COLLEGE OF MIDWIVES OF ONTARIO
ORDRE DES SAGES-FEMMES DE L'ONTARIO

Discipline proceedings

The Discipline Committee consists of members of the public and the profession; Discipline panels are appointed from the committee and must be composed of at least two public members of the Council of the College and at least one professional member of Council. The panel has a designated chairperson and is responsible for writing its own decision and reasons.

The Regulated Health Professions Act, Procedural Code requires the publication of Discipline panel decisions and reasons. The College is required to publish the member's name when the results of the hearing meet the requirements for inclusion on the register.

Publication of this summary provides the members of the College and the public with information about the College's disciplinary proceedings, thus providing an opportunity for education about what constitutes professional misconduct and incompetence. The information contained in this summary is based on evidence heard at the hearing and on the Decision and Reasons of the Discipline panel.

Copies of the panel's Decision and Reasons are available upon request. Please place your request by fax or email.

Definitions

The Regulated Health Professions Act Procedural Code ("the Code") Section 51.(1) (c) states that:
"A panel shall find that a member has committed an act of professional misconduct if, … the member has committed an act of professional misconduct as defined in the regulations."

The CMO's professional misconduct regulation is found is Section F of the Registrants Binder. In this case the professional misconduct related to the contravening a standard of practice of the profession.

Section 52 (1) of the Code states that:
"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 or disregard for the welfare of the patient of a nature or to an extent that demonstrates that the member is unfit to continue to practise or that the member's practice should be restricted."

Case Summary of Discipline Hearing

Hearing Dates: **October 22-26, 2001**
December 12, 2001
March 12, 2002

Member: **Mary Molnar**

Allegations

The following allegations were referred to the Discipline Committee:

That Ms. Molnar was guilty of professional misconduct and incompetence in respect of her care of four clients in that,

- she displayed poor clinical judgement in failing to recognize prolonged first and second stages.
- she failed to consult appropriately regarding prolonged first and second stage.
- she failed to maintain the standard of practice in her care of all four clients with respect to documentation, in one case she failed to record vital signs during a prolonged labour.
- she exercised poor communication with other health care providers in her care of all four clients.
- she failed to carry out a level one consultation.
- she failed to provide continuity of care.
- she failed to properly assess an infant.

Plea

Not guilty

Decision

The panel found that the member was incompetent in that: 1)she exercised poor clinical judgement including failing to recognize prolonged first and second stages of labour; leaving the client for approximately one hour during the second stage and failing to consult appropriately; 2)she failed to follow up on abnormal test results in the hospital; 3)she exercised poor communication with other health care providers and 4)she failed to properly assess an infant.

The panel found that the member was guilty of professional misconduct in that: 1)she failed to adequately document her care of the client including failing to record vital signs during labour; 2)she contravened a minimum standard of practice of the

profession by failing to carry out a category one discussion and 3)she exercised poor communication with other health care providers.

Client A:

Failure to consult for prolonged first stage
Ms. Molnar was the primary midwife during the first stage of labour of a multiparous client. She attended the labour in the woman's home until a decision was made to transport to the hospital. She made a call to the hospital prior to the transport and spoke to the obstetrician on-call. The obstetrician testified that the member discussed the option of an epidural for this client but did not describe the labour as prolonged. The obstetrician testified that the member did not request a consultation for a prolonged active phase.

The College's expert asserted that the combination of the client's obstetrical history and the presenting clinical picture met the definition of prolonged active labour and that discussions of transport to hospital and obstetrical interventions should have taken place two hours prior to when the member first documented these discussions.

The evidence presented made it apparent to the panel that the member had concerns and ultimately took steps to transport to hospital. However, from the evidence provided, the panel concluded that the member was comfortable allowing the labour to progress at home with no increased monitoring of maternal and fetal well-being, no consideration of ambulance services for transport, and inadequate consideration of appropriate obstetrical and pharmacological interventions.

