DISCIPLINE COMMITTEE
OF THE COLLEGE OF MIDWIVES OF ONTARIO

PANEL: Claudette Leduc, Chair
Isabelle Milot, Professional Member
Karen McKenzie, Professional Member
Marianna Kaminska, Public Member
Donald Strickland, Public Member

BETWEEN:

COLLEGE OF MIDWIVES OF ONTARIO	)	ERICA RICHLER for College of Midwives of Ontario
- and -	)	ANITA VARJACIC and MERYL RODRIGUES for [redacted]
[redacted] Midwife "A"	)	LUISA RITACCA Independent Legal Counsel
	)	Heard: January 10-12, February 28, 2022

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee of the College of Midwives of Ontario ("the College") on January 10, 2022 for three days. The matter resumed on February 28, 2022 for closing submissions. The matter was heard via video conference.

Preliminary Matter

At the outset of the hearing, the College advised the Panel that it would not seek a publication ban of the name and personal health information of the Client and the Client's family, but the College asked that the Panel anonymize the Client's name in these decision and reasons. The Member did not oppose the College's request.

The Allegations

The allegations against (the "Member") as stated in the Notice of Hearing dated April 20, 2021 (Exhibit #1) are as follows:

The Member

1. At the material times, [redacted] (the "Member") was a duly registered member of the College of Midwives of Ontario practising midwifery at [redacted] (the "Practice").

The Client

2. The "Client" was a client of the Practice.

3. On November 8, 2019 at approximately 8:32 a.m., the Client delivered a baby by caesarean section.

Post-Partum Care Provided by the Member to the Client

4. On November 9, 2019 at approximately 10:00 a.m., the Member attended at the hospital for the Client's day 1 post-partum appointment.

5. On November 9, 2019 at approximately 11:30 a.m., the baby had routine bilirubin testing at the hospital at 27 hours of age. The bilirubin result was 88 umol/L.

6. The Client and baby were discharged from hospital at approximately 8:00 p.m. on November 9, 2019.

7. On November 11, 2019, the Member attended at the Client's home for the day 3 postpartum appointment. The Member documented that the baby's skin/jaundice was tinged to the umbilicus.

8. It is alleged that the Client raised concerns with the Member about the baby's jaundice at the day 3 post-partum appointment and that the Member advised the Client that the Member was not concerned (or words to that effect).

9. On November 13, 2019, the Client paged the Member in advance of the scheduled day 5 post-partum appointment.

10. The Member spoke with the Client prior to the appointment on November 13, 2019. It is alleged that during this call the Client raised concerns with the Member about the baby's jaundice and asked if the Member could check the baby's bilirubin at the appointment.

11. On November 13, 2019 at approximately 5:00 p.m., the Member attended at the Client's home for the day 5 post-partum appointment. The Member documented that the baby's eyes were yellow and that the baby's skin/jaundice was moderate to the umbilicus.

12. It is alleged that the Client and her husband raised concerns with the Member about the baby's jaundice during the day 5 post-partum appointment. It is alleged that the Client asked the Member to test the baby's bilirubin. It is alleged that the

Member advised the Client that the Member was not concerned (or words to that effect).

13. The Member had the testing equipment with her but did not arrange to test the baby's bilirubin at or following the day 5 post-partum appointment.

14. Following the above events, on November 14, 2019 between approximately 6:30 a.m. and 7:30 a.m. the Client called an ambulance. The baby was taken to the hospital and initial bloodwork showed a bilirubin of 864 umol/L. The baby was admitted with severe hyperbilirubinemia. The baby died in hospital on November 20, 2019.

15. It is alleged that the Member failed to appropriately manage the baby's jaundice, in particular by failing to arrange to test the baby's bilirubin at or following the day 5 postpartum appointment on November 13, 2019.

Professional Misconduct Alleged

16. It is alleged that the above conduct constitutes professional misconduct pursuant to clause 51(1)(c) of the Health Professions Procedural Code, being Schedule 2 to the Regulated Health Professions Act, 1991, and as defined in one or more of the following paragraphs of section 1 of Ontario Regulation 388/09, made under the Midwifery Act, 1991:

a. Paragraph 2 (Failing to maintain a standard or practice of the profession); and/or

b. Paragraph 47 (Engaging in conduct or performing an act or omission relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional).

Member's Plea

The Member denied the allegations as set out in the Notice of Hearing.

Overview

The Member provided midwifery care to the Client, [redacted] and her newborn baby, [redacted], who was born on November 8, 2019 in hospital. While the birth and the baby's first days of life were generally unremarkable, the parties agree that the outcome in this case was tragic. [redacted] had routine bilirubin testing at the hospital at 27-hours of age. The total bilirubin result was 88 umol/L.

On November 11, 2019, the Member attended at the Client's home for the day 3 post-partum appointment. The Member documented that the baby's skin/jaundice was tinged to the umbilicus. On November 13, 2019, the Client paged the Member twice in advance of the scheduled day 5

post-partum appointment. The Member and the Client spoke in advance of the day 5 post-partum appointment.

