care

BC midwives provide continuity of care to all clients. This includes 24-hour on call availability by the midwife (or small group of midwives) known to the client, from intake to discharge. Continuity of care allows a relationship to develop over time between a client and their midwife/midwives. In order to share the responsibility of providing care on a 24-hour basis, midwives often work in small teams and share care of a pooled group of clients.

Informed Choice and Evidence-Based Practice

BC midwives assist clients and their families to make choices about their care by providing relevant, evidence-based information in a supportive, non-authoritarian manner. Midwives must keep current in their knowledge of relevant research.

Choice of Birth Setting

BC midwives must provide healthy, low-risk clients with the choice of giving birth at home or in the hospital. Midwives must have admitting and discharge privileges at their local hospital(s) with support from nursing staff and other health professionals as needed. At a home birth midwives work with another midwife or a CMBC approved second birth attendant. At a hospital birth, the client is supported by both their midwife and a nursing care during labour and birth.

Pay per Course of Care

BC midwives are self-employed, independent health care providers. They are not employees. The BC government funds midwifery and midwives are paid a flat rate per course of care.

Being a registrant of a regulated profession also means that midwives have a duty to other registrants of the same profession or other professions. Midwives interact with other health care professionals (including but not limited to: family physicians, nurses, consultant obstetricians, pediatricians, anesthesiologists, and dieticians) in different situations and should be prepared to explore ways of promoting collegial inter-professional relationships as well as how to navigate difficult relationships. Midwives have a duty to be courteous and work with their colleagues 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 must also collaborate with other health professionals and, when clients' risk status, condition or needs exceed midwives' scope of practice, consult with physicians or nurse practitioners.

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

As professionals, midwives 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.

1.1 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:

- No regulation at all. This allows the market to determine which activities or practitioners will be chosen.
- Consumer protection legislation. For example, buying a membership with a fitness centre is governed by BC's *Business Practices and Consumer Protection Act*.
- Direct government regulation. The government could have the Ministry of Health regulate the midwifery profession just like the Ministry of Education regulates teachers.
- Self-regulation. The government can designate a profession under the *Health Professions Act* and allow the profession to self-regulate.

In BC 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.

Midwifery is a self-regulated profession in BC. Being self-regulated means that the majority of the members of CMBC's governing Board are elected by registrants - midwives. In addition, the majority of the members of almost all CMBC committees and panels are midwives appointed to those committees and panels by the CMBC Board of Directors.

The Board establishes the CMBC's standards and policies and oversees the administration of regulatory activities of CMBC (e.g. it establishes the CMBC budget). CMBC operates through committees (e.g. the Registration Committee, the Quality Assurance Committee, the Inquiry Committee, etc.).

Self-regulation ensures that the regulatory actions of CMBC 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 CMBC because it has such a large say in them.

The duty of CMBC, like other health regulatory colleges, as set out in the *Health Professions Act* is to serve and protect the public and exercise its powers and discharge its responsibilities under all enactments in 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 HPA has numerous safeguards including the following:

- CMBC has an explicit mandate under the HPA to serve and protect the public, and to exercise its power and discharge its responsibilities under all enactments in the public interest.
- CMBC 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 CMBC. If CMBC is not acting in the public interest the Minister can appoint a supervisor to take over the role of the Board and senior CMBC staff.
- The government has to approve any changes to *Midwives Regulation* proposed by CMBC before they take effect. Proposed regulations and proposed bylaws changes have to undergo circulation and comment by the public and the profession before they are made.
- The government appoints individuals, who are not midwives, to the Board. These public members will also serve on CMBC committees.
- Decisions by CMBC in registration and complaints matters can be appealed to an independent body, the Health Professions Review Board (HPRB).
- Decisions in discipline matters can be appealed to the Supreme Court.
- Meetings of the CMBC Board 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.
- CMBC is required to publish its discipline decisions. That and other information about midwives must be placed on the public register which is available on the CMBC website.
- CMBC must establish and maintain a website that is accessible to the public setting out its roles, responsibilities and regulatory activities.

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

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

In contrast to CMBC or a health regulatory college, professional associations advocate on behalf of the profession and in the interest of the members of the profession.

Question - College vs. Association

What sentence correctly describes the respective roles of a college and a professional association?

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

The correct answer is i. A college's mandate is to regulate the profession in order to serve and protect the public. Answer ii is not a correct answer because a professional association is designed to serve the interests of their members. While a professional association also 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 a correct answer because a college is not permitted to serve the interests of its registrants under its statute. While it tries to ensure it regulates its registrants sensitively and fairly and consults with its registrants, a college's mandate is the public interest. Answer iv is not correct. While a 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.

1.2 Ethics, Professional Conduct, Professional Standards, 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, professional conduct, standards of practice, competence and physical and mental capacity are slightly different. Midwives need to understand each of these concepts in order to meet their professional obligations.

Ethics

The CMBC *Code of Ethics* sets out the principals directing the conduct of midwives and provides a framework to enhance a midwife's capacity for effective ethical decision making and reflection.

Professional Conduct and Misconduct

Professional misconduct is conduct that falls below the minimum expectations of a safe and ethical midwife. It is further defined in the *Health Professions Act* to include sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession. Many CMBC publications will assist midwives to recognize how to avoid engaging in professional misconduct. The issue of sexual abuse/sexual misconduct is covered later in this handbook.

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

Scenario - Permitting Illegal Conduct

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

The answer is yes. It is professional misconduct to permit a person to hold themselves out as practicing a profession when they are not registered. Renata condoned the conduct occurring in the practice. Renata could face an inquiry investigation into the conduct. CMBC will also take the required actions against Joan who practices midwifery illegally in BC as Joan is not registered. The actions may include CMBC first sending a cease and desist letter to Joan.

Confidentiality

Midwives must keep all client information confidential. Failing to maintain confidentiality can be considered professional misconduct. There are exceptions depending on the circumstances. The concept of confidentiality is discussed in its own section along with privacy in a later chapter of this handbook.

Conflict of Interest

Midwives must not 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 interests of clients. Where a 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 the midwife's 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 constitutes professional misconduct.

To determine whether a situation amounts to conflict of interest, one needs to determine 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?

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

Scenario - Conflict of Interest

Deepika is a midwife who has a busy and successful practice. Recently, Deepika 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 the feedback from clients and that Deepika likes eating and recommending the bread. The company asks Deepika if Deepika would like to be in a new advertising campaign they are going to put into some magazines targeted at young clients where Deepika would provide similar statements. They plan to put a picture of Deepika within the advertisement and identify Deepika by name and qualifications. They say they cannot pay Deepika because they are still a small company and don't have the budget for it. Deepika thinks, why not? Deepika likes the bread and since they are not getting paid, they are 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 a midwife's dealings with clients, colleagues, third party payers or CMBC. 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 the midwife's training, qualifications or experience.

Improper Billing and Fees

Midwifery services are covered by the Medical Services Plan (MSP) of British Columbia. The Midwives Association of British Columbia (MABC) is responsible for the negotiation of payment contract for midwives with the BC Ministry of Health.

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 health care services that are not funded or covered by the government, including midwifery services, lab tests, consultations by physicians and hospital stays.

Establishing fees and administering payment to midwives are not part of the mandate of CMBC. However, CMBC does regulate professional misconduct related to billing, including:

- Submitting false payment claims to MSP; or
- Charging a fee or accepting payment from a client for services that have been covered or paid by MSP.

Midwives should direct funding and billing questions to the MABC.

Marketing and 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 the midwife's privileges at that hospital are under suspension is misleading. Midwives should also take reasonable steps to ensure that their advertisements meet the CMBC bylaws.

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

If a midwife engaged in false or misleading marketing and advertising, it could result in a breach of CMBC bylaws.

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 other midwife or health care practitioner asks for a copy of the record (with client consent), the midwife cannot simply ignore the request. 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 such obligation is that midwives must accept the regulatory authority of CMBC. Examples of conduct towards CMBC, which can constitute professional misconduct, include:

- Publicly challenging the integrity of CMBC's role or actions;
- Breaching an undertaking given to CMBC;

- Failing to cooperate in, or obstructing, a CMBC investigation;
- Failing to participate in the Quality Assurance Program;
- Failing to comply with an order or direction of a CMBC Committee (e.g. Inquiry Committee, Discipline Committee, QA Committee or Registration Committee);
- Failing to respond appropriately and promptly to correspondence from CMBC;
- Failing to make a mandatory report; and
- Practicing while suspended.

Disregarding Restrictions on Certificate of Registration

A midwife must confine their practice to what is legally permissible. If the HPA or CMBC restricts a midwife practicing in certain areas (e.g. the midwife's certificate of registration is subject to terms, conditions or limitations), it would be professional misconduct for the midwife to exceed those restrictions. For example, a midwife who is required to practise under supervision must no longer practice independently.

Scenario - Professional Misconduct

Donna, a midwife, has recently been told by a colleague, Wendy, who works in the same practice, that sometimes Donna is too loud with clients. Wendy mentions that in speaking loudly Donna is disrupting other midwives in the office. Donna apologizes for disrupting Wendy and any of their clients and that Donna will try to keep their voice down out of respect for the rest of the practice. But Wendy feels this is a serious problem and that Donna should be reported to CMBC for professional misconduct because Wendy cannot stand loud noise during visits with clients. Wendy wants the very best atmosphere created for clients and thinks loud talking is completely unprofessional. Is Wendy correct in saying this would be professional misconduct?

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 general consensus of the profession.

Question - Professional Misconduct

Which of the following situations is possible professional misconduct?

i. Failing to maintain client confidentiality.
ii. Using verbal threats and insults to a client in an email to them when they miss an appointment.
iii. Accepting a fee from a physician for a referral.
iv. All of the above.

The best answer is iv. All of the situations described are clear examples of professional misconduct.

Professional Standards

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

Sometimes the details of professional standards are not formally outlined by CMBC. For example, CMBC does not have a document describing exactly how a midwife must assess 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, experience in practice and in discussions with other midwives. Professional standards are always changing.

However, to assist registrants, CMBC 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 practice safely, ethically, and effectively. These publications are on CMBC'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 or policy is considered non-compliance and can result in inquiry or disciplinary proceedings.

An overview of high-level midwifery professional standards is set out in the CMBC document titled *Standards of Practice*. It identifies the following 16 standards of practice. More in-depth information about each standard is set out in the document and links to related other CMBC policies are provided:

1. *The midwife shall be the primary care provider within the midwives' scope of practice.*
2. *The midwife shall collaborate with other health professionals and, when the client's risk status, condition or needs exceed the midwives' scope of practice, shall consult with a physician or nurse practitioner.*
3. *If primary care is transferred to a physician, the midwife may continue to counsel, support and advise the client.*

4. *The midwife shall work in partnership with the client recognizing individual and shared responsibilities.*
5. *The midwife shall uphold the client's right to informed choice and consent.*
6. *The midwife shall provide continuity of care to the client.*
7. *The midwife shall respect the client's right to make informed choices about the setting for birth and shall provide care in all appropriate settings.*
8. *The midwife shall ensure, within reason, that a second midwife or qualified second birth attendant who is currently certified in neonatal resuscitation and cardiopulmonary resuscitation assists at every birth.*
9. *The midwife shall ensure that no act or omission places the client at unnecessary risk.*
10. *The midwife shall maintain complete and accurate health care records.*
11. *The midwife shall ensure confidentiality of information except with the client's consent, or as required to be disclosed by law, or in extraordinary circumstances where the failure to disclose will result in immediate and grave harm to the client.*
12. *The midwife shall be accountable to the client, the midwifery profession and the public for safe, competent and ethical care.*
13. *The midwife shall participate in ongoing education and evaluation of self, colleagues, and the community.*
14. *The midwife shall critically assess research findings for use in practice and shall support research activities.*
15. *The midwife shall only prescribe, order or administer drugs and substances in the categories as set out in Schedules A and B of the Midwives Regulation and these shall be prescribed, ordered or administered in accordance with CMBC Standards.*
16. *The midwife shall only order, perform or collect samples for and interpret screening and diagnostic tests in accordance with CMBC's Standards, Limits and Conditions for Ordering and Interpreting Screening and Diagnostic Tests.*

Competence and Incompetence

Midwives are expected to be competent in providing care to clients. Incompetence is where a midwife shows a serious lack of knowledge, skill or judgment when assessing or treating a client. Concern that a midwife is incompetent can be investigated by CMBC, initially through an Inquiry Panel appointed by the Inquiry Committee. If a midwife is found to be incompetent, restrictions can be imposed on the midwife's registration (e.g. prohibiting the midwife from practicing some scope or restricting the midwife from acting as the primary midwife) or the midwife's registration may be suspended or revoked.