The panel found that the member failed to initiate a required category two consultation with a physician for prolonged first stage of labour.

Poor communication with other health care providers
Once in hospital the primary care was transferred to another midwife in the member's practice, who had been unavailable at the outset of labour due to her attendance at another labour. This midwife was a new member of Ms. Molnar's practice. The member submitted that this practice partner was the primary midwife, therefore solely responsible for the management of the second stage of labour and the delivery of the baby. The outcome in this case was fetal demise and death.

The member's position that she was not responsible for the management, care and/or decision making with respect to the prolonged second stage, or in fact, was not responsible for the decisions ultimately made by the primary midwife is of grave concern to the panel. The midwife team shared this client's care, the panel rejects any argument advanced by the member that she was relieved from responsibility or liability for the conduct of the second stage. Her ultimate responsibility and obligation was to ensure that the client received appropriate and safe care.

The College requirement that two midwives be present at a birth speaks to the concept of teamwork. In this situation, the member was asked by her partner for a report of the labour upon the transfer of primary care. The member did not provide a report, she suggested that her partner read the chart. The panel finds, and the member concedes, that the charting was incomplete in this labour and fell below the minimum standard of practice of the profession. Moreover the panel found it to constitute professional misconduct. It was clear from the evidence that if her partner had read the chart it would not have provided the full picture of the labour to that point.

A similar situation occurred when her practice partner asked Ms. Molnar about the blood work results. She suggested her partner read them herself; this response was unhelpful to her partner and most importantly, the client.

When the member took over the role of second midwife she did not inform her partner midwife that she was not charting. The member was aware that her partner was new to the practice. It would have been prudent and appropriate professional behaviour for the member to ensure that charting according to College standards was occurring and that the roles of each midwife were clear. Regardless of the roles assigned to primary and second midwives, the two care providers present share responsibility for the care of the mother and her baby, including the documentation of that care. This was absent in the care of this client.

The panel finds that the member displayed a lack of knowledge, skill and judgement and disregard for the welfare of the client and her baby amounting to incompetence.

Failure to consult for prolonged second stage
Ms. Molnar's practice partner acknowledged in her testimony that she was the primary midwife during the second stage. Despite this statement the panel finds that the two midwives shared in the care of the client. Accordingly, the panel rejects any argument advanced by the member that she was relieved from responsibility or liability for the conduct of the second stage. The panel finds it difficult to believe that any obstetric care provider would not recognize a 3 hour second stage in a multiparous woman as prolonged, particularly when there had been concerns identified regarding a prolonged first stage and an obstetrical history that included a prolonged labour.

The panel finds that the member failed to recognize that the second stage was prolonged and failed to intervene appropriately.

The member had an unquestionable responsibility and obligation while present and attending the labour, at any stage, to ensure that the client received appropriate and safe care.

Failure to adequately document client care

The member admitted that the charting was inadequate in three areas. The panel agrees with the member as to these identified deficiencies. Additionally the panel finds that the charting deficiencies are greater than those admitted. The panel accepts the evidence of the College's expert and finds that there was inadequate documentation in the following areas:

- failing to identify care providers, many entries are not initialled or signed;
- failing to indicate when other care providers arrived and left the home;
- failing to document all findings of vaginal examinations;
- failing to document the frequency, length and strength of contractions, particularly as a tool to identify an effective labour pattern;
- failing to document informed choice discussions with respect to:
  i) the use of blue cohosh
  ii) the reasons for, and possible care management of, transfer to hospital
- failing to appropriately obtain and document maternal vital signs on admission to hospital;
- failing to follow the standards or ensuring that these were followed concerning fetal heart assessment in the second stage;
- failing to chart events such as:
  i) the time that the member left the hospital;
  ii) any follow up with the obstetrician regarding their earlier phone call, such as a courtesy report
  iii) the time when lab results were received and reviewed; and
  iv) any arrangements for a second midwife or alternate attendant to assist during the member's absence from hospital.