In the evening of November 13, 2019, the Member attended at the Client's home for the day 5 post-partum appointment. The Member recorded that the baby's eyes were yellow and that the baby's skin/jaundice was moderate to the umbilicus. The Member completed the day 5 appointment, without repeating the baby's bilirubin testing.

The Client paged the Member in the early morning hours of November 14, 2019 and in a subsequent phone call with the Member reported that the baby had thrown up. Ultimately, the Client decided to call for an ambulance a few hours later. The baby was taken to the hospital, where initial bloodwork showed the baby had a total bilirubin of 864 umol/L. [redacted] was admitted with extreme hyperbilirubinemia.

[redacted] died in hospital on November 20, 2019. The cause of death was recorded as "cardiopulmonary arrest after re-direction of the care (comfort care) due to severe kerinectrus [sic] encephalopathy resulting from severe hyperbilirubinema [sic]".

The issue before the Panel was whether the Member met the standards of practice of the profession in her decision-making with regard to [redacted], and having regard to all of the circumstances, on the day 5 post-partum visit.

For the reasons set out below, the Panel concludes that the College has not satisfied its burden of proving, on a balance of probabilities, that the Member engaged in professional misconduct as alleged. The Member made reasonable clinical decisions based on the Client's report and on the baby's clinical presentation. In doing so, the Panel cannot conclude that she failed to maintain the standard of practice of the profession or that her conduct would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional. The fact that there was a tragic outcome in this case does not mean that the Member failed to maintain the standards as required.

Dispute regarding the Allegations

In the course of receiving the parties' closings submissions, a dispute arose whether it was open to the Panel to consider a finding of professional misconduct on the basis that the Member failed to engage in an informed choice discussion with the Client about the risks and benefits of repeating the bilirubin test at the day-5 visit, where the Client had specifically requested such a test.

The Member argued that she was not provided with notice that the College would be asking for such a finding and that the particulars of this specific allegation were not set out in the Notice of Hearing.

In support of her position, the Member submitted that she confirmed the basis upon which the College was proceeding via an email exchange between counsel on July 19, 2021. In that email (which was provided to the Panel together with the parties' written closing submissions), the College confirmed that, "The allegations relate to the lack of testing on Day 5 (November 13, 2019)". Further, she submitted that it was evident throughout the hearing that the only allegation at issue was with respect to the lack of testing at or after the day-5 appointment. She argued that neither counsel mentioned a lack of an informed choice discussion, whether one was necessary or

whether one took place in their opening submissions. She argued that the witnesses were not squarely asked about the informed choice allegations during the hearing and that it was clear from a review of the expert reports that the alleged lack of an informed choice discussion was never one of the allegations of professional misconduct that was raised with either of them.

In response to the Member's argument, the College argued that the Notice of Hearing put the Member on notice that her discussions with the Client about the bilirubin test would be in issue, including whether she had an informed choice discussion with the Client about the test. The College acknowledged that the phrase "lack of informed choice" was not used in the Notice of Hearing, but argued that phrase is simply a label for what is set out factually in the specified allegations.

Further, the College argued that the question of whether the Client specifically asked the Member about a repeat bilirubin test was front and center in the College's opening submissions and was an issue discussed with the witnesses. The only reason such a question is relevant is because the informed choice principle is a foundation of midwifery care. Finally, the College submitted that it should have been no surprise to the Member that it is the College's position that the Client's request for a retest of the bilirubin should have prompted the Member to have an informed choice discussion about the test and that her failure to do so is a basis to find that she failed to meet the standards of practice of the profession and/or engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Panel considered this issue in the course of its deliberations and concluded that it was not clear from the Notice of Hearing or from the manner in which the evidence was presented that it was open to them to make a finding of professional misconduct on the issue of whether the Member should have engaged in an informed choice discussion with the Client when the Client specifically asked about repeating the bilirubin testing. While the experts were asked in a tangential way about informed choice, they were not asked directly about whether such a discussion was required in the circumstances.

The Member has a fundamental right to have notice of the allegations that are being advanced against her. The Member should not learn of allegations for the first time at the hearing itself. The Notice of Hearing should contain sufficient factual and legal particulars of the allegations the Member must confront. Upon review of the Notice of Hearing, the Panel was not satisfied that allegations relating to an informed choice discussion were set out therein. While the Panel recognizes that the Notice of Hearing does not need to contain every single detail, the allegation that the Member failed to undertake an informed choice discussion is sufficiently separate from the clear allegations set out in the Notice of Hearing such that if the College intended to advance such a position, it should have been more clearly set out.

The Evidence

At the outset of the hearing, the Panel received into evidence the parties' Agreed Statement of Facts, which was found in the parties' Joint Document Book, marked as Exhibit 2. As was clear from both the Agreed Statement of Facts and much of the oral evidence received, many of the facts were not in dispute. There was no dispute regarding the timing of the Member's post-partum visits with the Client and her baby in hospital, and at home at day-3 and at day-5. There was also no dispute regarding the baby's bilirubin test results completed on November 9. Further, there

was no dispute that the Client contacted the Member before the day-5 appointment reporting some concern. Finally, the parties did not dispute the evidence filed regarding the baby's final visit to the hospital, his death or the cause of death.

