Association of Ontario Midwives
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June 20, 2019

Tiffany Haidon, President
College of Midwives of Ontario
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Toronto, ON M4V 2Y7

Dear Tiffany:

Re: Mandatory Reporting Obligations

We are writing to update you on our concerns arising from the College of Midwives of Ontario (CMO) interpretation of the mandatory reporting requirements under the *Health Professions Procedural Code* (HPPC) (e.g. in the *Guide on Mandatory Reporting Obligations*) (1,2). In 2015 and 2016, the Association of Ontario Midwives (AOM) and CMO exchanged correspondence on this subject and were unable to reach an agreement. Since that time, we have had numerous conversations with affected members, and we hope that you will carefully consider the insights provided by this perspective. We are hoping to reopen this dialogue based on the experience of members working with the reporting requirements and a recent legal opinion that we received.

The duty to report is intended to safeguard the public. As Barbara Borland (then President of the CMO) wrote in February 2016, the reporting requirements target the practice of "passing the bad apple" where one workplace terminates the relationship with a practitioner for reasons of misconduct, incapacity, or incompetence without revealing these concerns to the regulatory body. The practitioner could continue to practice elsewhere without appropriate regulatory action, and could ultimately go on to cause harm to patients.

The AOM strongly supports the intended purpose of HPPC. However, over the past two years, we have seen increasing evidence that the CMO's interpretation has unintended negative consequences for safe practice by midwives (articulated below). As a result, we sought legal advice about how to counsel members, and looked at guidance advice from other regulatory colleges. Our concern is that the CMO's interpretation of the duty to report in the *Guide on Mandatory Reporting Obligations* is not well-grounded in the wording of the relevant statutory provisions and differs significantly from the interpretations of other regulatory bodies, such as the College of Nurses of Ontario (CNO) and the College of Physicians and Surgeons of Ontario (CPSO). (3-5)

There are three areas where our legal counsel disputes the interpretation of the duty to report in the *Guide on Mandatory Reporting Obligations*: "reasonable grounds to believe", "incompetence", and "incapacity". Each of these concerns is addressed in greater detail below. In addition to the suggestions below, we ask that you consider the potential harm to public safety of providing information in the *Guide* which may be confusing or misleading for midwives.

Reasonable Grounds to Believe

The guide states that "a report must still be made even though the person who should be making the report does not believe that the midwife actually did anything wrong." By removing the requirement for a subjective belief based on objective evidence, the Guide overstates the relevant threshold of "reasonable grounds to believe". The case law clearly references the need for both a bona fide subjectively held belief and that such belief have an objective basis in credible information. Here is a typical example of case law which describes "reasonable grounds to believe" very differently than the CMO guidance:

> The standard of [reasonable grounds to believe] has been extensively discussed in Federal Court jurisprudence, and a summation is that it is less than the balance of probabilities, but there must be an objective basis for the belief, something going beyond speculation or conjecture. It is a bona fide belief in a serious possibility based on compelling, credible and corroborated evidence. (6)

In her letter to Lisa Weston in February 2016, Barbara Borland stated that the CMO has no authority to interpret the Registered Health Professions Act more narrowly than it is defined in law. However, the interpretation in its Guide is broader than that of other regulatory colleges. For example, the CPSO's *Guide on Mandatory and Permissive Reporting* simply states that reporting is required where a person has "reasonable grounds to believe that a regulated health professional practising in the facility is incompetent, incapacitated or has sexually abused a patient." (5) The guide does not ask the professional to refrain from exercising their judgment. **We suggest that the CMO follow the example of the CPSO and the CNO and not provide interpret the term "reasonable grounds to believe" in a way that requires midwives to suspend their professional judgement and beliefs.**

Incompetence

The CMO Guide explains incompetence as "a lack of knowledge, skill or judgment in respect of a client that would likely involve regulatory intervention if known by the College." This is a significantly broader interpretation of the meaning of incompetence than the statutory definition, which is found in section 52(1) of the Procedural Code:

> A panel shall find a member to be incompetent if the member's professional care of a patient displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the member is unfit to continue to practice or that the member's practice should be restricted. (1)

The College's interpretation replaces the threshold of "of a nature or to an extent that demonstrates that the member is unfit to continue to practice or that the member's practice should be restricted"

with that of "likely to involve regulatory intervention". The latter statement is much broader and more general and has no basis in the statutory wording.