The process by which complaints of misconduct or incompetence are handled by CMBC is outlined in the document *Information Sheet for Registered Midwives on the Inquiry and Disciplinary Process*, which can be found in the Registrant's Handbook, written in accordance with Part 3 – Inspections, Inquires and Discipline of the *Health Professions Act*.

Scenario - Incompetence

Donna, a midwife, does not really assess clients. Donna 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 a hospital and was immediately admitted for the remainder of the pregnancy. Paula complained to CMBC about Donna's incompetence. The CMBC Registrar referred the complaint to the Inquiry Committee for investigation. The Committee appointed an Inquiry Panel to investigate the complaint. The Panel looked at Paula's health records, reviewed Donna's response and explanation for what had been done and concluded that Donna showed a lack of knowledge, skill and judgment. The Panel resolved the complaint by requesting Donna to consent to undergo a period of supervised practice before Donna can practice independently again.

Capacity and Incapacity

Midwives must not practice or provide care to clients when incapacitated or impaired. The Inquiry Committee will investigate where concerns are expressed about a midwife practicing while incapacitated or impaired. If there is reason to believe that incapacity is involved, the Inquiry Committee may appoint a Fitness to Practice Panel to investigate. Even a midwife with a severe disability can practise safely so long as the midwife understands their limits and gets the necessary help. An incapable midwife may 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.

Scenario - Incapacity

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, Deepika 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 complains to CMBC. At first Deepika denies the problem. However, during the investigation, CMBC learns that some of Deepika's midwife colleagues have noticed a significant change in Deepika's behaviour in recent months. CMBC also learned Deepika has been charged with impaired driving. CMBC sends Deepika to a medical specialist who diagnoses Deepika with a serious substance abuse disorder. CMBC encourages Deepika to go for treatment and Deepika agrees. Deepika and CMBC agree to a consent agreement requiring Deepika to stop drinking, attend Alcoholics Anonymous group meetings, see a new substance abuse specialist regularly, have a colleague monitor Deepika at work and send regular reports to CMBC.

Conclusion

Each of the above sections looks at different aspects of professional practice. Each section also serves a different purpose. Ethics and professional misconduct deals with the minimum conduct necessary to avoid inquiry and discipline. Professional standards deal with ways to practise safely, effectively and professionally. 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 impair a midwife's ability to practice midwifery.

2. REQUIREMENTS UNDER THE *HEALTH PROFESSIONS ACT*

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 statute midwives in BC need to be most aware of is the *Health Professions Act*.
- ***Regulations*.** Regulations are made by the government when permitted by a statute. Under the *Health Professions Act,* the *Midwives Regulation* contains specific details on the midwife's scope of practice, protection for the title "midwife" and the specific restricted activities for registered midwives. The regulation can be proposed by CMBC or by the Minister of Health.
- ***Bylaws*.** Bylaws are made by the CMBC Board. The bylaws describe the governance structure of CMBC, its Board and Committees, and set out rules and procedures for Committees to register and regulate the practice of midwives. Some bylaws affect registrants (e.g. fees, professional liability insurance, information that must be provided by midwives to CMBC, election of midwives to the CMBC Board).
- ***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.
- ***Guiding documents*.** While they are not binding laws themselves, CMBC 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 CMBC Committees understand and interpret the laws that govern the profession. Midwives should read and understand CMBC's guiding documents.

The *Health Professions Act* is the statute that governs all of the regulated health professions in BC. The *HPA* sets out the duties and objects of health regulatory colleges. The HPA also imposes a number of obligations on the members of regulated health professions, including midwives.

2.1 Duty to report

Part of being a registrant 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 *Health Professions Act* sets out the duty of a registrant to report on another registrant, either from the same health profession or of another health profession.

Duty to report registrant

In accordance with *the HPA*, a registrant must report in writing to the Registrar of an other person's college if the registrant, on reasonable and probable grounds, believes that the continued practice of a designated health profession by the other person might constitute a danger to the public.

If a registrant terminates the employment of an other person or dissolves a partnership or association with an other person based on a belief that on reasonable and probable grounds that the continued practice by the other person might constitute a danger to the public, the registrant must report in writing to the Registrar of the other person's college.

Scenario - Duty to Report Registrant

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

Duty to Report Sexual Misconduct

If a registrant has reasonable and probable grounds to believe that an other registrant has engaged in sexual misconduct, the registrant must report the circumstances in writing to the Registrar of the other registrant's college. Despite this duty to report, if a registrant's belief concerning sexual misconduct is based on information given in writing, or stated, by the registrant's client, the registrant must obtain, before making the report, the consent of the client or a parent, guardian or committee of the client, if the client is not competent to consent to treatment. If consent is not given, a report is still required by law but the client's name and identifying data cannot be given in the report.

On receiving a duty to report from the registrant, the Registrar must act as though the Registrar had received a complaint.

Both the HPA and case law provide immunity (i.e. legal protections) to practitioners who report other practitioners. Under the *HPA,* no action for damages may be brought against a person for making a report in good faith as required under the duty to report sections.

The duty to report requirements also create an exception to the practitioner's usual duty of confidentiality. There is more information on duty to report in relation to privacy and confidentiality later in this handbook.

Scenario - Duty to Report Sexual Misconduct

Donna, a midwife, is told by Paula, a client, that Paula had an affair with Paula's family doctor. Donna asks Paula if the family doctor was treating Paula while the affair was ongoing. Paula says yes. Donna tells Paula that Donna is required by law to report this information to the Registrar of the College of Physicians and Surgeons of British Columbia (CPSBC). Donna explains that the CPSBC will need to investigate the report under the HPA. It will be very difficult for the CPSBC to investigate the report if Paula's name and contact information are not included in the report. The CPSBC 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 CPSBC 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 consent to include Paula's name and contact information will not be given to Donna. Donna then provides the report in writing to CPSBC without identifying Paula.

Further information about sexual misconduct within the midwifery profession is found in later chapter of this handbook.

Duty to Disclose – Self Report

In accordance with the CMBC bylaws, an applicant for registration, a former registrant applying for reinstatement of registration, a Non-practising registrant applying for return to practice or a registrant applying for renewal of registration, must disclose on the application all information that relates to the applicant/registrant and their practice of midwifery, or is otherwise relevant to the safe and ethical practice of midwifery, including but not limited to the following, regardless of where the events took place:

1. A find of professional misconduct, incompetence or incapacity by a regulatory authority;
2. An investigation in process with a regulatory authority;
3. A reprimand or imposition of conditions or educational requirements by a regulatory authority as a result of a complaint;
4. An agreement to an undertaking made by consent with a regulatory authority;
5. A dismissal for cause by an employer;
6. A denial of registration by a regulatory authority;
7. A voluntary resignation of registration on the request or advice of a regulatory authority;
8. Any verdict and recommendations of a coroner's investigation, coroner's inquiry or coroner's inquest;
9. A coroner's investigation, inquiry or inquest that is in process;
10. A denial, suspension, restriction or modification of hospital admitting privileges or a permit to practice;
11. A voluntary resignation of hospital privileges on the request or advice of a hospital or health authority administration;
12. A professional liability insurance claim;

13. Particulars of any pending civil/criminal action, a notice of claim, and/or settlement or judgment in any civil/criminal law suit where the applicant is a party;
14. A conviction in relation to any federal or provincial offence;
15. A physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs ability or practice midwifery.

Disclosures should contain the following information:

- the nature of complaint or incident;
- the date of the incident;
- names and addresses of institutions;
- agencies or professional organizations involved;
- jurisdiction where the incident occurred;
- any findings and outcomes; and
- any deficits in ethics, clinical practice or preparation revealed by the matters disclosed have been remedied.

The report will be reviewed by CMBC and may result in an investigation as deemed necessary.

Scenario - Duty to Disclose

Donna, a midwife, is found guilty of failing to wear a seatbelt under the *Motor Vehicle Act*. Six months later, on CMBC's annual renewal application form Donna sees a disclosure question asking if a conviction in relation to any federal or provincial offence applies. Donna cannot believe that this question is meant to include the seatbelt charge. Donna calls CMBC for clarification. Donna is told that the CMBC bylaws require 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 CMBC. Donna discloses it on the renewal form. Donna receives a reply from CMBC thanking Donna for the disclosure, stating that CMBC does not believe that this finding is worth investigating further.

Scenario - Duty to Disclose

Bernice, a midwife, is sued in Small Claims Court by a client, Paula. Paula claims that they told Bernice they were having severe pain in their lower abdomen but that Bernice 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 Bernice should have referred Paula 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 Bernice to pay Paula $10,000 for malpractice. Bernice discloses the incident and outcome to CMBC.

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 must 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.

Scenario - Duty to Warn

Donna, a midwife, has a client, Paula, who is having serious difficulties with the 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." Peter storms out shouting "I am going to kill that b----". Donna immediately calls the police and leaves a message for Paula on Paula's cell phone.

2.2 Public Register

The *Health Professions Act* requires that the CMBC Registrar maintain a register which the public has access to and which contains certain information about registered midwives or former registrants. The register sets out for every registered midwife:

- The person's name, whether the person is a registrant or a former registrant, and if the person is a registrant, the person's business address and business telephone number;
- The class of registrants in which the person is or was registered;
- If the person is a registrant, any limits or conditions imposed on the practice;
- A notation of each cancellation or suspension of the person's registration; and
- Any additional information required under the CMBC bylaws or specified by the registration committee, inquiry committee or discipline committee.

The register is a complete listing of midwives that have ever been registered with CMBC. Its purpose is to provide the public with information about BC 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 legally permitted to. For example, if a midwife is suspended for three months, the public can more easily report to CMBC if the midwife is still working during the suspension period when the suspension shows on the public register.

The register is posted on the CMBC's website. A digital copy can be requested. CMBC can also give information on the register over the telephone. Where a person asks about a midwife, CMBC must help the person find whatever information the person wants that is on the register.

Scenario - Public Register

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

3. MIDWIVES REGULATION AND CMBC BYLAWS

The *Health Professions Act* authorizes CMBC to develop regulations and bylaws to regulate the profession. Regulations and bylaws are both forms of law.

3.1 Midwives Regulation

The *Midwives Regulation* sets out CMBC's name, the reserved title "midwife" and a list of restricted activities for midwives. Amendments to the *Midwives Regulation* must be approved by the Minister of Health. There are certain procedures and processes to follow for requesting an amendment. The scope of practice, use of titles and restricted activities stated in the *Midwives Regulation* are discussed further in a later section.

3.2 CMBC Bylaws

The CMBC bylaws outline the structure of its Board and Committee, administration, class of registration and their requirements, the inquiry and disciplinary process, and the responsibilities of registrants. Amendments to the CMBC bylaws must be proposed and approved by the Minister of Health. There are certain procedures and processes to follow for requesting an amendment.

Bylaws pertaining to Registration

The bylaws set out the registration classes and the requirements for obtaining and maintaining registration with CMBC. There are nine classes of registrants:

1. ***General*** registrants meet all the conditions and requirements to practice in the full scope of midwifery in British Columbia;

2. ***Temporary*** registrants qualify for General registration and practice in the full scope of midwifery in British Columbia, but may wish to practice for a short periods of time (e.g. as locum midwives). Graduates from a CMBC recognized midwifery education programs may also be granted Temporary registration while awaiting the results of the Canadian Midwifery Registration Examination;

3. ***Temporary (limited scope)*** registrants may provide only antepartum and/or postpartum care. They may also provide intrapartum care as a second midwife, but only if they hold current certificates in neonatal resuscitation and cardiopulmonary resuscitation;

4. ***Temporary (emergency)*** registrants are persons who apply and receive registration when an emergency situation has been declared by the CMBC Registrar, according to criteria set by the Board. The scope of practice for this class of registration will be determined to address the emergency situation;

5. ***Conditional*** registrants do not meet all the conditions or requirements for General registration but in the opinion of the Registration Committee are likely to meet the

applicable requirements by completing educational upgrading courses or a period of supervised practice during a monitored and specific time period;

6. ***Conditional (return to practice)*** registrants do not meet all of the conditions or requirements for return to practice as General registrants but in the opinion of the Registration Committee are likely to meet the applicable requirements by completing educational upgrading courses or a period of supervised practice during a monitored and specific time period;

7. ***Conditional (remedial)*** registrants either have had their registration suspended under the *Health Professions Act* or limits or conditions imposed on their practice of midwifery under the *HPA*. An example of a limit might be to not provide intrapartum care. An example of a condition might be to only practice under supervision;

8. ***Non-practising*** registrants must not practice midwifery or any restricted activities in British Columbia; and

9. ***Student*** registrants are students currently enrolled in a CMBC recognized midwifery education program and may only provide midwifery services in connection with fulfilling the conditions and requirements of the education program.