The Client's Evidence

The Client, [redacted] is a mother to two living children, born on January 8, 2013 and June 30, 2021. Her son, [redacted] was born on November 8, 2019 and died on November 20, 2019. [redacted] is an educational assistant, married to [redacted]. [redacted] testified that she and her husband are of Middle Eastern descent.

[redacted] testified that she chose midwifery care for her pregnancy with [redacted] because she had done the same with her daughter who was born in 2013. She explained that in her view she and her baby received more attention and care from midwives, than they would have from a doctor. She also valued the fact that part of the care included at-home visits following the birth.

The Client testified that she had an uneventful pregnancy with [redacted], who was born via Caesarean section on November 8. She said that following the birth, the Member visited her and the baby in hospital on November 9. The Member confirmed that everything looked good and that the Client and the baby could go home. The Member noted the discharge date as November 10, but the Client testified that she left the hospital later in the day on November 9 instead.

The Client confirmed that the baby had bilirubin testing done within approximately a day of his birth. She was told that his bilirubin level was 88 umol/litre, but the results were not explained to her by the Member or anyone at the hospital.

The Client testified that the Member attended at her home for the day-3 postpartum visit (November 11). She said that her mother (the baby's grandmother) was also present in her home during the visit, but that she was in the kitchen area during the appointment. The Client explained that during this visit she expressed her concern about the baby's colour, which she described as yellow. She said that she asked the Member whether they needed to repeat the bilirubin test. The Client said that the Member told her that a repeat test was not needed.

The Client explained that between the day-3 and day-5 visits, her concerns regarding [redacted] increased. She testified that she paged the Member twice on November 13, 2019 because of her concerns. She said that the Member called her back after the second page. The Client testified that she told the Member that the baby's colour was not normal and asked her if she could bring the equipment necessary to test the baby's bilirubin. The Client explained to the Panel that she made this request at the suggestion of her mother, who is a retired midwife. The Client's mother had advised her that midwives may not necessarily carry the bili tubes needed to perform the bilirubin testing, when it is not planned. Under cross examination, the Client stated that the Member confirmed that she would have bili tubes with her when she attended for the appointment.

In her testimony, the Client described her baby's colour as yellow from head to toe. She provided the Panel with photos of the baby, who she described as having jaundice all throughout his body, including in his eyes.

The Client testified that at the day-5 appointment, which took place in the evening of November 13 and following the Client and the Member's discussion earlier in the day, the Client asked the Member three times to check [redacted] bilirubin.

The Client explained that in response to her concerns, the Member explained that all babies get jaundice and that Italian and Middle Eastern babies tend to show jaundice in their skin and African babies tend to show it more in their eyes. Further, the Member told the Client that the retest was not needed because the baby's jaundice was mild. The Client conceded on cross-examination, that the Member explained to her the importance of the baby having regular pees and bowel movements to get rid of the jaundice. The Client's mother was once again present in the home during the day-5 visit.

The Client testified that while she was still concerned about [redacted], she trusted the Member, who was the medical professional and who knew better. She said her mother left their home around 7pm that evening.

Overnight, the Client explained, [redacted] was having trouble feeding, he would not latch and he was arching his back, moaning and had gone cross-eyed. The baby had also projectile vomited at some point in the night. At approximately 2:30am, the Client paged the Member to tell her that the baby had vomited and to ask whether she should go to the hospital with him. The Client testified that the Member advised her that it was not necessary to bring him to the hospital for one vomit and that if she did, she'd likely be waiting there a long time. Instead, the Member advised the Client to keep trying to feed the baby. The Client told the Panel that she could not remember if she told the Member about the baby moaning or being cross-eyed.

The Client testified that the baby did not improve through the night. She spoke with her mother in the morning, who upon seeing the baby via video call, advised the Client and her husband to call an ambulance immediately. The Client also paged the Member, who advised her to bring the baby's records (which she left in a white envelope in the Client's home) with her to the hospital.

The Client testified that the emergency room physician told her husband that it would be a miracle if the baby survived, given the level of jaundice.

[redacted]'s Evidence

[redacted] is the Client's husband and [redacted]'s father. He moved to Canada from Iraq in 2014. [redacted] testified that while he was working as a lawyer in Iraq, he is currently working as a truck driver.

[redacted] explained that because he was not in the country for his first child's birth, he had no real experience of what to expect after [redacted] was born. He testified that he did notice and was immediately concerned about [redacted]'s colour. [redacted] was not present for the day-3 postpartum visit and was only in attendance for the last part of the day-5 visit. He confirmed that before arriving home for that visit, he called his wife to ask her to speak with the Member about the baby's colour and about the need for her to bring the bili tubes to perform a retest of the baby's bilirubin levels.

[redacted] confirmed that when he arrived home, he asked the Member why the baby was so yellow. He did not specifically ask her to retest the baby's bilirubin.

The Member's Evidence

The Member testified that she has been practising as a midwife for almost 20-years. Prior to obtaining her degree in midwifery, the Member worked as a nurse. At the time of the hearing, the Member was the clinical lead and midwifery rep on the [redacted] Hospital's interdisciplinary team.