In contrast, the CPSO uses only the definitions verbatim from the statutes on their website guidance to members. (5) The CNO guide includes the conditions set out in the statutory definition, and elaborates that not every mistake or breach of practice standards in the care of a client means that a nurse is incompetent:

> The definition of incompetence includes the following three key components:
>
> 1. it must relate to the nurse's professional care of a client;
> 2. the nurse must display a lack of knowledge, skill or judgment; and
> 3. any deficiencies must demonstrate that the nurse is unfit to continue to practice, or that their practice should be restricted.
>
> A nurse is incompetent if their client care shows such significant and repeated deficiencies in knowledge, skill or judgment that the nurse's practice must be restricted to ensure client safety.
>
> Not every mistake or breach of the CNO's practice standards means that a nurse is incompetent. Rather, incompetence is demonstrated by poor insight, or gaps in comprehension or application of basic nursing principles. A lack of appreciation for the seriousness of potential outcomes for clients who receive substandard care can also demonstrate incompetence. (3)

We ask that the CMO reconsider its interpretation of incompetence to better align it with the courts' interpretation and that of the CMO's peers.

Incapacity

The College's Guide defines incapacity as typically referring "to an illness that has the potential to affect a midwife's judgment, such as an addiction or certain mental illnesses." This is much broader and open to misinterpretation than the definition in the statute. The statutory definition in the procedural code states:

> "Incapacitated" means, in relation to a member, that the member is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the member's certificate of registration be subject to terms, conditions or limitations, or that the member no longer be permitted to practice. (1)

The CMO's interpretation in the Guide differs from the statutory definition in the procedural code in two ways. It focuses attention on mental illness and addiction, without mention of physical conditions. The phrase "has potential to affect a midwife's judgement" is a much broader

interpretation than stating that the reportable condition makes it desirable in the public interest that the member's right to practice be limited or revoked.

In contrast, the CNO website provides "Mandatory Reporting Scenarios" to guide members on when to report. *Reporting Incapacity: Scenario # 2* describes a nurse who has bipolar disorder. The guidance given by the CNO is that the facility manager should not make a report to the CNO, because the nurse's health condition has not affected their nursing practice. The nurse removes themself from practice when necessary to manage their illness. (4) However, the CMO's guidance suggests a report is required because bipolar disorder "has potential to affect judgement."

We ask that the CMO reconsider its interpretation of incapacity to better align it with the courts' interpretation and that of the CMO's peers.

The Impact of these Interpretations

Because the definitions of the terms "reasonable grounds to believe", "incompetency" and "incapacity" used in the CMO Guide differ from those used in statute, the CMO appears to be requiring reporting in circumstances where there would be no duty to report if statutory definitions were used. Our concerns about these interpretations are outlined in the sections that follow.

1. Clinicians experience stress when complaints are made to their regulatory body, even if dismissed. Stress is known to compromise client safety.

The stress experienced by clinicians when clients make complaints about their care to regulatory colleges is well documented (7-8). This stress is not fully mitigated by a decision to dismiss the complaint (7-8). The negative impact of clinician stress on client safety is also well documented. (9) It is reasonable to assume there is harm to client safety and satisfaction when reporting to the CMO is encouraged beyond what is required under statute.

The end of relationships in midwifery practice groups are often complicated, multifactorial and fraught with emotion. The central reason for a termination is usually that there is not a good 'fit' between the midwife leaving and the majority of other midwives in the group, or the midwives feel that the history of conflict makes a harmonious work environment unachievable. We often hear of irritation about the way client care has been delivered, or minor mistakes which appear more significant because of the conflict. The broad definitions of "incompetence" and "reasonable grounds to believe" in the CMO Guide, combined with the intensity of emotion surrounding the departure leads some midwives to question whether a report to the College is required, when under statutory definitions, it is not.