General Requirements for Registration as a Midwife

There are certain requirements that must be met by all applicants for registration:

- The applicant must fully complete an application form and pay applicable fees.
- The applicant must show proof of authorization to reside and work in Canada, or in the case of a Student applicant, to reside and study in Canada.
- The applicant must inform CMBC of any criminal or other findings or regulatory proceedings or findings against them.
- The applicant must 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 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, fetal health surveillance).
- The applicant must have adequate fluency in English.
- The applicant must not be incapacitated (i.e. have an illness that prevents them from practicing safely, like a drug addiction that is not under control). As mentioned in an earlier chapter, each applicant must also disclose any past proceedings.
- All applicants, except applicants for Student registration must also successfully complete the Canadian Midwifery Registration Examination and the BC Jurisprudence Examination.

Specific Requirements

There are specific requirements for each class of registration. For example, applicants for General registration must have completed a CMBC recognized midwifery educational program or midwifery bridging program, and meet the clinical experience requirements. Applicants for Conditional registration must meet the same requirements as the General class other than meeting the clinical experience requirements.

Temporary registration applicants must have taken the Canadian Midwifery Registration Examination and be waiting for their results.

All applicants except student applicants must have completed a jurisprudence course on the laws and regulations that apply to the practice of midwifery in BC.

There are provisions in the bylaws pertaining to registration that allow the mobility of registered midwives across Canada. CMBC does not require qualified midwives currently registered in another midwifery regulated Canadian jurisdiction where the applicant is registered as the equivalent of a General registrant to once again prove that they have adequate education, experience and examination credentials.

Conditions of Registration

Once a midwife is registered with CMBC, 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, emergency skills and fetal health surveillance must be kept current for practicing midwives. If a midwife is found guilty of a criminal or other offence, the registrant must inform CMBC at the annual renewal of registration. If a midwife is disciplined by another professional regulator, the registrant must also inform CMBC.

Midwives in all classes of registration, except Non-practising, are required to maintain an active practice in order to meet the requirements for registration. If a midwife falls short on the currency and competency requirements or the active practice requirements, the midwife can be required to address the shortfall by practicing with a plan (and related terms, conditions and limitations) set by relevant CMBC Committees.

Non-practising midwives must not engage in the practice of midwifery. They can be a General registrant, a Temporary registrant or a Temporary (limited scope) registrant prior to applying to change their class to Non-practising . A registered midwife from another Canadian jurisdiction whose current status is Non-practising may also apply for Non-practising registration in BC. Once registered, they may apply to return to practice. In addition, before resuming General registration status, a Non-practising midwife may be required to successfully complete a requalification program that is tailored to their circumstances. The requalification program may include a period of supervised practice, completing practice requirements or completing educational upgrading courses.

Scenario - Bylaws re Registration

Donna is a registered midwife with General registration status. Donna has been practising for 10 years. In the last three years, Donna has reduced their own client caseload to be able to complete a part-time Master's degree in public health. At the recent renewal of registration, Donna declares that they have not provided intrapartum care at home as principal midwife for the last three years. Donna is notified that Donna does not meet the currency and competency requirements for renewal of General registration. Donna explains that they are returning to full time practice now that their Master's degree is complete. Donna is advised that a return to practice plan will be prepared to support Donna to practice in full scope of midwifery again. Donna is eligible for renewal of Conditional (return to practice) registration. Donna agrees to comply with the plan and has registration renewed in a Conditional (return to practice) class.

Bylaws pertaining to Investigation, Inquiry and Discipline

Part VI of the bylaws sets out the investigation, inquiry and discipline process in accordance with the *Health Professions Act.* For example, where the Inquiry Committee has reason to believe that a registrant may be incapacitated, the Committee may appoint a fitness to practice panel to investigate the complaint. Another example is the Registrar's authorization to dismiss a complaint under section 32 (3) of the HPA.

Bylaws pertaining to Registrant Records

Part VII of the bylaws sets out the privacy requirement and the requirements for the storage, retention, transfer, destruction and/or disposition of client medical records.

Bylaws pertaining to Marketing and Advertising

Part VIII of the bylaws sets out the acceptable marketing and advertising activities that can be undertaken or authorized by registrants in respect of their professional services and which activities are likely to violate the bylaws.

A CMBC registrant is expected to be familiar with the abovementioned sections of the bylaws.

4. THE ROLE OF CMBC

CMBC has a number of roles and responsibilities in order to protect the public interest. Under the *Health Professions Act* and the CMBC bylaws, CMBC has established various committees, programs and processes to carry out the regulation of the profession.

4.1 Registration Process

Registration is the way for a person to enter the profession and become a midwife (registrant of CMBC). CMBC aims to ensure that its registration process is fair, transparent, objective and impartial.

To become a registrant of CMBC, a person submits a completed application form to CMBC and pays the applicable fees. Through the application form the applicant provides CMBC with information about their education, training and experience, their past conduct, and other information that may affect their ability to practise effectively (e.g. language fluency, current experience, etc.). The applicant must then successfully pass the qualifying examination(s) to become a registrant. The applicant should provide enough information in the application 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, CMBC will register the applicant in the appropriate class of registration. In this case, a certificate of registration is issued to the new registrant.

However, if it appears that the applicant does not meet the registration requirements, the applicant will be advised of the reasons and be given an opportunity to respond. The Registration Committee will consider the application further and determine the applicant's eligibility to become a registrant. 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:

- Request the applicant to complete further training or examinations;
- Register the applicant with terms, conditions and limitations; or
- Decline the application.

If registration is not granted by the Registration Committee, the applicant may appeal the decision to the Health Professions Review Board (HPRB). HPRB is appointed by the government and is independent of CMBC. HPRB will review the submission and determine that an applicant meets the registration requirements or direct the Registration Committee to obtain additional information and make a new decision. HPRB's decision can be appealed to the courts.

Where an applicant is registered in another Canadian jurisdiction, CMBC must, with rare exceptions, accept the applicant's education, experience, and examination credentials without

further inquiry. CMBC can still review the other registration requirements (e.g. good character, practice limits or conditions) through requesting a Letter of Conduct and Professional Practice from the originating jurisprudence and professional references for the applicant.

Scenario - Registration Process Making False Statements

Deepika fills out an application form for registration, but when answering the question about previous criminal findings Deepika does not want to put down the shoplifting conviction they received 20 years ago when they were 15 years old. Deepika is worried it would affect the application. So, on the application Deepika reports that they do not have any previous criminal findings. Based on the information on the application form, CMBC registers Deepika. A few years later CMBC is informed about Deepika's previous conviction. CMBC realizes that Deepika made a false statement. CMBC can now revoke Deepika's registration because Deepika 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 Deepika was a youth at the time and because Deepika had no other wrongdoings or convictions in 20 years. However, because making a false statement on the application form is serious and reflects current dishonesty, there is a possibility that Deepika may be removed from registration and 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 to CMBC.

4.2 Complaints and Inquiry/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, appropriate action and process must be taken by CMBC following the *Health Professions Act* and the CMBC bylaws.

The CMBC *Information Sheet for Registered Midwives on the Inquiry and Discipline Process* details the steps involved if a complaint is lodged against a midwife. The process that CMBC follows to investigate and address complaints protects the interests of the public while treating registrants with fairness and respect.

The following are some of the examples of conduct of midwives which the Inquiry Committee might investigate:

- a contravention of the *Health Professions Act*, the *Midwives Regulation* or the CMBC bylaws;
- failing to abide by the CMBC *Standards of Practice*;
- failing to comply with a limit or condition on registration;

- failing to consult with another health professional or to transfer the care of a client when required;
- discontinuing necessary services without arranging for alternative services;
- giving out information about a client without the client's consent;
- incompetence;
- practicing while incapacitated or impaired;
- verbal, physical, emotional or sexual abuse; or
- other issues of professional conduct.

Inquiry Process

The inquiry process addresses concerns about professional midwifery practice. The Inquiry Committee directs the investigation of all complaints, and whenever possible, resolves them by consent. The inquiry process is not about ensuring outcomes, assessing injury or awarding compensation. In some cases, however, the Inquiry Committee may be investigating a complaint that is also the subject of a civil litigation.

When a complaint is received by the Registrar, the Registrar may seek clarification from the complainant. The Registrar asks for a complaint to be put in writing. The complainant must be identified, and the complaint must raise concerns about specific actions or behaviours of a registrant or former registrant in order to be referred to the Inquiry Committee.

When the Registrar refers a complaint to the Inquiry Committee, the Inquiry Committee Chair appoints an Inquiry Panel to investigate the complaint. The Panel will be composed of three members, two professional members who do not work with or have a personal relationship with the midwife who the complaint is about, and one public member of the Inquiry Committee. The Panel is independent and members have no prior knowledge of the situation under investigation. If there is reason to believe that incapacity is involved, the chair may appoint a Fitness to Practice Panel.

The midwife involved will be notified and provided with a copy or summary of the complaint. The midwife will be asked to respond to the complaint and provide CMBC with a copy of the records of care. The midwife is encouraged to contact the professional association (Midwives Association of BC) or the professional liability insurer seeking legal advice before responding to the complaint.

The Inquiry Committee Chair or the Inquiry Panel may direct the Registrar to investigate the complaint or may appoint an outside investigator, who will interview and take statements from the people who were involved in the events surrounding the complaint.

The Inquiry Panel will review the letter of complaint, the records of care, the midwife's response, and other materials collected in the investigation. The Panel may ask the inspector to obtain more information. When the investigation is complete and the Panel has heard from everyone involved, including the midwife, it makes its decision.

The Inquiry Panel is responsible for determining if there is sufficient information to substantiate a complaint. At the conclusion of the review of the complaint, the Panel may:

- dismiss the complaint; or
- request that the midwife do one or more of the following through Consent Agreement:
  - agree not to repeat the conduct (a common response if the conduct only happened once and was not dangerous);
  - agree to take specific educational courses;
  - consent to a reprimand; and/or
  - consent to any other specified action, which could include such things as conditions on registration, supervision or mentoring.

A Consent Agreement becomes a part of the midwife's Registration file and, upon request, may be accessed by the public.

If, during the investigation, the Inquiry Panel is concerned about a possible ongoing risk of harm or danger to the public, the Panel may set limits or conditions on the midwife's registration, or even suspend the registration until the investigation is completed and the matter is resolved.

Complainant's Right to Review

As required by the *Health Professions Act*, the complainant is notified of the results of the Inquiry Panel's process and, if the complainant is not satisfied, the complainant may apply to the Health Professions Review Board (HPRB), established under the HPA, for a review of the disposition made by the Inquiry Committee. Upon receipt of an application, the Health Professions Review Board will conduct a review of the disposition and consider:

- the adequacy of the investigation conducted respecting the complaint; and
- the reasonableness of the disposition.

On completion of its review, the Health Professions Review Board may make an order:

- confirming the disposition of the complaint made by the Inquiry Committee;
- directing the Inquiry Committee to make a disposition that could have been made by the Inquiry Committee in the matter; or
- sending the matter back to the Inquiry Committee for reconsideration with directions.

An order made by the Health Professions Review Board is final.