Consistent with the Client's evidence, the Member recalled that the Client's pregnancy was quite normal. The Member said she felt that the Client "was lovely". The Member believed that the Client was comfortable with her and the other midwife in charge of her care and that she was able to clearly communicate her wishes. The Member said that, for example, she spoke to the Client about the safety of attempting a vaginal birth after having a c-section with her first birth. The Client very clearly communicated that she did not trust the idea of trying labour and that her strong preference was to have a scheduled cesarian section.

The Member confirmed that she was familiar with Canadian Pediatric Guidelines, her hospital guidelines and the Provincial Guidelines regarding testing for and identifying jaundice in newborns. In particular, she said she was familiar with the Canadian Pediatric Guideline which identified Middle Eastern descent as a specific risk factor to consider in the treatment of jaundice.

The Member explained that based on [redacted]'s initial bilirubin test results, he was in the "low risk" zone for developing hyperbilirubinemia. The Member testified that at the day-3 postpartum visit she undressed the baby, recorded his vital signs and examined him from head to toe. She explained that typically she likes to undress the baby so that she can better assess the baby's complete presentation. She also asked the Client for a clean diaper and proceeded to change the baby's diaper herself. During the appointment, she spoke to the Client about newborn care, including umbilical cord care. She also showed the Client that she could see some yellow on the baby's skin and explained that just because he was at "low risk" that did not mean that he would not get some jaundice. The Member testified that it was very normal for babies to get yellow and that it was common to see the yellow around day 2 or 3 of life. The Member explained that she used the word "tinged" in her notes to describe what she saw on the baby, which she said was what she expected. She also testified that she expected to see the jaundice peak around day 5 and disappear around day 7. She told the Panel that is why she spaces her home visits to coincide with this timeline.

The Member testified that she told the Client that the baby was doing fabulously. The Member said that after she attended to the baby, she visited briefly with the Client and her mother. The Member knew the Client's mother from school and was happy to see her there to support the Client and [redacted].

The Member said that she had further discussions with the Client and her mother present about jaundice in relation to the importance of making sure that the baby was feeding and voiding regularly. The Member explained that because the baby was at a "low risk" that meant that his body was able to process the jaundice on its own, so long as he continued to eat and void. At the end of the appointment, the Member testified that she told the Client that the baby's stool would change colour and that he would get more yellow (in the face and eyes) before the jaundice cleared.

The Member acknowledged that she may have said something about Italian and Middle Eastern babies appear to show more jaundice in their skin than those of other ethnic backgrounds. She

explained that she made this comment to support a similar comment that was made by the Client's mother

The Member testified as to her recollection of her discussions with the Client before attending at the day-5 postpartum appointment on November 13. She confirmed that the Client had paged her twice that morning. The Member called the Client back at which time they discussed the Client's concern that the baby's face was "yellow". The Member said that she reminded the Client that facial jaundice was to be expected and that what she was reporting was not concerning. The Member also confirmed for the Client that she had the equipment necessary to perform bilirubin testing at home, if such a test was indicated.

The Member testified that she attended the Client's home in the evening of November 13th. She was later than expected because of a snowstorm. She confirmed that in addition to the Client and baby, the Client's mother and older daughter were also present in the home. The Member recorded in her notes that the baby's jaundice did not progress beyond the umbilicus and that she used the term "moderate" to describe it. The Member explained to the Panel that in her experience "jaundice to the umbilicus" was a normal finding and that if you think of the baby's body as having three zones, you would expect to see jaundice in the zones including the face and torso. The baby did not have jaundice in his limbs.

The Member asked the Client about the baby's feeding and voiding. The Member testified that the Client told her that the baby was eating and that he had a wet diaper for every change. The Member acknowledged that the Client asked her whether the baby needed to be retested because his face was yellow. The Member testified that she told the Client that the baby had a normal level of yellowness for a day-5 baby and that she would expect that the jaundice would go down after this day. The Member also advised the Client that if the baby still had jaundice at the two-week mark, then they would plan to retest his bilirubin. The Member testified that the Client's mother was present for this discussion and seemed to agree that it was a good plan. Further, the Member testified that it seemed to her that the Client was reassured by the Member's comments.

The Member confirmed that [redacted] arrived home at some point during her visit on November 13. She recalled that the clinical visit lasted about 45-minutes and that [redacted] joined during the social part of the visit. She confirmed that [redacted] asked her about the baby's yellow face and that she explained to [redacted] that it was normal. The Member testified that she told [redacted] that they were not going to retest the baby's bilirubin because he appeared to be doing very well otherwise.

Following the day-5 postpartum visit, the Member confirmed that she received a page from the Client at around 2:30am. The Member returned the call in the [redacted] Hospital parking lot, as she was heading home from a delivery. The Client told the Member that she was concerned because the baby had projectile vomited a couple of hours prior. The Member testified that she took a history from the Client and based on what she was told, she advised the Client that it would likely be a waste of time to attend the hospital immediately. The Member reminded the Client that while one instance of vomiting is not cause for immediate concern, the Client should call her back if the baby was projectile vomiting after every feed. The Member testified that the Client did not report that the baby was suffering with any other symptoms to her during that call.