Further, the fear of such reports may lead vulnerable midwives to feel that they cannot leave a practice group for fear of triggering a mandatory report. As organizational culture is so important

to safety of healthcare (10), it is best that midwives do not feel that they must remain a practice group that is not a good cultural fit for fear of a College report.

2. Reporting obligations may deter midwives from honestly self-reflecting on mistakes and seeking the support that they need from their colleagues.

A very broad definition of duty to report for incompetence can also prevent midwives from openly discussing mistakes with colleagues in case reports or peer reviews. It may also deter midwives from asking for support in improving skills. Reviewing clinical cases and identifying both system and individual errors is central to the provision of safe, quality care. (10) So is midwives' reflective practice of identifying weaknesses, seeking out opportunities to improve, and the ability of practice groups to recommend and provide learning opportunities. Based on our discussion with members, the impact of the CMO broadening the definition of incompetence in the Guide is contrary to the safety of the public as midwives may fear reporting – especially when feeling vulnerable in their practice groups (e.g. a less experience midwife). This issue does not arise through the statutory definitions provided to members of the CPSO in their guidance. The clarifying statement of the CNO makes it clear that not every mistake or breach of standards means incompetence.

3. Midwives with mental health disabilities may be more reluctant to discuss them with their colleagues or to seek available supports (e.g. disability funding) for fear of a mandatory report.

Midwives calling the AOM for advice are often reluctant to report a colleague because they do not really believe the midwife's disability is placing clients at risk. The CMO's guidance can be interpreted as a duty to report any midwife with a mental illness, just because the midwife has this diagnosis whether or not they believe that there is a risk to client safety. The list of mental illnesses with "a potential to affect judgement" is long and the prevalence in the general population is high. Psychological safety for midwives with health conditions, physical or mental, and ultimately the safety of their clients, is best served in an atmosphere of openness between colleagues. (10) In our discussions with members, we sometimes find this openness restricted by concern that it will trigger a mandatory report based on the broad definitions in the CMO guide.

Through the AOM, midwives have successfully negotiated to make benefits available which help ensure client safety by allowing midwives to step back from normal duties when medically indicated. Accessing long-term disability benefits and applying for Schedule Q funding to accommodate temporary or long term disabilities is a responsible action which protects client safety and should not automatically trigger a duty to report. We have spoken to midwives who are reluctant to apply for these supports for fear of a CMO report which would be stressful, potentially damaging to their careers and see their personal health information shared more widely than they feel inclined to share.

It is difficult for the AOM to advise members because the CMO's interpretation and our legal opinion that questions that interpretation differ. Given the broad interpretation of duty to report found in the CMO Guide, AOM risk management staff and lawyers must advise midwives of the contradictions in the CMO's interpretation and our legal advice.

We hope that the CMO carefully considers both the legal opinion presented on definitions found in the Guide on Mandatory Reporting Obligations and the risks to public safety identified through our work with members on issues related to this guidance. We want you to be aware of the difficulties we face in advising members on the management of risk, when we have a legal opinion that some of the guidance provided by the CMO may misrepresent, no doubt unintentionally, some of the requirements of the Health Professions Procedural Code.

Given the opinion of our legal counsel, decisions made by the College based on the definitions which counsel found to be inconsistent with the statutory definitions would be subject to appeal and are unlikely to withstand legal scrutiny. By sharing our experiences and concerns with you, we hope to continue to work together for the improvement of the profession of midwifery and safe quality care.

We are happy to further discuss any of these points with you and again, appreciate this opportunity to provide feedback.

Yours truly,

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Cc: Kelly Dobbin, CEO & Registrar, CMO
Kelly Stadelbauer, Executive Director, AOM
Allyson Booth, Director, Quality and Risk Management, AOM

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