Scenario - Complaints and Inquiry/Discipline

A client sends a letter of complaint to CMBC saying that Donna, a midwife, was rude to the client. The client says that Donna became angry when the client expressed concern that the care was unhelpful. The client says that Donna "threw the client 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 Donna could to explain the proposed care management plan to the client, the client became verbally abusive. Donna had to terminate the professional relationship. Donna's letter is sent to the client who replies that the client was never verbally abusive to Donna and that Donna is making this up to defend themselves. The Inquiry Committee through its investigation of the complaint 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. As there have been no previous complaints about Donna and around this issue, the Inquiry Committee decides to resolve the complaint by reminding Donna of the need to be professional in dealings with clients even in challenging circumstances.

Scenario - Complaints and Inquiry/Discipline

Donna is a midwife. Donna's former practice partner, Rebecca, calls the Registrar to express 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 (Donna is rude to colleagues and not receptive to feedback). Rebecca states that Rebecca is particularly concerned because there have been a number of bad client outcomes, as well as many "close calls". The Registrar refers the complaint to the Inquiry Committee for investigation. An appointed inspector obtains 25 client charts and interviews Rebecca, other midwives that work with Donna and several clients. Donna has been the subject of one previous investigation where Donna was alleged for failing to consult with a physician for a repair of a third-degree laceration. As a result of that investigation, Donna was asked to sign a Consent Agreement in which Donna undertook to take an education course to address the gap in the competency area. The Inquiry Committee considers all of the information obtained before them as well as Donna's response and submissions and determines that the concerns are serious enough to require Donna to sign a Consent Agreement to undertake relevant remedial courses as well as practice under supervision for a specified period to address the incompetence. Donna's registration is changed to Conditional (remedial) and the Consent Agreement is published.

Scenario - Fitness to Practise

Deepika is a midwife working with Jordan, another midwife. Jordan reports to CMBC that Jordan is terminating partnership with Deepika because Deepika's drinking is beginning to affect work. Jordan is tired of covering for Deepika when Deepika comes to the midwifery clinic two hours late after a binge. The Registrar makes some inquiries that tend to confirm Jordan's report. Deepika, however, denies any problems. The Registrar reports the matter to the Inquiry Committee. The Inquiry Committee asks Deepika for consent to obtain a copy of Deepika's medical records, which Deepika provides. Those records indicate that Deepika has separated from their spouse, who accused Deepika of drinking, and that Deepika has recently been charged with impaired driving. The Inquiry Committee appoints a Fitness to Practice panel to investigate. The panel 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 Fitness to Practice panel recommends to the Inquiry Committee to take immediate necessary action to protect the public under section 35 of the *Health Professions Act* while the panel continues the investigation. The Inquiry Committee suspends Deepika's certificate of registration until the investigation by the Panel 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 conclusion of the investigation, the Fitness to Practice panel confirms that Deepika is incapacitated, recommends to the Inquiry Committee that Deepika sign a Consent Agreement to undertake to continue in regular treatment, and work with another midwife who will monitor Deepika's performance at work, and that regular reports be made to CMBC of Deepika's progress. Deepika signs the Consent Agreement and registration is reinstated as Conditional (remedial).

Discipline Process

In rare cases where a registrant and the Inquiry Panel cannot reach an agreement, or if a registrant does not comply with the terms of an undertaking or agreement, or if a matter of public protection is considered so serious that it cannot be addressed by consent, the Inquiry Panel may direct the Registrar to issue a citation for a Discipline Committee hearing.

A Discipline Committee hearing is conducted by a Discipline Panel appointed by the Chair of the Discipline Committee. This Discipline Panel is made up of professional and public members who have not previously been involved in reviewing the complaint. They will act as the decision-making body at the hearing.

The Discipline Committee may set limits or conditions or suspend registration if it has concerns about public safety between the time the matter is referred and when there is a decision from the hearing.

If a complaint is referred to the Discipline Committee, the midwife, the complainant and CMBC may all appear with legal counsel at the hearing. CMBC will retain counsel to prosecute and separate counsel to advise the Discipline Panel.

A Discipline hearing is a hearing in every sense of the word, with full disclosure of all of the materials in CMBC's file. The hearing is usually public, and testimony is taken under oath. The midwife, or the counsel, have the right to cross-examine witnesses and call evidence in defense. The Discipline Committee has the power to order a person to attend and give evidence or produce records. A Discipline hearing can also proceed in the absence of the registrant.

The Discipline Panel may:

- dismiss the matter;
- issue a reprimand;
- impose limits or conditions on registration;
- assess the costs of the hearing against the midwife;
- fine the midwife in accordance with the CMBC bylaws; or
- suspend or cancel registration.

Any of the parties may appeal a Discipline Committee hearing decision to the Supreme Court.

4.3 Quality Assurance

In accordance with the *Health Professions Act*, a college has an object to establish, monitor and enforce standards of practice to enhance quality of practice and reduce incompetent, impaired or unethical practice amongst registrants. The HPA further states that a college may make bylaws to establish a quality assurance program.

CMBC has established a Quality Assurance Program. The purpose of the program is to assure and improve the quality of midwifery practice, with the underpinning philosophy that registrants are responsible and accountable for sustaining and enhancing their own knowledge, skills, attitudes and competencies over a lifetime of practice. Participation in the program is mandatory for all registrants, excluding Non-practising registrants.

It is expected that the focus of the program will be enhancing the quality of midwifery practice in British Columbia primarily through peer feedback, education and support. Failure to comply with the program may result in inquiry or changes to registration status.

The following are components of the CMBC Quality Assurance Program:

- Currency and Competency requirements
  - Current clinical experience
  - Continuing competencies
  - Continuing professional development

    - Self-assessment;
- Provision of clinical information;
- Peer Case Review;
- Evaluation of Midwifery Care; and
- Peer Practice Review.

Details of the program can be found in the CMBC *Quality Assurance Program Framework.*

Scenario - Quality Assurance

Donna, a midwife, is randomly selected to report on peer case review as per the CMBC *Peer Case Review Policy*. Donna's Peer Case Review Log is inspected by CMBC and it is determined that Donna has not meet the policy requirement for the previous year. As a result, Donna is required to submit a short self-assessment questionnaire to CMBC for review. Further, Donna is pre-selected for an audit of their peer case review log for the next registration year.

5. SCOPE OF PRACTICE, RESERVED TITLES AND RESTRICTED ACTIVITIES

Each health regulatory college has a profession-specific statute which establishes that college under the *Health Professions Act*. The *Midwives Regulation* is the profession-specific statute which establishes the College of Midwives of British Columbia (CMBC).

5.1 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. Registrants of other health professions may perform some scope that midwives can do; however people cannot perform a restricted activity unless they have the legal authority to do so.

It is important for midwives to know their scope of practice. In the Midwives Regulation, the scope of practice states "A registrant may practice midwifery." The midwifery scope and model of practice as defined in the CMBC Midwifery Scope and Model of Practice found in the Registrant's Handbook provides the broad boundaries of midwifery practice in BC. CMBC's *Standards of Practice* and associated policies detail the minimum requirements for safe practice of midwifery within the midwifery scope and model. The *Competencies of Registered Midwives* in the Registrant's Handbook provides details of the skills and knowledge expected of a midwife in BC.

The CMBC *Indications for Discussion, Consultation and Transfer of Care* outlines general requirements for midwives when making decisions to consult or transfer care.

Should a client refuse an indicated consultation or transfer or care, the registrant should refer to the *Policy on Informed Choice* and the *Policy on Client Requests Outside Midwifery Standards of Practice* of the Registrant's Handbook.

Scenario - Scope of Practice

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

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

5.2 Reserved Titles

The *Health Professions Act* states if a regulation prescribes a title to be used exclusively by registrants of a college, a person other than a registrant of the college must not use the title, an abbreviation of the title or an equivalent of the title or abbreviation in another language to describe the person's work, in association with or as part of another title describing the person's work, or in association with a description of the person's work, or expresses or implies that the person is a registrant or associated with the college. The title "midwife" is reserved for exclusive use by registrants of CMBC, as set out in the *Midwives Regulation*. 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 can use any form of the title "Doctor" when providing or offering to provide health care services in BC. 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.

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 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, eg. Registered Midwife, R.M. The reserved title in French is translated as "sage-femme". The approved French variation will be "sage-femme autorisée", and the approved abbreviation will be "s.f.a.". An indigenous midwife practicing indigenous midwifery as described in the Midwives Regulation may use the title "aboriginal midwife". The approved French variation will be "sage-femme autochtone".

In addition, people who are not registered as midwives cannot hold themselves out as midwives. This prevents people from pretending that they are midwives when they are not. CMBC can take legal action to stop illegal practitioners from using reserved title or practising midwifery.

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

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

Scenario - Reserved Titles

Deepika, a midwife with a PhD, teaches at a midwifery education program. Deepika also supervises students at the clinic. The students refer to Deepika as "Doctor Deepika" at the clinic. A colleague pulls Deepika aside and tells Deepika to ask the students to stop using "Doctor" in the clinic where there are clients. Deepika reviews the *Health Professions Act* and realizes that the colleague is correct.

5.3 Restricted Activities

Each health profession has its own specific activities that are restricted to their practice. They are called "restricted activities". No one can perform restricted activities of a health profession without the legal authority or being registered with the relevant regulatory college. Below is the list of restricted activities that a midwife in BC has the legal authority to perform under the *Midwives Regulation.*

The following is excerpted from the *Midwives Regulation.* Midwives should familiarize themselves with the entire regulation.

Restricted activities

5 (1) A registrant in the course of practicing midwifery may do any of the following:

- (a) make a midwifery diagnosis identifying a condition as the cause of signs or symptoms of an individual;
- (b) perform a procedure on tissue below the dermis or below the surface of a mucous membrane, for the purposes of
  - (i) performing episiotomies or amniotomies,
  - (ii) repairing episiotomies or simple lacerations, or
  - (iii) taking a swab or specimen required for a screening or diagnostic test;
- (c) insert acupuncture needles under the skin for the purpose of pain relief during labour or the post-partum period;
- (d) for the purpose of collecting a blood sample, perform venipuncture;
- (e) for the purpose of wound care during the post-partum period, administer a solution by irrigation;
- (f) administer a substance by
  - (i) injection,
  - (ii) inhalation, or
  - (iii) parenteral instillation

  for the purposes of
  - (iv) pain relief,
  - (v) preventing or treating dehydration or blood loss,
  - (vi) resuscitation or other emergency measures, or
  - (vii) other purposes as required for midwifery practice;
- (g) put an instrument or a hand or finger

(i) beyond the point in the nasal passages where they normally narrow, for the purpose of suctioning a newborn,
(ii) beyond the pharynx, for the purpose of intubating a newborn,
(iii) beyond the opening of the urethra, for the purpose of catheterization of a woman during labour or the post-partum period,
(iv) beyond the labia majora, for the purposes of
(A) conducting internal examinations of women,
(B) performing episiotomies or amniotomies,
(C) repairing episiotomies or simple lacerations, or
(D) conducting the vacuum-assisted emergency delivery of a baby,
(v) beyond the anal verge, for the purposes of
(A) assessing perineal repairs,
(B) administering a substance, or
(C) assisting in the emergency delivery of a baby, or
(vi) into an artificial opening into the body, for the purpose of assisting in the surgical delivery of a baby;

(h) manage labour or normal, spontaneous vaginal delivery of a baby;
(i) apply ultrasound for the purpose of fetal heart monitoring;
(j) give an instruction or authorization for another person to apply, to a named individual, ultrasound for diagnostic or imaging purposes, including any application of ultrasound to a fetus;
(k) in respect of a drug specified in Schedule I or IA of the Drug Schedules Regulation that is prescribed by a medical practitioner or a nurse practitioner,
(i) compound the drug,
(ii) dispense the drug, or
(iii) administer the drug by any method;
(l) in respect of a drug specified in Schedule I or IA of the Drug Schedules Regulation,
(i) prescribe the drug,
(ii) compound the drug,
(iii) dispense the drug, or
(iv) administer the drug by any method;
(m) in respect of a drug specified in Schedule II of the Drug Schedules Regulation,
(i) prescribe the drug,
(ii) compound the drug,
(iii) dispense the drug, or
(iv) administer the drug by any method.

(1.1) Only a registrant may provide a service that includes the performance of an activity set out in subsection (1).