The Member testified that she learned that the baby was on route to the hospital later that morning. At that time, the Client told the Member that the baby was arching his back. The Member said

that what the Client was reporting to her was very concerning. The Member told the Client that she would likely be sent to the local children's hospital and that she should take the baby's health records, which the Member had left in a white folder in the home.

The Member met the Client and the baby at the hospital. At that time, the Member testified that she was told by the medical team that the baby was being admitted with extremely high bilirubin. She said that one of the fellows on the team said that this was not a case of normal jaundice, and that this might be a case of severe G6PD. G6PD or Glucose-6-phosphate dehydrogenase deficiency is a hereditary condition that affects the red blood cells causing them to break down more quickly, releasing bilirubin and increasing the incidence of severe hyperbilirubinemia in infants. (*as described in the CPS Guideline for detection, management and prevention of hyperbilirubinemia in term and late preterm newborn infants, Feb 28, 2018*)

Under cross-examination, the Member denied that the Client asked her to perform the bilirubin test. Instead, the Member explained that while the Client raised concerns about the baby's colour and did ask about whether there was a need to repeat the test, once she completed her assessment and explained to the Client that all of the clinical factors were positive, she believed that the Client was reassured that a retest was not necessary. The Member conceded that she did not have a discussion with the Client about the risks and benefits of the retesting, given that her assessment was that a retest was not necessary.

The Expert Evidence

In addition to the fact witnesses called at the hearing, the Panel heard from two witnesses – Lisa Morgan and Sylviane Devos - who were qualified to provide expert evidence on the issue of the standards of practice of the profession in the treatment and care of hyperbilirubinemia and jaundice, and in particular on whether the Member's decision not to repeat MA's bilirubin test was a breach of the operative standards of practice at the time. Both Ms. Morgan (called on behalf of the College) and Ms. Devos (called on behalf of the Member) were qualified by the Panel to provide the same opinion evidence. There was no opposition by either party to one or the other expert.

Lisa Anne Morgan

The Panel heard evidence of Ms. Morgan's extensive academic and community work as a midwife in the Province of Ontario. Ms. Morgan was the director of the school of midwifery at Laurentian University from 2019 to 2021. She was a practice owner in Cambridge from 2000 to 2013 and confirmed that she has been present for hundreds of births and has attended many post-partum visits. She is currently in the inactive class of practice and has been for the last 9 years.

At the request of the College, Ms. Morgan prepared three reports setting out her opinion and answering specific questions asked. In brief, Ms. Morgan's opinion was that the Member's management of the baby's jaundice in this case fell short of the relevant standards of practice. Ms. Morgan testified that in her professional opinion the member should have repeated the baby's bilirubin test at the day 5 visit, given the signs the baby was presenting.

Ms. Morgan testified that the relevant standards in place as at November 2019 include the standards set out by the Canadian Pediatric Society (2007) and by the Provincial Counsel for

Maternal and Child Health & Ministry of Health and Long Term Care (MHLTC)(2013) (reissued in 2015 and 2018). Ms. Morgan explained that the Canadian Pediatric Society Guideline provides that a baseline risk assessment for jaundice should be completed within the day of birth. If the baby is identified as having a "low risk", then routine monitor and care is all that is required. That means retesting is only necessary if concerns develop.

Ms. Morgan explained that sudden increases in a baby's total serum bilirubin (TSB) can happen within the first two or three days of life, even if the baby presented in the normal range after the initial screen. Ms. Morgan testified that as a result of these possible sudden changes, where the baby is presenting with concerning signs, a repeat test is required.

Ms. Morgan testified that the standards as set forth in documents published by the Canadian Pediatric Society and the Provincial Counsel for Maternal and Child Health & MHLTC make clear that clinical judgment should be used to determine the need for a repeat TSB measurement, but that visual estimation of bilirubin levels alone can lead to errors and so where there is doubt about the degree of jaundice, the test should be repeated.

In this case, Ms. Morgan explained that in her opinion the Member should have considered her observations of the baby at the day 3 and day 5 visits, together with the fact that the baby was of Middle Eastern descent to conclude that a retest was necessary. Ms. Morgan explained that the Provincial Counsel for Maternal and Child Health & MHLTC have identified Middle Eastern ethnicity as a risk factor for developing hyperbilirubinemia given the baby's increased risk of having G6PD. Further, she testified that the change from day 3 to day 5 from "tinged" to "moderate" jaundice should have concerned the Member, especially given that the level of jaundice was below the nipple line on day 3 already.

Ms. Morgan acknowledged that the baby also presented with reassuring signs, including the fact that he was reportedly eating and eliminating regularly, both urine and stool. He had gained weight and the Client reported to the Member that feeding was going well. Ms. Morgan explained, however, that there should have been concern over the increasing jaundice given that the level on day 3 was already at the umbilicus, below the nipple line which in her professional opinion is concerning, and given the increased baseline risk for this baby given the parents' Middle Eastern decent. Ms. Morgan stated that in her opinion, given these above risks, the Member should have had a higher degree of suspicion for pathological jaundice and a conservative approach would have been more prudent.