The panel finds that the member repeatedly contravened the minimum standards of the profession in her documentation of this client's labour and delivery constituting professional misconduct.

Client B

Poor communication with other health care providers

The material issue in this case is whether sufficient relevant medical information was communicated to hospital staff. The client began bleeding while labouring at home. She had a history of a previous cesarean section. When the member called the hospital to inform them that she was bringing in a client who was bleeding, she did not inform the nurse that the client had had a previous cesarean section. She also did not inform the ambulance attendants.

The panel finds that the member communicated adequate, though not optimal, information that was sufficient in obtaining the specific medical attention required. The panel finds that the member met the minimum standards of the profession.

Inadequate documentation
The College's expert found that while the member's record keeping was not optimal it did meet the minimum standards of practice of the profession; therefore the panel accepts the recommendation of the College, supported by the member, that no finding be made in regard to this allegation.

Client C

Failing to carry out a Category 1 Discussion
The client's obstetrical history required a category one discussion. The client had an obstetrical history of one previous premature labour at 32 weeks, a subsequent miscarriage at 8 weeks; followed by a third pregnancy. The member submits that she did not perform a category one discussion in the third pregnancy because one had been conducted during the second pregnancy six months earlier. She asserts that because the second and third pregnancies were so close in time, a category one discussion for the third pregnancy was not required.

The panel finds that the member's failure to carry out a category one discussion contravenes a minimum standard. The panel finds that a category one discussion was required independent of the one that was carried out in the second pregnancy. The circumstances had changed since the second pregnancy (e.g. a miscarriage had occurred). Additionally, a new practice partner had joined the practice in the ensuing six months since the second pregnancy.

Inappropriate documentation with regard to a Level 1 consult
Based on the College expert's evidence that failing to document a level one discussion is not a contravention of a minimum standard, no finding is made by the panel with respect to this allegation.

Client D

Poor communication with other health care providers
The member was leaving on a holiday; one of her practice partners was to oversee the member's clients in her absence. The member made notes for her partner respecting her clients on the back of an envelope. The member asserts that she was most concerned about the mother's emotional state and did not indicate any concerns about the baby. The panel finds that the member failed to properly assess the baby and was unaware that the baby was failing to thrive. The baby was the member's client and was still in her care; therefore there should have been very clear and comprehensive communication about the baby's well-being, not just her mother's, when the member was transferring care to another midwife.

The panel finds that the member's communication with her practice partner was wholly inadequate. The reference to 'sadness' on the envelope; compounded by the failure to

communicate any plan of care or direction to pursue in the member's absence with respect to follow up care for the mother; the failure to mention any instruction given to her student about contacting a social worker; and the failure to refer to the baby at all, in any limited instruction, constitutes professional misconduct.

Failing to properly assess an infant
The member made postpartum visits on days 1,3,5,6,11,17 and 20 before going on vacation. She weighed the baby only on days 1,6 and 11. The College's expert noted that of significance was the fact that the baby gained only two ounces in the five days between days 6 and 11. That was below the expected minimum weight gain and should have prompted another check the following week. The member saw the baby twice in the next nine days and yet neglected to weigh her despite a history of insufficient weight gain. This failure to properly assess an infant led to a feeding problem not being identified and a Level 2 consultation not being undertaken. The information was not passed on to the member's practice partner and therefore appropriate follow-up was delayed even further.

The panel finds the member was incompetent in her care of the baby.

Penalty

At the commencement of the penalty hearing Ms. Molnar advised the panel of her intention to resign her registration with the College and agree to execute an undertaking not to reapply to the College in the future. The panel accepts her resignation. As a result there was no hearing or submissions on penalty.

Costs

On the issue of costs the panel heard evidence from Ms. Molnar and submissions from counsel for the College and Ms. Molnar. In considering the evidence and weighing the submissions, the panel does not believe a cost award is merited in this case.