Prescribing and Testing Standards

Midwives are authorized to perform the restricted activities of administering, by injection or inhalation, a substance designated in the regulation and specified in the following standards, found in the Registrant's Handbook:

- *Standard, Limits and Conditions for Prescribing, Ordering and Administering Therapeutics;*
- *Standard, Limits and Conditions for Ordering and Interpreting Screening and Diagnostic Tests;*
- *Standard, Limits and Conditions for Prescribing, Ordering and Administering Controlled Substances;*
- *Standard, Limits and Conditions for Prescribing, Ordering and Administering Drugs for Sexually Transmitted Infections;* and
- *Standard, Limits and Conditions for Prescribing, Ordering and Administering Contraceptives*.

This includes the substances midwives may administer, by injection or inhalation, on their own initiative as well as those substances the midwife may administer by injection or inhalation on the order of a physician in the course of providing midwifery services.

Limits or Conditions on Services and Restricted Activities (excerpts from Midwives Regulation)

6 (1) A registrant must consult with a medical practitioner or nurse practitioner regarding any deviations from the normal course of pregnancy, labour, delivery and the post-partum period that indicate pathology and transfer responsibility for care to another health professional when necessary or appropriate.

(2) A registrant may provide a service that includes the performance of an activity described in section 5 (1) (c), (g) (iv) (D) or (vi) or (l) only if the registrant has successfully completed a certification program established, required or approved under the bylaws to ensure registrants are qualified and competent to provide the service and perform the activity.

(3) A registrant may perform an activity described in section 5 (1) (k) only after consulting with a medical practitioner or a nurse practitioner, unless the registrant is authorized under section 5 (1) (l) and subsection (4) of this section to perform the activity.

…

(6) A registrant may perform an activity described in section 5 (1) (k) to (m) only in respect of a woman or her newborn, as the case may be, during pregnancy, labour, delivery or the post-partum period.

Exceptions to prohibitions

The *Health Professions Act* states that despite prohibitions regarding practice of designated health profession, nothing in the HPA, the regulations or the bylaws prohibits a person from

14 (b) providing or giving first aid or temporary assistance to another person in case of emergency if that aid or assistance is given without gain or reward or hope of gain or reward.

Scenario - Restricted Activities

Deepika, a midwife, sees a 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 go to the closest hospital's emergency department, but Paula will not go. Deepika therefore applies a cast to the fracture. Later Deepika wonders if a midwife is permitted to apply the cast under the *Midwives Regulation* or if the act is restricted for another health profession under their regulation.

Applying a cast to a fracture is a restricted activity. Midwives are not authorized to perform that restricted activity by the *Midwifery Regulation*. 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 the midwife to perform a restricted act.

Scenario - Restricted Activities

Donna, a midwife, performs an episiotomy on a client Jane. An episiotomy is a restricted activity that midwives are authorized to perform under the *Midwifery Regulation*. Donna is authorized to perform that restricted activity.

Scenario - Restricted Activities

Deepika, a midwife, discovers that a client Melva has gone into diabetic shock. Deepika looks in Melva's briefcase and finds a syringe and insulin. Deepika injects the insulin into Melva's muscle and calls 911. Melva recovers. While Deepika did perform a restricted activity not authorized by the *Midwives Regulation* (injecting insulin, a drug not authorized to be injected by midwives), it was done in an emergency situation, which is a recognized exception to the restricted activities rule.

Scenario - Restricted Activities

Deepika, a midwife, has a client who needs a cesarean section in labour. The obstetrician who will perform the cesarean asks Deepika to assist during the surgery. Deepika has acquired additional certification from CMBC for surgical assist at cesarean section, so is able to provide this service.

Question - Restricted Activities

Which of the following is a restricted activity:

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 restricted activity. 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 restricted activities.

6. INFORMED CHOICE AND CONSENT

Many complaints against midwives are the result of poor communication with clients, midwifery colleagues or other health professionals. 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. an inquiry or discipline hearing). This chapter of the handbook deals with client choice during assessment and treatment of clients. Another chapter 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 BC. It recognizes clients as the primary decision-makers and provides informed choice in all aspects of care by:

- providing information so that clients are informed when making decisions about their care;
- 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. Information should include research evidence including deficiency of clear evidence as well as relevant community standards of care. The midwife informs the client of any considerations according to the CMBC *Indications for Discussion, Consultation and Transfer of Care* and makes recommendations supported by evidence, CMBC and community standards;
- making efforts to understand and appreciate what is motivating clients' choices;
- allowing clients adequate time for decision-making;
- ensuring treatment is only provided with the client's informed and voluntary consent unless otherwise permitted by law; and
- 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-centered.

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 procedure will result in a benefit?
- 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 registrant 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.

Scenario - Informed Choice

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. Are you OK with me doing a full history with you?" If Paula agrees, Donna obtained informed choice for taking a full history.

Question - Informed Choice

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 required.
- Implied Consent. A client can give consent by their actions. For example, in the above scenario, the client Paula could just nod the head, implying consent for Donna to begin asking 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) and Care Facility (Admission) Act (HCCA)

The Health Care (Consent) and Care Facility (Admission) Act (HCCA) sets out rules about consent to care especially where there is concern about the capacity of the client to consent to the care. 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. There are specific exceptions made for emergencies. These can be found in the HCCA. The Midwives should familiarize themselves with this Act.
http://www.bclaws.ca/civix/document/id/consol27/consol27/00_96181_01

Consent Where the Client is Incapable

"When deciding whether an adult is incapable of giving, refusing or revoking consent to health care, a health care provider must base the decision on whether or not the adult demonstrates the understanding of the information a reasonable person would require to understand the proposed health care and to make a decision, including information about

(i) the condition for which the health care is proposed,
(ii) the nature of the proposed health care,
(iii) the risks and benefits of the proposed health care that a reasonable person would expect to be told about, and
(iv) alternative courses of health care,

and that the information applies to the situation of the adult for whom the health care is proposed". (HCCA)

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. There are circumstances where involving the incapable client in the discussions will not be possible (e.g. the client is unconscious).

If a person is incapable, sometimes they will have a personal guardian or representative that is authorized to make health care decisions for them. If this is not the case, a temporary substitute decision-maker will be needed. "To obtain substitute consent to provide major or minor health care to an adult, a health care provider must choose the first, in listed order, of the following who is available and qualifies under subsection (2):

(a) the adult's spouse;
(b) the adult's child;
(c) the adult's parent;
(d) the adult's brother or sister;
(d.1) the adult's grandparent;
(d.2) the adult's grandchild;
(e) anyone else related by birth or adoption to the adult;
(f) a close friend of the adult;
(g) a person immediately related to the adult by marriage.

(2) To qualify to give, refuse or revoke substitute consent to health care for an adult, a person must
  (a) be at least 19 years of age,
  (b) have been in contact with the adult during the preceding 12 months,
  (c) have no dispute with the adult,
  (d) be capable of giving, refusing or revoking substitute consent, and
  (e) be willing to comply with the duties in section 19.

(3) If no one listed in subsection (1) is available or qualifies under subsection (2) or if there is a dispute about who is to be chosen, the health care provider must choose a person,

including a person employed in the office of the Public Guardian and Trustee, authorized by the Public Guardian and Trustee.

(4) A health care provider is not required to do more than make the effort that is reasonable in the circumstances to comply with this section." (HCCA)

Information related to the authority, duties and restrictions on temporary substitute decision makers are listed in the HCCA.

Scenario - Consent

Donna's client, Paula, pages with signs and symptoms consistent with premature labour at 34 weeks gestation. Donna advises Paula to meet them at the hospital immediately. Paula has a mental illness that prevents them from understanding the issue. Paula is clearly incapable. Donna knows that Paula, while still well, appointed a friend Pat to be a representative for Paula's health care decisions. However, Pat is travelling outside of the country and cannot be reached. Therefore, Pat is not able to fulfill the role as Paula's representative. Donna contacts Paula's elderly mother, but Paula's mother is frail and does not feel confident in making decisions regarding Paula's health care. Thus, Paula's mother is not willing to act as a temporary substitute decision-maker. Paula's sister is willing and able to make decisions on Paula's behalf and appears to understand the information and its consequences for Paula. Paula's sister is able to act as the temporary substitute decision maker even though not the highest ranked substitute.

"When an eligible person is not available, or there is a dispute in choosing between equally ranked decision makers, the Public Guardian and Trustee (PGT) is called upon to authorize a suitable decision-maker or to make substitute treatment decisions."
http://www.trustee.bc.ca/services/services-to-adults/Pages/personal-decision-services.aspx

Question - Consent

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

i. The client's spouse.
ii. The client's sister.
iii. The client's mother.
iv. The client's adult son.

Assuming that all of those listed meet the other qualification of a temporary substitute decision-maker as listed in subsection 2, the best answer is i, the client's spouse. If the spouse is not available, the client's adult son would be the next in line to be the temporary substitute decision-maker. Next in line, after the son, would be the client's mother and then the client's sister.

7. PROFESSIONAL BOUNDARIES AND SEXUAL ABUSE/ MISCONDUCT

In order to understand the nature of professional boundaries and the harm that can result from crossing boundaries, including sexual abuse or sexual misconduct, 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 may 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 is required 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. Physical touch can be open to misinterpretation. 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.

Consent

It is essential that clients' autonomy and ability to provide full, free and informed consent be maintained at all times. Informed consent is defined as the process by which a client is provided with information about a clinical procedure and understands the purpose, benefits, potential risks and alternatives, and voluntarily agreed to the procedure.

Principles

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

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

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.

Scenario - Self-Disclosure

Paula is having difficulty deciding whether to get married to their boyfriend and talks to Donna, the midwife, about this issue a lot during their visits. To help Paula, Donna decides to tell Paula details of Donna's own doubts in accepting the proposal from Donna's first husband. Donna tells of how those doubts had long-term consequences, gradually ruining the first marriage as both Donna and Donna's 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 the pregnancy.

Giving or Receiving of Gifts

Giving and receiving gifts is potentially dangerous to the professional relationship. However, a small token of appreciation by the client 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 new Canadians might be unfamiliar with the tradition).

The CMBC *Code of Ethics* states "Midwives act as effective role models by maintaining both professional and ethical conduct. Midwives should not engage in any activity that would adversely affect the honour, dignity, or credibility of the profession. To do so, the midwife does not accept any gift, favour or hospitality which might be reasonably seen to create a conflict of interest."

The CMBC *Policy on Appropriate Client-Midwife Relationships* discusses "non-trivial gifts from clients." Gifts should never be solicited from clients. It may be acceptable on some occasions to accept a modest gift from clients. If a gift must be refused, midwives should explain why in a sensitive manner. When deciding whether or not to accept a gift, midwives should consider:

- whether the gift will change the nature of the relationship;
- the context in which the gift is offered, including the monetary value and appropriateness of the gift;
- the client's intent in offering the gift; and
- whether the client will expect a different level or nature of care."

Scenario - Gift Giving

Donna, a midwife, has a client from a Mediterranean culture with a large family, many of whom need Donna's services. The client brings food on every visit. Donna thanks the client but tries not to treat it as an expectation. On one visit Donna happens to mention a home-made pizza recipe. The client insists that Donna bring it over to the client's 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

As defined in the CMBC *Policy on Appropriate Client-Midwife Relationship*, dual relationship in the health service context pertains to relationships in which the registrant has more than one relationship with the service recipient.

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.

Given the need for established professional boundaries, midwives are restricted from providing midwifery care to a related person, defined as family and/or household members. Midwives should avoid, as much as possible, any professional relationships with clients where the midwives' objectivity or competence could reasonably be expected to be impaired because of the professional's present or previous familial, social, sexual, emotional, financial, supervisory, political, administrative, or legal relationship with the client or with another relevant person associated with or related to the client. Likewise, relationships such as these could affect the clients' willingness to give an accurate history or disagree with any of the midwives' recommendations.

At times, it may be unavoidable that midwives must provide midwifery care to family members, for example in emergencies or in small communities. In such instances, midwives should document the specific circumstances, an account of why the dualities or conflicts were unavoidable and document the informed consent of the clients for all services. Whenever possible, overall responsibly for care should be transferred to another health care provider.

It is important to familiarize yourself with the CMBC *Policy on Appropriate Client-Midwife Relationship.*

Scenario - Dual Relationship

Donna, a midwife, has Paula as a client. Paula is a refugee with very little money. Paula works part-time as a house cleaner. Donna decides to hire Paula to clean their 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 the house on a specific date. Paula, who was planning to visit family at that time, feels unable to say no because of concern of losing the housecleaning job with Donna and also possibly with Donna's friends if Donna complains about Paula. Paula may also be worried about the midwife-client relationship. The dual relationship may have contributed to Paula's concerns. Donna should not have engaged in this dual relationship.