Ms. Morgan further testified that in her opinion while a midwife is not required to perform a test simply because the Client asks for it, such a request should lead to an informed choice discussion. She also stated though, that given the potential risks associated with hyperbilirubinemia, if a parent asks for bili testing, "it should have been done without question"

On cross-examination, Ms. Morgan conceded that with the normal progression of jaundice in a newborn, you would expect to see the jaundice increase between day 3 and day 5 and then start to disappear. She also conceded that in her initial report to the College, she suggested that the retest should have been done at day 3, but that she was now satisfied that such a retest was not clinically indicated at the day 3 visit. Further, Ms. Morgan agreed that there was no written guideline or standard that requires a midwife to repeat the bilirubin test where there is visible jaundice to the umbilicus.

Sylviane Devos

Ms. Devos is a practice partner with Community Midwives of Kingston. She is also the deputy head midwife at Kingston Health Science Centre. She confirmed that she has been in continuous practice since 2007 and that she has had cared for babies with jaundice as part of her regular practice. In addition, Ms. Devos acts as a preceptor for the midwifery program at Ryerson, Laurentian and McMaster Universities.

At the Member's request, Ms. Devos prepared three reports setting out her opinion in this matter. Ms. Devos told the Panel that in her opinion the Member met the standards of midwifery care relating to [redacted]

By way of background, Ms. Devos explained that it is her usual practice to tell her clients that jaundice can be normal and that the reasons for the jaundice is that all babies are undergoing the same physiological process – they are converting their fetal hemoglobin into adult hemoglobin. The leftover by-product of such a process is bilirubin, which the baby's liver must process in order for it to be excreted. Ms. Devos explained that sometimes there can be a "line up" at the liver, which may result in the baby having jaundice over a longer period of time.

Ms. Devos testified that the applicable guidelines in place for the detection and treatment of jaundice as at November 2019 would have included any relevant hospital guidelines, as well as the CPS guideline 2007. She stated that she was also aware of the 2015 and 2017 updates. She stated that although she did rely on the Provincial Counsel for Maternal and Child Health & MHLTC guideline update beyond (2013) in putting together her statements, she is not convinced that all practices had integrated this guideline into practice by November 2019 as it can take up to five years for a new guideline to trickled into practice, based on her research. Regardless, she did not feel that the PCMCH guideline added any substantive new information to the existing guidance in the management of hyperbilirubinemia prevention, beyond that of the CPS and hospital guidelines she relied on. As Ms. Morgan testified, Ms. Devos explained that generally babies should be screened for TSB within the first 24-72 hours of life. The midwife should then consider the initial screening result, together with any known risk factors to determine how closely the baby will need to be monitored for follow-up.

Ms. Devos explained that common risk factors include ethnicity, gestational age, blood type incompatibility, significant bruising, and if the baby's sibling(s) required phototherapy.

In this case, Ms. Devos concluded based on her review of the records and the agreed facts that given [redacted]'s initial result of 88 umol/L, it was appropriate for the Member to conclude that he had "low risk" for developing hyperbilirubinemia. Ms. Devos explained that in light of the initial screening, follow-up within two to three days was appropriate.

With respect to the baby's presentation at the day-3 visit, Ms. Devos explained that in her opinion there were lots of signs to show that the baby was doing very well. He was reportedly feeding and voiding more than you would expect and his weight loss (which is expected) was well within the normal range. In addition, baby was stooling normally, his vital signs were normal and his mother reported that feeding was going well.

Similarly, Ms. Devos concluded based on her review of the day-5 visit notes that there was nothing documented that caused her concern.

Ms. Devos testified that the reported progression of jaundice from day-3 to day-5 appeared within the normal range, taking into account the other clinical findings. Ms. Devos said that she would expect a baby to look a little more jaundice at day 5 versus day 3, as the bilirubin level usually peaks between days 3 and 5. Further, she explained that you would expect that a baby who is actively feeding, voiding, stooling, and gaining weight, could tolerate the usual amount of bilirubin.

Ms. Devos explained that whether a retest was necessary would depend on the midwife's full clinical judgment on how the baby was doing at the appointment. In her opinion, the Member's decision not to repeat the test was clinically appropriate and in keeping with the standards.

On cross-examination, Ms. Devos said that even if the Client had asked multiple times for a retest of the baby's bilirubin, the Member was not required to in fact do the retest, if based on her assessment, one was not necessary.

Further, when pressed on cross-examination, Ms. Devos agreed that if the Member saw jaundice beyond the umbilicus (i.e. into the limbs) or if there were other concerning signs (i.e low output, lethargy) then a repeat test would have been indicated. Here, Ms. Devos concluded that in light of the fact that the Member did not see jaundice beyond the umbilicus and the fact that the baby had no other concerning signs, there would not have been any "doubt" or need to repeat the test.

Decision and Reasons

As set out above, the Panel finds that the College failed to establish on a balance of probabilities that the Member engaged in professional misconduct as alleged. In reaching its decision, the Panel considered the following key questions:

1. What were the operative written guidelines in place as at November 2019 with regard to the treatment of jaundice in newborns?

The Panel was satisfied that in the present circumstances, the operative written guidelines that should have dictated the Member's care of [redacted] included the CPS Guideline, 2007, the [redacted] Hospital Guideline and the Provincial Counsel for Maternal and Child Health & MHLTC Guideline, including its most recent iteration from 2018. The Panel was not persuaded by the Member's expert, who proposed that the 2018 Guideline would not have been as prominently in use in the fall of 2019. There was sufficient time between the update and the care provided in this case for the Member to have been aware of the Guideline update.

We also acknowledge that following the assessment of the 2018 PCMCH guideline update, the protocol committee at [redacted] Hospital chose to leave Middle Eastern descent out of the list of risk factors on their protocol, and acknowledge that this puts into question for the panel, the level of risk Middle Eastern descent presents in assessing a baby's risk for hyperbilirubinemia and for guiding management.

2. What did the Client say to the Member about the baby's jaundice before and at the day-5 visit?

The Panel found both the Member and Client to be credible witnesses. The Panel is satisfied that the Client did ask questions and raise her concern with the Member regarding the baby's jaundice before and at the day-5 visit, the Panel is also satisfied that based on the Member's recollection and contemporaneous notes, the Client did provide the Member with information to reassure her with regard to the baby's progress.

a. Did the Client explicitly or implicitly ask the Member to repeat the bilirubin test?

The Panel found the Client and [redacted] to be credible and well-meaning witnesses. They were clearly trying to recount their interactions with the Member as best they could. The Panel recognized that it was no doubt difficult for them to relive the last few days of their son's life.

While we are satisfied on a balance of probabilities that the Client and her husband wanted the baby's bilirubin re-tested, we are not satisfied that this was explicitly communicated to the Member. The Client testified that she asked the Member multiple times about whether retesting was necessary, but she did not confirm that she ask for the test to be repeated. Similarly, [redacted] explained that while he wanted the baby's retested, he did not specifically ask the Member to do so. They asked about whether the Member had the necessary equipment to perform the retested and about whether the test was necessary, but we are not satisfied that there was an explicit request for retesting.

In support of our conclusion, we note as well that there was no evidence before us to suggest that the Client's mother (an experienced midwife and clinician) said that a retest was necessary or that she questioned the Member's advice that a retest was not needed.

The Client and [redacted] both acknowledged that they trusted the Member and did not question her ultimate advice.

We also note that based on the evidence presented, the Client asked for care outside of the community standard on one or two occasions during her pregnancy and the Member appeared to oblige. For example, the Client asked for an early c-section to be scheduled and asked for additional ultrasounds. If the Client had explicitly asked for a repeat test, it seems to the Panel that the Member would have likely obliged.

b.If the Client did ask (either explicitly or implicitly) to repeat the bilirubin test, did the Member breach the standard of practice of the profession in failing to repeat the bilirubin test as requested?

Even if the Panel had found that the Client had specifically requested a repeat of the bilirubin test, the Panel is not satisfied that it was a breach of the standards of practice for the Member to decline the request. The standard of practice does not require a midwife to perform all tests requested by clients. Midwives must exercise their professional judgement to determine what is necessary and what is not.

Further, the Panel is satisfied that by answering the Client's questions and addressing her concerns regarding the baby's jaundice, the Member met the Client's needs. She provided education and advice, and on the Client's own evidence, she reassured her that a retest was not needed.

> 3. Did the Member meet the standards of practice of the profession in her decision-making with regard to this infant on the day 5 visit?

The Panel finds that the Member met the standards of practice of the profession in the provision of care for [redacted]. In particular, the Panel finds that the Member did not fail to maintain the standard of practice with respect to her decision not to repeat the baby's bilirubin test at the day-5 visit.

In coming to its decision, the Panel carefully considered the information it received from the two experts. Both were well-qualified and experienced midwives, yet they reached different conclusions on the issue of whether a repeat test was necessary in the circumstances. The fact that the experts reached different conclusions revealed to the Panel that the question of whether to repeat the bilirubin test in all of the circumstances was one of clinical judgement and not one of professional standards. The Member applied the relevant written standards to the case before her and made a decision that was reasoned and appropriate.

The CPS Guideline acknowledges that breastfeeding support is a good tool in keeping bili levels normal in newborns since breastfed babies are at higher risk of jaundice. The baby was nursing well as assessed by the Member and as reported by the Client. The CPS Guideline also states that 60% of infants develop jaundice and 2% have high levels of bilirubin.

Because midwives are bound to use technology judiciously, it is prudent for midwives to assess the need for testing carefully, weighing the benefits and the risks of testing or not testing. In the care and management of jaundice, in light of the high prevalence of normal jaundice in newborns in comparison the much lower prevalence of hyperbilirubinemia as stated above, a midwife must rely on the guiding documents prepared by the experts in the field based on the most current evidence to make decisions and exercise professional judgement.