Becoming Friends

Becoming a personal friend with a client is a form of a dual relationship. Clients should not be placed in the 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. The CMBC *Code of Ethics* state "The midwife develops a relationship of trust and partnership with the client. To do so, the midwife may respectfully choose to not provide care to which they conscientiously object; however, the emphasis on individual conscience should not deprive anyone of essential health services". 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.

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.

Understand when to use gloves for reasons relating to universal precautions. The use of gloves when touching sexual areas decreases intimacy that might be interpreted as sexual. When doing vaginal examinations, a glove should also be worn on the opposite hand if that hand is touching the labia.

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/Sexual Misconduct

"Professional Misconduct" is defined in the *Health Professions Act* (Part 3) to include "sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession".

"Sexual Abuse or Sexual Misconduct" is defined in the CMBC *Policy on Appropriate Client-Midwife Relationships* as:

(a) sexual intercourse or other forms of physical sexual relations between the midwife and the client, or
(b) touching, of a sexual nature, of the client by the midwife, or
(c) behaviour or remarks of a sexual nature by the midwife towards the client,
but does not include touching, behaviour and remarks by the midwife towards the client that are of a clinical nature appropriate to the service being provided.

For example, telling a client a sexual joke is sexual misconduct. Hanging a calendar on the wall with sexually suggestive pictures (e.g. a provocative "fire fighters" calendar) is sexual misconduct. Making non-clinical comments about a client's physical appearance (e.g. "guys won't be able to keep their hands off of you") is sexual misconduct. Unnecessary or inappropriate comments about a client's sexual orientation, gender identity or gender expression is sexual misconduct.

It is always the responsibility of the midwife to prevent sexual misconduct 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.

Scenario - Sexual Misconduct

Donna, a midwife, tells a colleague about a romantic weekend with Donna's husband 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 Paula overheard the remark and is curious as to what Donna meant by this, as in Paula's experience, wine helps the libido of both partners. Has Donna engaged in sexual misconduct?

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 Paula. It would be sexual misconduct 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.

Under the *Health Professions Act*, a college has to establish a patient relations program to seek to prevent professional misconduct of a sexual nature. The Act further requires all colleges to establish a Patient (Client) Relations Committee and establish educational requirements and guidelines for registrants respecting their relations with patients. CMBC's Client Relations Committee has the role to administer a client relations program to prevent professional misconduct within a client-midwife relationship. CMBC views the task of defining professional standards of behaviour in a broader context of clear communication and respect for the integrity, independence and individual needs of each client in midwifery care.

CMBC supports zero tolerance of all forms of abuse. CMBC, however, stresses that zero tolerance does not preclude professional supportive behaviour that may include physical contact that is nurturing or helpful and, therefore, acceptable to the client.

The client-midwife relationship is based on mutual trust and respect and any act of abuse is a betrayal of that trust. CMBC will investigate and act upon all complaints or reports of inappropriate behaviour received in writing.

CMBC maintains that sexual abuse or misconduct within a client-midwife relationship is unacceptable and will not be tolerated. CMBC is committed to prevention of such behaviour through education of its registrants and establishing deterrents through administration of processes that reflects the seriousness of the violation. CMBC acknowledges the potential vulnerability of clients and strives to provide a reporting process that is accessible and sensitive to their needs.

Tips for Preventing Sexual Misconduct Concerns

All midwives should consider ways of preventing sexual misconduct (or even the perception of sexual misconduct) from arising. Experience indicates that most sexual misconduct 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 misconduct 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;
- 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 and obtain informed consent before touching a client;
- Ensure that informed consent is an ongoing process, rather than a single discussion;
- 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; and
- Ensure any incidents or misunderstandings are fully and immediately documented.

Sexual Relationship Following Termination of Midwife-Client Relationship

Midwives cannot enter into a sexual relationship with any client. However, if one year has passed since the last professional contact with the client, the former client will no longer be considered a client and a sexual relationship with the former client would be permitted. Likewise, if there has been a previous sexual or romantic relationship, at least one year must have passed since the relationship ended before the midwife may accept the person into care.

In the event that a former client requires midwifery care while engaged in a sexual relationship with a midwife, the midwife is not authorized to provide any midwifery services to the former client.

Scenario - Sexual Misconduct

Fran, a midwife, is attracted to a client Anna. Fran notices looking forward to Anna's visits. Fran extends the visits a few minutes in order to chat informally with Anna. Fran thinks Anna might be interested as well by the way that Anna makes eye contact. Fran notices Fran is touching Anna on the back and the arm more often. Fran decides to ask Anna to join them for a coffee after Anna's next visit to discuss whether Anna is interested in Fran. If Anna is interested, Fran will transfer Anna's care to a colleague. If Anna is not interested, then Fran will make the relationship purely professional. Fran decides to ask a colleague, Vanessa, for advice.

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

Question - Sexual Misconduct

Which of the following is sexual misconduct?

i. Performing a clinically indicated abdominal and internal examination.
ii. Using glamour shots of scantily dressed Hollywood stars an interior design theme in order to attract younger clients.
iii. Discussing concerns a client has about their sexual life.
iv. Dating a former client more than a year after they have been discharged from midwifery care.

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 discussing concerns a client may have about their sexual life can be part of and relevant to midwifery care. Answer iv is not the best answer because the person has not been a client for over a year since your last professional encounter with them.

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 misconduct is a particularly serious example of a boundary crossing.

Midwives need to understand what kinds of conduct amount to sexual misconduct, the harm that can result from such behaviour, the need to take reasonable measures to avoid even the perception of sexual misconduct. A midwife found to have engaged in sexual misconduct will face serious consequences.

8. PRIVACY, CONFIDENTIALITY AND RECORD KEEPING

Personal Information Protection Act (PIPA)

Midwives have a legal and professional duty to protect the privacy of clients' personal health information. The *Personal Information Protection Act* (PIPA) governs midwives' use of personal health information, including its collection, use, disclosure, and access. An overview of important information about PIPA can be found in the CMBC *Personal Information Protection Act (PIPA) Requirements*.

The Office of the Information & Privacy Commissioner for British Columbia (https://www.oipc.bc.ca/) published *A Guide to BC's Personal Information Protection Act for Businesses and Organizations*: https://www.oipc.bc.ca/guidance-documents/1438. As set out in the guide, personal information means information that can identify an individual (for example, a person's name, home address, home phone number or ID number). It also means information about an identifiable individual (for example, physical description, educational qualifications or blood type). Personal information includes employee personal information but does not include business contact information or work product information"

As stated in the CMBC *Personal Information Protection Act (PIPA) Requirements*, the *Personal Information Protection Act* (PIPA) requires a midwifery practice to have policies about the protection of personal information in place and assign one of its members to be the office's privacy officer, responsible for helping client's understand how personal information is being managed and how to access their own personal information, and generally be responsible for ensuring the practice is in compliance with the PIPA.

Scenario - PIPA

Three midwives work together in a clinic. They have policies in place about the protection of personal information. The midwives decide amongst themselves that Rianne, the most senior midwife, will be the office's privacy officer. While all the midwives will educate clients about the protection of their personal information during their initial visit, Rianne will be responsible for checking in regularly with the other midwives to confirm that this is happening and that clients understand the laws pertaining to the use of their personal information and how to access their personal information.

Protecting Personal Health Information

Midwives must put in place practices to protect the personal health information they collect.

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 CMBC requirements.

The CMBC *Policy on Medical Records* states that what is required by the *Limitation Act* (amended in 2013); medical records must be retained for a minimum period of sixteen years from either the date of the last entry or from the age of majority (19 years of age in British Columbia), whichever is later, except as otherwise required by law (i.e. 35 years).

Scenario - Record Keeping

Donna, a midwife, provided midwifery care to a client, Paula, in 2010. Paula's baby was born on June 1, 2010 and the last postpartum appointment for both Paula and the newborn was held on July 15, 2010. Donna had no involvement in the care after that. Donna is required to keep the record until July 15, 2045, which is 16 years after the newborn's 19th birthday, a total of 35 years.

Information on maintaining or transferring records upon leaving a practice or retiring can also be found in the CMBC *Policy on Medical Records.*

Scenario - Record Keeping

Deepika, a midwife, has been practising for 25 years in the same practice and has built up a busy and successful practice. Deepika decides to retire but wonders about proper procedure for client records. Ordinarily Deepika would have to retain client records for 16 years from the last interaction with the client or the newborn's 19th birthday, whichever is later. However, Deepika is transferring the practice over to another midwife in the same community. Deepika ensures that all original retained records of clinical care that are still within the legal retention period are transferred to the other midwife who has agreed to take over the custody of the records. The transfer of records from Deepika to the other midwife is documented including:

a) the stored location, and safety and confidentiality of client records;
b) a requirement that the receiving midwife notify Deepika and CMBC if the location changes;
c) Deepika's right of access;
d) the client's right of access; and
e) the duration of record storage required and appropriate means of disposing of records.

The CMBC is notified regarding access details and where in BC the records are securely stored.

Collection, Use and Disclosure of Personal Health Information

Ten Principles for the Protection of Privacy

From PIPA Tool #4: BC Ministry of Management Services

BE ACCOUNTABLE - you are responsible for the personal information under your control and for ensuring that you have policies to support your compliance with legislative requirements.

IDENTIFY THE PURPOSE - collect only what is necessary. The purpose for collecting personal information must be available to the client.

OBTAIN CONSENT - client knowledge and consent to collect, use or disclose personal information is required.

LIMIT COLLECTION - only collect personal information for the purposes that a reasonable person would consider appropriate in the circumstances.

LIMIT USE AND DISCLOSURE - use or disclose personal information only for the purpose it was collected.

BE ACCURATE - ensure personal information is accurate, complete and current.

USE APPROPRIATE SAFEGUARDS - ensure personal information is safeguarded against unauthorized access, disclosure, use, copying, modification, disposal, etc. regardless of format.

BE OPEN - share your privacy policy with clients so they understand how you protect personal information.

GIVE INDIVIDUAL ACCESS - make provisions for individuals to access their personal information.

PROVIDE RECOURSE - ensure your compliance and complaints process is simple and easy to understand.

Consent

When a client provides information regarding their health and the reasons for their visit, it is considered that the client has given the midwife implicit consent to the collection, use and disclosure of that information for use in providing health care, including implicit consent to send all or part of the client information to a third party (lab, hospital, other physician, etc.) so long as it is in relation to the provision of direct midwifery care.

This should be explained to the client at their initial visit. If concerns arise, further discussion should take place and a solution to their concerns found.

Scenario - Handling Personal Information

Francie, a midwife, has found that Celeste has high blood pressure at 38 weeks. Francie discusses the need to consult with an obstetrician and Celeste agrees. Francie calls the obstetrician's office and asks if they can see Celeste the next day. They are able to. Francie sends a letter of consultation and the pertinent information from Celeste's file faxed over to the obstetrician's office via secure fax. Francie also orders the appropriate lab work with a copy to go to the obstetrician and asks Celeste to go to the local lab today. Francie informs Celeste of warning signs associated with high blood pressure and asks Celeste to page if any occur. The obstetrician pages Francie the next day to discuss the visit with Celeste. A care plan is agreed to and the obstetrician faxes over the consultation letter the next day by secure fax.

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.

Scenario - Protect Personal Information

Jan, a midwife, is attending Louise at home in labour. Louise's sister, Cheryl, is Louise's main support person for the labour. At one point Jan sees Cheryl is over by Louise's chart and is just about to open it to start to look at it. Jan quickly goes over and recovers the chart and explains to Cheryl that the chart is Louise's private health information and not available for others to look at without Louise's permission.

Scenario - Handle Personal Information

Betty is a client of South Lake Midwifery Practice. Betty came to the initial visit with their partner Tom and during the health history said that this was a first pregnancy. Betty comes to the second visit alone and informs the midwife, Jan, that Betty had an abortion 3 years ago and doesn't want the partner to know about it. At chart review, Jan informs the other midwives in the practice of the sensitive nature of Betty's history. A note is made on the chart to this effect so that it is not mentioned in the presence of anyone who is not directly involved in the care as a health care provider.