Recommendation 31 of the Provincial Guideline provides that: "*If there is any doubt about the degree of jaundice, the TSB level should be measured. - Visual estimation of bilirubin levels can lead to errors, especially in darkly pigmented infants*".

Ms. Morgan opined that there ought to have been doubt about the level of jaundice on the day-5 visit given that the level of jaundice was below the nipple line and increased from day 3. As a result, Ms. Morgan testified that the repeat test was necessary.

However, the Member testified that she did not have any doubt about the jaundice level, was not concerned and given the overall condition of the baby, she felt reassured. Ms. Devos agreed that considering the Member's reports as to the baby's overall condition, a retest was not necessary. Ms. Devos opined that there was no doubt that the degree of jaundice noted on day 5 was normal, that the baby was in a low-risk category based on the universal screening results, according to the guidelines, and given the fact that the jaundice was only to the level of the umbilicus, there had been a normal and expected increase in the 2 days between the assessment on day 3 and day 5, and the baby was exhibiting all signs of wellness as described in

Recommendation 30 of the Provincial Guideline: "*The follow-up assessment should include - Infant's weight and % change from birth weight - Adequacy of intake - Pattern of voiding and stooling - Presence or absence of visible jaundice Expectations: - Weight loss should be no more than 10% of birth weight - 4 to 6 wet diapers and 3 to 4 stools per day by the fourth day - Stools in breastfed infants should have changed from meconium to mustard yellow - Consider observing breastfeeding to assess effectiveness* "

The Panel was persuaded by Ms. Devos' opinion that the assessment of the baby's wellness supported the Member's decision not to retest. Again, the Panel acknowledges that as did Ms. Morgan, some midwives may have made a different judgement call, the decision was consistent with the standards and a reasonable use of professional judgement.

Further, the Panel notes that the baby's grandmother (a midwife) left the Client's home after the day 5 visit, presumably feeling comfortable enough with the baby's condition to do so. The evidence was that the grandmother lived over an hour away and only planned to return after a few days. The Panel inferred from the grandmother's conduct that she did not have concerns with the care provided by the Member or with the decision not to retest the bilirubin on day 5.

The College's expert relied heavily on the increased risk of G6PD given the parents' Middle Eastern background to support her opinion that the Member's failure to perform the retest fell below the standards of practice. The Member's expert testified that the Middle Eastern background presented a small increased risk, which was offset by all of the other assessments of wellness, including that the baby's visual jaundice was at the levels to be expected.

The Panel also notes that there is no notation of family history of G6PD in the antenatal records therefore, there was a background increased risk but not a known risk identified. Furthermore, the Panel received no evidence of why the bilirubin level climbed so high so quickly as the coroner's report was not entered into evidence during the proceedings.

Ms. Morgan stated in her testimony on more than one occasion that she felt that a conservative approach is always best. These statements point more to a personal opinion of style of practice rather than to a standard of practice that must be met. Although the Panel acknowledges Ms. Morgan's right to have a preference of style of practice, the Panel is not prepared to impose this style of practice onto the Member as a standard to be met.

It is difficult to keep the outcome of this case and the tragic death of the child out of our decision-making, but it is the task the Panel had. The Panel considered whether there would be any question of professional misconduct for not doing a bili test on day 5 if the baby survived and we concluded that there would have been no consideration at all. The Panel felt extreme empathy for the Client and her family, however, the Panel could not conclude – even given the tragic outcome – that the Member engaged in professional misconduct.

For the reasons set forth above, the Panel found Ms. Devos to be a compelling witness. Her opinion was squarely based on what is required by the written guidelines available to midwives in the Province.

It is important to note that the Panel's decision should in no way be read as a rejection of the Client's testimony. The Panel found the Client to be a compelling witness. There was no doubt that testifying about her son and the events leading up to his death was difficult and traumatizing. The Client was poised and helpful. She did not appear to exaggerate or take positions not supported by the clinical records and the evidence of others. For the most part, the Member's and Client's recollection of the relevant visits did not differ significantly one from the other. As discussed above, the Panel was not satisfied that the Member failed to maintain the standards in this case. The Panel's decision is based largely on the Member's clinical findings, as recorded in her notes. Whether the Client specifically requested a retest or whether she asked about having the baby retested, is not relevant to the Panel's findings. Ultimately, the Client said she trusted the Member's advice regarding the retest. There was no suggestion in the evidence to indicate that the Client insisted on the retest, which the Member refused. On the contrary, both the Client and the Member testified that the day-5 visit involved a fulsome discussion regarding the baby's current presentation and why a retest was not indicated.

In summary, the Panel was not satisfied that the Member engaged in professional misconduct as alleged. On the contrary, the evidence demonstrated that the Member used judgment and reason to assess and treat [redacted] She employed the standards of the practice in doing so and there can be no suggestion that her conduct could be regarded as unprofessional.

I, Claudette Leduc, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel as listed below:

Claudette Leduc, Chair

May 24, 2022
Date

Isabelle Milot, Professional Member
Karen McKenzie, Professiona Member
Marianna Kaminska, Public Member
Donald Strickland, Public Member