Right to Access Personal Client Information

In accordance with the CMBC *Policy on Medical Records*, midwives are required to provide a copy of the complete midwifery record within thirty (30) days to the client upon request and that midwives are required to transfer a copy of the complete midwifery record to another registrant or health care practitioner upon request by the client.

A client has the right at any time to request access to the client's chart held in the midwife's office, but does not have automatic access to everything in the file. In certain circumstances a midwife may decide to allow partial access to a chart or hold back certain information if the midwife believes this information could cause harm to the client or to others. It is expected that such circumstances would be rare.

Right to Correct any Errors or Omissions in Personal Client Information

A client may request a correction to the records if they believed there is an error or omission and within 30 days of receiving such a request, the midwife must correct any information in the client's chart that has been verified to be inaccurate and then send a copy of the corrected record to each organization to which the incorrect or incomplete information was disclosed within the past year.

If the midwife determines that no incorrect information exists in the record, a note must be made and include it in the record to indicate a correction was requested but not made and the client must be notified and provided with the reason(s) for not making the requested correction.

Complaints Process

If a client has a complaint or concern about the way their personal information has been collected, used, or disclosed to a third party, the midwifery practice must have a process in place to deal with it that is readily accessible to their clients.

If a client is not satisfied with the outcome of dealing with your practice's procedures or policies, the client may contact CMBC and ask CMBC to solve the issue. If that procedure is unsatisfactory, the client may contact the Office of the BC Privacy Commissioner and the Privacy Commissioner will have the final word on the matter.

Question - Right to Access Information

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 College of Midwives of BC and the Office of the BC 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 College of Midwives of BC or the office of the BC Privacy Commissioner. 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.

Transmitting Client Information (Electronic Communication)

Midwives have the professional and ethical responsibility to ensure that both they and their staff exercise care in the collection, use and disclosure of clients' personal information, regardless of format. Midwives should be aware that all means of electronic communication and information can be retrieved and can be used in a court of law. Midwives are responsible for ensuring that their practice follows provincial and federal privacy laws.

The CMBC *Guideline for Using Electronic Communication to Transmit Client Information* provides further guidance on this matter.

1. When transmitting client information electronically, client confidentiality and security must be maintained and protected in the same way as required with any medical record. A public Wi-Fi connection should never be used when transmitting client information electronically as these connections are vulnerable to unauthorized interception.

2. Informed consent must be obtained from the client or client's designated representative and documented prior to sending any client information by email, fax, instant message or text message. Implied consent may be relied upon when sharing information with other health care providers that form a client's circle of care (e.g. consultants, lab technologists, etc.).

3. The use of email, instant message and/or text message is strongly discouraged when communicating with a client about a diagnosis or lab result, a clinical care recommendation or any other sensitive information.

4. If emailing information is necessary, midwives must ensure that: a) the sender has the correct contact for the recipient; b) the information was received as intended; c) all sensitive or confidential client information is password-protected or encrypted; d) a password is provided to the client or client's designated representative; e) the password or cryptographic key is sent separately to the intended recipient, preferably by telephone or other non-electronic communication; and f) the email contains a confidentiality disclaimer.

5. The use of text message or instant message is not considered a confidential means of communication. In rare situations where use of texting or instant messaging information is necessary and the only feasible means of communicating, and client consent to do so has been obtained, midwives must confirm that: a) the sender has the correct contact for the recipient and b) the information was received as intended.

6. When faxing client information midwives must: a) confirm the correct number for the recipient; b) include a cover page that identifies both the sender and recipient including contact information, indicates the total number of pages sent, and contains a confidentiality disclaimer; and c) confirm that the fax was sent to the correct place and that all pages were transmitted and received.

7. Medical records must include documentation of all emails, faxes, text messages, instant messages, phone calls and any other encounters related to client care.

Midwives should develop clear, written protocols around the use of email, fax, instant message and text message in their midwifery practice. All midwives and office staff in the practice should be made aware of the protocols.

CMBC provides a template consent form on their website: *Use of Electronic Communications Informed Consent*. Use of this consent form is optional. While a midwife is under no obligation

to obtain a client signature, reviewing the information and signing this form is an opportunity to document an informed choice discussion between midwife and client regarding the use of electronic communications. Further, a midwife is under no obligation to use electronic communication with a client.

More on Duty to Report

As discussed in Chapter 2 of this handbook, there are situations where a midwife is obliged by the duty to report requirements to disclose a person's personal health information. One situation is 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.

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

- Health Care (Consent) and Care Facility (Admission) Act (HCCA) for the purposes of determining, assessing or confirming capacity;
- Disclosure to a College in accordance with the *Health Professions Act*; 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 below there are other circumstances in which disclosure of personal health information is mandatory.

Under the *Public Health Act* there is mandatory reporting for certain communicable diseases. http://www.bclaws.ca/civix/document/id/lc/statreg/167_2018

Duty to Report a Child in Need of Protection

Midwives have a duty, by law, to report a child in need of protection and to be aware of the circumstances which could give rise to this duty. This is legislated in British Columbia in the *Child, Family, and Community Services Act* (CFCSA). Section 13 of the CFCSA describes the circumstances under which a report is necessary. Section 14 of the CFCSA states that a person who has reason to believe that a child needs protection under Section 13 must promptly report the matter. A child is defined as a person under 19 years of age. This includes but is not limited to newborns, other children of the client and clients under the age of 19.

Section 13 sets out the circumstances under which a child needs protection. A midwife must report a child if they have reason to believe any of the following:

- if the child has been, or is likely to be, physically harmed by the child's parent;

- if the child has been, or is likely to be, sexually abused or exploited by the child's parent;
- if the child has been, or is likely to be, physically harmed, sexually abused or sexually exploited by another person and if the child's parent is unwilling or unable to protect the child;
- if the child has been, or is likely to be, physically harmed because of neglect by the child's parent;
- if the child is emotionally harmed by:
  - the parent's conduct, or
  - living in a situation where there is domestic violence by or towards a person with whom the child resides;
- if the child is deprived of necessary health care;
- if the child's development is likely to be seriously impaired by a treatable condition and the child's parent refuses to provide or consent to treatment;
- if the child's parent is unable or unwilling to care for the child and has not made adequate provision for the child's care;
- if the child is or has been absent from home in circumstances that endanger the child's safety or well-being;
- if the child's parent is dead and adequate provision has not been made for the child's care;
- if the child has been abandoned and adequate provision has not been made for the child's care;
- if the child is in the care of a director or another person by agreement and the child's parent is unwilling or unable to resume care when the agreement is no longer in force.

How to Contact a Child Protection Social Worker

The most efficient way to report a concern to a child protection social worker is to call Child Protection Services in BC any time of the day or night at **1-800-663-9122.**The person who answers will make sure all concerns are directed appropriately. If the child is in immediate danger, midwives must call 911 or the local police.

Between Monday and Friday (8:30am to 4:30pm), midwives should call their local Ministry of Children and Family Development (MCFD) office or local Delegated Aboriginal Child and Family Services Agency.

For more information on this topic, please refer to CMBC's *Policy on Reporting a Child in Need of Protection.*

Scenario - CFCSA Reporting

Client Jane discloses having physically harmed their son Fred (age 10) to midwife Donna. Jane expresses remorse about this and asks Donna not to disclose this information to anyone. Donna informs Jane that they have a duty to report this to Child Protection Services, despite Jane having reported this in confidence and in the course of assessment or treatment. Ideally, Donna would have informed Jane of the limits of confidentiality at their initial visit. If two months later Jane says something that makes Donna suspect that Jane has physically harmed Fred again, Donna has a duty to make another report.

Scenario - CFCSA Reporting

Rachel had been planning a home birth for a third baby. Rachel lives with husband, Jeff, and two daughters Miriam, age 5 and Adele, age 10. Rachel and Jeff have been together for 2 years. During labour they transfer to the hospital for complications in the first stage of labour. After the birth, Rachel has a significant postpartum hemorrhage and a manual removal of the placenta. Deepika, the midwife really wants Rachel to stay in the hospital overnight due to heavy blood loss. Rachel becomes visibly upset and at first refuses to stay away overnight. Eventually Rachel tells Deepika of their fear of leaving the girls alone with Jeff as Jeff has sexually abused them in the past. Jeff has promised that it will never happen again but Rachel is very afraid that it will. Deepika informs Rachel that Deepika has a duty to report the situation to a Child Protection Social Worker. Rachel is very angry and feels that a confidence has been betrayed. In hindsight, Deepika realizes they should have made it clear to Rachel in their initial visit in which situations they have a duty to report. Deepika reports the situation to a Child Protection Social Worker.

BC Human Rights Code

Every person is entitled to access and receive health care services in a manner that respects their human rights. Within the *BC Human Rights Code* under Section 8 Discrimination in accommodation, service and facility, it states:

8 (1) A person must not, without a bona fide and reasonable justification,
- (a) deny to a person or class of persons any accommodation, service or facility customarily available to the public, or
- (b) discriminate against a person or class of persons regarding any accommodation, service or facility customarily available to the public

because of the race, colour, ancestry, place of origin, religion, marital status, family status, physical or mental disability, sex, sexual orientation, gender identity or expression, or age of that person or class of persons.

If a person feels that a midwife or practice they are affiliated with has violated the *BC Human Rights Code*, the person can complain to the Human Rights Tribunal. 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 license, a person who believes their human rights have been violated may also bring a complaint to CMBC.

Duty Not to Discriminate

It is not discrimination to make clinical decisions or to accept or refuse to continue seeing a client for reasons other than discriminatory 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. prescribing hormonal contraception for a former client at six months postpartum), a midwife should not accept or continue to care for a client.

In order to meet the obligations of CMBC 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.

Duty to Accommodate

If a midwife's conduct or policy discriminates against a person 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 areas of possible discrimination within the BC *Human Rights Code*.

Scenario - Human Rights Code

Donna, a midwife, is unable to continue to provide care to a client Pat because Pat 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 Pat is due in the winter months Donna is concerned about being able to be there for Pat or other clients in a timely way due to possible difficult weather conditions. Pat is unhappy about Donna's decision and believes that Donna has always had a problem with Pat because of Pat's race and religion. Donna should carefully communicate the reasons for terminating the midwife-client relationship, so that Pat is not left with the misunderstanding that the decision was based on a discriminatory reason such as the Pat's race or religion. Donna should also arrange for an appropriate alternative care provider that is acceptable to Pat.

Scenario - Human Rights Code

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 what would help to 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.

Scenario - Human Rights Code

Donna, a midwife, has a client, Thea, who has been diagnosed with a mental illness. Donna has been having increasing difficulties interacting with Thea. Thea 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 Thea's mental illness. Donna cannot stop providing treatment or health services because of Thea's mental illness, unless Donna concludes it is beyond the level of Donna's competence to continue treating Thea or unless there are health and safety concerns for Donna or the staff. If Donna believes a transfer to another health care practitioner with the appropriate competencies to manage Thea's health care needs is necessary, Donna should clearly explain the reasons for the decision to Thea. 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.

Conclusion

If a legal issue arises, midwives are encouraged to discuss it with their colleagues and their professional association and to check with CMBC as to its expectations. Midwives should not rely on CMBC's documents as the complete text of the laws and regulations referred to in it, or as a complete statement of the law. Keep in mind that statues and regulations may be amended at any time and CMBC will endeavor to keep this manual updated, but makes no warranty or representation as to the currency, completeness or accuracy of the information. Errors of omissions in CMBC documents do not affect registered midwives' obligation under the legislation referred to. Midwives are encouraged to obtain legal advice, whenever appropriate, about laws relevant to practice. CMBC cannot provide legal advice.

9. INTERPROFESSIONAL COLLABORATION

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

The *Health Professions Act* requires CMBC to promote interprofessional collaboration. CMBC models this collaboration by working together with other health colleges. In addition, Standard Two of the CMBC *Standards of Practice* requires that midwives collaborate with other health professionals and, when the client's risk status, condition or needs exceed the midwives' scope of practice, requires that midwives consult with a physician or nurse practitioner.

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.

Under the CMBC *Personal Information Protection Act (PIPA) Requirements,* when a client provides information regarding their health and the reasons for their visit, it is considered that the client has given the midwife implicit consent to the collection, use and disclosure of that information for use in providing health care, including implicit consent to send all or part of the client information to a third party (lab, hospital, other physician, etc) so long as it is in relation to the provision of direct midwifery care.

The CMBC *Policy on Medical Records* also states that midwives may, for the purpose of providing or assisting in the provision of health care to a client, permit a health professional to examine the client health record or give a health professional any information contained in the record without the consent of the client.

Clients should be informed of the practice when they first enter care. If they have any concerns about this, these concerns should be discussed and a suitable solution arrived at.

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 Information Protection Act* 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. If a client is asking a midwife to provide care outside a midwife's scope of practice, the midwife should refer to the CMBC *Policy for Client Request outside Midwifery Standards of Practice*.

Midwives should discuss any planned interprofessional collaboration with the client when possible and as early as possible. However, there are circumstances when this may not be 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.

Where interprofessional collaboration involves working in a multidisciplinary setting (i.e. a place where registrants of different professions work together and where clients are often seen by multiple health care practitioners, such as a hospital), good communication between all health care providers is essential and using SBAR (Situation, Background, Assessment, Recommendation) is an effective communication tool for patients' handoff. SBAR is a reliable and validated communication tool which has shown a reduction in adverse events in a hospital setting, improvement in communication among health care providers, and promotion of patient safety.

Scenario - Interprofessional Collaboration

Felice, a midwife, has a client named JoAnn. JoAnn's family doctor calls unexpectedly to say JoAnn is not responding to the thyroid medication as the doctor had expected. The doctor has just learned that JoAnn is being cared for by Felice during the pregnancy. The doctor wonders if there's anything Felice is doing that might interfere with JoAnn's medication. In the past, Felice has hinted to JoAnn that Felice is not supportive of the medication JoAnn is on. Felice wonders if JoAnn has stopped taking the medication without telling either Felice or the doctor. What should Felice say?

There has already been a failure of interprofessional collaboration in this scenario. Felice should have already discussed with JoAnn the benefits of interprofessional collaboration. Rather than hint at concerns about the medication that JoAnn is on, Felice should have told JoAnn that there are some questions about the medication that Felice would like to discuss with JoAnn's doctor. Given that now the doctor has phoned Felice, Felice should let the doctor know that Felice will check with JoAnn about the medication. When Felice talks to JoAnn, Felice should find out what is happening, listen to any concerns JoAnn may have, stress the importance of inteprofessional collaboration and tell JoAnn that Felice would like to discuss the situation further with JoAnn's doctor.

Scenario - Interprofessional Collaboration

Marie lives in a Northern community and Celeste the midwife has just discovered the fetus is in a breech presentation at 37 weeks gestation. Celeste informs Marie that Celeste will need to consult with the local obstetrician who is new in town. An appointment is set up for the next day. Celeste faxes over Marie's records via secure fax. Marie calls Celeste, after seeing the obstetrician, and is very upset as the OB has informed Marie that a C-section for the birth is all that is available in their community. This surprises Celeste as the last OB did do breech deliveries if the OB thought all the indications were favourable. Celeste lets Marie know that Celeste will discuss the situation further with the OB.

Celeste is able to talk with the OB at the end of the day. Celeste explains that Marie is really wanting to have a vaginal birth if at all possible and is very upset that a C-section seems like the only option. The OB is not comfortable doing breech deliveries. They discuss what other options might be possible for Marie. There are OBs in the next town (45 minute drive away) that do breech deliveries and the OB agrees to refer Marie on to that practice so they can access Marie's suitability for a vaginal delivery. If by chance the labour progresses very quickly the local OB agrees to meet them at the hospital to provide care.

Celeste calls Marie that evening to discuss the conversation with the OB and the possible solution that they arrived at. Marie is very happy with this plan. Marie is seen by one of the OBs in the next town. The OB does think Marie is a good candidate for a breech delivery and when Marie goes into labour at 38 weeks Marie does have a successful vaginal breech delivery. Marie is very happy with the care provided by all the health care practitioners and greatly appreciates how collaboratively they worked together.

10. CMBC STANDARDS, POLICIES AND GUIDELINES

CMBC has published all of their standards, policies and guidelines that guide the practice of a registrant on CMBC website. Many of the standards, policies and guidelines are referenced in the preceding chapters of this handbook.

- ***Model of Practice Standards***
  This section of the handbook has the midwifery model of practice and related policies.

- ***Prescribing and Testing Standards***
  Midwives prescribing authority is regulated through the Midwives Regulation Schedules A and B and in the *Standards.*

- ***Indications for Discussion, Consultation and Transfer of Care***
  This document explains when a midwife discusses care of a client, consults, and/or transfers primary care responsibility.

- ***Home Birth Standards***
  This section contains standards that apply specifically to out-of-hospital births. It also has the Planned Place of Birth Handbook that midwifery clients must have access to. The Planned Place of Birth topic and Informed Consent form should be discussed and reviewed by a midwife with clients.

- ***Records, Data and Privacy Standards***
  Important information on record-keeping and data collection can be found in Part VII of the CMBC Bylaws and in the Records, Data and Privacy Standards section of the Registrant's Handbook. As health care professionals in private practice, midwives are also responsible for knowing the *Personal Information Protection Act* (PIPA), that affects their practice and complying with the legislation. The PIPA governs the collection, use and disclosure of personal information by private organizations, including midwives' office.

BC Jurisprudence Examination

All applicants for registration with CMBC as midwives are required to write and pass the BC Jurisprudence Examination (BC Exam), a requirement for registration under the CMBC bylaws. To prepare writing the BC Exam, the applicant should review the *Midwives Regulation, CMBC Bylaws* and all CMBC standards, policies and guidelines. More specifically, the applicant is expected to demonstrate understanding of the standards, policies and guidelines listed in the Appendix and posted on the CMBC website under "Standards & Policies".

The BC Exam is 2 hours in length. The examination includes multiple choice, matching and true or false questions. While the exam is primarily focused on applying midwifery knowledge specific to BC regulation and practice (eg. labs, prescribing, indications for discussion, consultation and transfer of care) in clinical situations, there are a number of case-based questions on the exam that test BC specific knowledge in the context of overall basic midwifery

knowledge. Exam candidates who are ready to practice midwifery in BC are expected to know the materials covered in the exam.

In order to pass the examination a candidate must achieve a grade of 78% or higher. Pursuant to the CMBC bylaws, an applicant who fails the initial attempt of the exam is entitled to two further opportunities. The CMBC policy further requires a candidate to wait a minimum of two weeks from the date of exam results notification before re-attempting the examination. If a candidate fails the examination twice, the candidate must wait a minimum of three months before the final attempt. This is to allow the candidate sufficient time in reviewing the materials thoroughly and preparing for re-attempting.

11. IMPORTANT STAKEHOLDERS AND CONTACTS

Midwives Association of BC

Midwives Association of BC (MABC) is the association protecting the interests of the midwives in BC. MABC is responsible for negotiating the funding contract for midwifery services. They also administer professional liability insurance for midwives which is provided through the BC Ministry of Finance. MABC can also provide midwives with information on how to bill the Medical Services Plan for midwifery care. www.bcmidwives.com

Midwives Protection Program

The Midwives Protection Program (MPP) is administered and delivered by the Risk Management Branch (RMB) of the Ministry of Finance in conjunction with the Ministry of Health and MABC. MPP covers the professional practice liability concerns of registered midwives who are members of MABC and who are in good standing with CMBC.

Billing to Medical Services Plan

Midwifery services are covered under the BC Medical Services Plan (MSP). All new midwives enrolling with MSP will be required to sign a form as part of their registration process. Visit the MSP website, http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/midwives for more information.

Perinatal Service BC

Perinatal Service BC (PSBC) is an agency of the Provincial Health Services Authority who produces and shares evidence-based information, education, and resources about perinatal health with health professionals across the province. All midwives in BC are required to use PSBC data collection and documentation tools in their practice. These tools and instructions on their use can be reviewed at www.perinatalservicesbc.ca/health-professionals/forms

Interprofessional Colleagues and Hospital Privileges

Midwives interact with other health care professionals (family physicians, nurses, consultant obstetricians, pediatricians, anesthesiologists) in clinical practice and should be prepared to explore ways of promoting collegial interprofessional relationships as well as how to navigate difficult relationships. Midwives should look for and review information about hospital privileging, hospital bylaws, rules and regulations within each hospital and the range of privileging processes in different hospitals/health authorities that midwives can encounter around BC, including back-up plans and protocols that must be in place with hospitals for transport from a home birth.

Hospital Act and Hospital Orientation

The *Hospital Act* governs hospital care in BC. Despite CMBC standards and policies, midwives should adhere to the *Hospital Act* and the policies and procedures of the hospital where they have privileges. Hospitals are responsible for orienting midwives to hospital operations, protocols, policies and procedures.

Vital Statistics Act

A midwife who attends at a birth must complete the notice of birth under the *Vital Statistics Act*. It is the midwife's responsibility for registering births with the BC Vital Statistics Agency. Information on registering births can be found in the Vital Statistics Agency website.

BC Coroners Service

The Coroners Service of British Columbia is responsible for the investigation of all unnatural, sudden and unexpected, unexplained or unattended deaths. The Coroner is responsible for ascertaining the facts surrounding a death and must determine the identity of the deceased and how, when, where and by what means the deceased died. More information can be found on their website.

Orientation to Midwifery Practice in BC

CMBC recommends that any individual interested in practising midwifery in BC set aside some time with a midwife to discuss the realities of practice, which can vary from community to community. These include:

- Typical practice organization and call schedules;
- accessing labs and diagnostic testing, orientation to filling out lab requisitions;
- local hospital bylaws and privileging processes;
- hospital protocols and procedures;
- clinical community standards, particularly those that vary from CMBC's;
- how to obtain formal orientation to the hospital;
- organization of local midwifery medical staff in hospital;
- home birth transport plans in place;
- level of ambulance service available locally and the usual transport times;
- expectations when working with specialists - obstetricians, pediatricians, anesthetists;
- services available in the community and circumstances that require transferring out; and
- community resources, supports for clients with special needs, relationship with public health.

APPENDIX

To prepare writing the BC Jurisprudence Exam, an applicant should review the *Midwives Regulation, CMBC Bylaws* and is expected to demonstrate understanding of the following standards, policies and guidelines, posted on the CMBC website under "Standards & Policies":

- *Standards, Limits and Conditions for Prescribing, Ordering and Administering Therapeutics*
- *Standards, Limits and Conditions for Ordering and Interpreting Screening and Diagnostic Tests*
- *Standards, Limits and Conditions for Prescribing, Ordering and Administering Controlled Substances*
- *Standards, Limits and Conditions for Prescribing, Ordering and Administering Drugs for Sexually Transmitted Infections*
- *Standards, Limits and Conditions for Prescribing, Ordering and Administering Contraceptives*

- *Indications for Discussion, Consultation and Transfer of Care*

- *Standards of Practice*
- *Philosophy of Care*
- *Code of Ethics*
- *Midwifery Scope and Model of Practice*
- *Policy on Informed Choice*
- *Policy on Supportive Care*
- *Policy Statement on Complimentary Therapies*
- *Policy Statement on Vaginal Birth after Cesarean Section (VBAC)*
- *Policy for Client Requests outside Midwifery Standards of Practice*
- *Policy for Required Procedures for Midwife or Client-initiated Termination of Care*
- *Standards for Postpartum Care*
- *Policy on Hospital Privileges*
- *Policy on Alternate Practice Arrangements*
- *Position Statement on Fatigue Management*

- Policy for Home Birth Transport Plan
- *Required Equipment and Supplies for Home Birth Setting*
- *Policy for Second Birth Attendants*
- *Planned Place of Birth Handbook*

- *Policy on Medical Records*
- *Policy on Midwifery Data Submission*
- *Personal Information Protection Act Requirements*
- *Guideline for Participating in Social Media*
- *Guideline for Using Electronic Communications to Transmit Client Information*

- *Clinical Practice Guidelines*
- *Guideline for Managing the Second Stage of Labour*
- *Guideline for the Use of Water in Labour and Birth*
- *Policy on Reporting a Child in the Need of Protection*

- *Policy on Infection Prevention and Control*
- *Guideline for Protection from Blood and Bodily Fluid Exposure*
- *Policy on Registrants Infected with Blood-Borne Pathogens*