COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

IN THE MATTER OF
A HEARING UNDER THE *HEALTH PROFESSIONS ACT*,
RSA 2000, c. H-7

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF DR. JACQUIE MCCUBBIN

DECISION OF THE HEARING TRIBUNAL OF THE COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

I. INTRODUCTION

1. The Hearing Tribunal held a hearing into the conduct of Dr. Jacquie McCubbin on November 3, 2021. The hearing was conducted virtually via Zoom.

2. The members of the Hearing Tribunal were:

   Dr. Don Yee of Edmonton as Chair,
   Dr. Sita Gourishankar of Edmonton,
   Mr. Douglas Dawson of Edmonton (public member) and
   Ms. Archana Chaudhary of Edmonton (public member).

3. Ms. Heidi Besuijen acted as independent legal counsel for the Hearing Tribunal.

4. Also in attendance at the hearing were:

   Mr. Craig Boyer, legal counsel for the Complaints Director
   Dr. Jacquie McCubbin
   Mr. William Hembroff, legal counsel for Dr. McCubbin.

II. PRELIMINARY MATTERS

5. Neither party objected to the composition of the Hearing Tribunal or its jurisdiction to proceed with the hearing.

6. There were no matters of a preliminary nature.

7. There was no application to close the hearing.

8. Counsel for the Complaints Director explained that given the sensitive nature of the matters in issue that he would not refer to the parties who received care by name but instead refer to them as "the patient" or "the parent" for his submissions.

9. The Hearing Tribunal was provided the following documents in advance of the hearing:

   a. The agreed exhibit book;
   b. Brief of law on joint submissions;
   c. Signed admission and joint submission agreement.

III. ALLEGATION

10. The Allegation before the Hearing Tribunal was set out in the Amended Notice of Hearing as follows:

    1. That during December 8 and 9, 2017, the care provided to your patient, [redacted], and her unborn child, failed to meet the minimum standard of care expected of an obstetrician and gynecologist.

IV. EVIDENCE

11. By agreement, the following Exhibits were entered into evidence during the hearing:

Exhibit 1: Exhibit Book containing tabs 1 to 14

Tab 1: Amended Notice of Hearing dated November 1, 2021

Tab 2: Complaint form dated March 19, 2018

Tab 3: Letter from Covenant Health dated May 9, 2018 with newborn admission records

Tab 4: Letter from Covenant Health dated May 9, 2018 with inpatient records for [redacted]

Tab 5: Letter of Response from Dr. J. McCubbin dated June 14, 2018

Tab 6: Undated Letter from Dr. [redacted] with office records for [redacted] received by CPSA in July 2018

Tab 7: Expert Opinion from Dr. [redacted] to Dr. Langley dated October 30, 2018

Tab 8: Addendum to Expert Opinion from Dr. [redacted] dated November 13, 2018

Tab 9: Letter of Response from Dr. J. McCubbin dated June 3, 2019

Tab 10: Expert Opinion from Dr. [redacted] dated November 1, 2019

Tab 11: Memorandum by Dr. J. Langley dated January 30, 2002 re interview of Nurse [redacted]

Tab 12: Memorandum by Dr. J. Langley dated February 5, 2020 re interview of Nurse [redacted]

Tab 13: College and Association of Registered Nurses of Alberta Hearing Tribunal decision dated June 4, 2021 re Nurse [redacted]

Tab 14: College and Association of Registered Nurses of Alberta Disciplinary Complaint Resolution Agreement dated July 20, 2021 re Nurse [redacted]

Exhibit 2: Signed Admission and Joint Submission Agreement

V. SUBMISSIONS

Counsel for the Complaints Director

12. Mr. Boyer reviewed the allegation against Dr. McCubbin and stated it involves the care Dr. McCubbin provided to a patient who went into labor in December 2017. The outcome was tragic, and the baby did not survive.

13. Mr. Boyer indicated that Dr. McCubbin has admitted the allegation is true and that her conduct amounts to unprofessional conduct. He stated that even though Dr. McCubbin has admitted to the allegation, the Hearing Tribunal still needs to consider the evidence before them to determine if it supports the admission and find whether the conduct amounts to unprofessional conduct.

14. Mr. Boyer highlighted portions of Exhibit #1 including the amended Notice of Hearing, the patient complaint, and list of care providers involved in the labor and infant delivery. He pointed out that two nurses were disciplined by their regulatory body (College and Association of Registered Nurses of Alberta) and the details of those proceedings were included in the Exhibit book.

15. Mr. Boyer pointed out the hospital records for the parent and the patient. He explained the parent's pregnancy was complex and included a number of hospitalizations before going into labor in December 2017. The parent's hospital chart including triage notes,

patient care orders, patient care notes, labour and delivery flow sheets and fetal monitoring strips were included.

16. Mr. Boyer highlighted the response from Dr. McCubbin to the complaint, expert opinion for the Complaint's Director along with the expert's addendum. A further letter from Dr. McCubbin is included. An expert opinion Dr. McCubbin obtained is included.

17. Mr. Boyer pointed out the parent submitted a complaint to CARNA about one of the nurses involved in her labor room care, resulting in an admission, and the nurse was found guilty of unprofessional conduct.

18. Mr. Boyer pointed out the expert opinion for Dr. McCubbin concluded the event occurred on a very busy shift in the labour and delivery ward and a number of failures of other team members contributed to the tragic outcome.

19. Mr. Boyer submitted that the expert opinions and hospital records in Exhibit 1 do provide sufficient evidence to support the admission to the allegation, and therefore the Hearing Tribunal should accept Dr. McCubbin's admission. He stated Dr. McCubbin's admitted conduct does amount to unprofessional conduct.

Counsel for Dr. McCubbin

20. Mr. Hembroff expressed no disagreement with Mr. Boyer's submissions. He characterized the case as a communication breakdown amongst team members. He explained that different staff in a hospital setting such as a labour and delivery unit have specific roles, some of which are crucial to ensure that other team members can make appropriate decisions and take appropriate actions for patients.

21. Mr. Hembroff indicated that the fact that the event occurred on a busy shift is not an excuse but is the reality of this case. In this context, a physician must rely heavily on the other team members like nurses who carry out delegated tasks to perform them correctly. He acknowledged that it is the physician's ultimate responsibility to personally assess patients and make clinical decisions based on their personal assessment. Incorrect or partially correct information from team members can snowball in a busy situation into the inaccurate synthesis of information and result in incorrect actions.

22. Mr. Hembroff stated that Dr. McCubbin fully accepts her role in the outcome from the chain of misinformation and incomplete information that was propagated amongst team members in this case. The result was the team went down an incorrect clinical path and the outcome was catastrophic. He stated the entire team caring for the parent and the patient that night was left devastated by the outcome.

23. Mr. Hembroff submitted that this is not a case of a physician trying to avoid doing another C-section on a busy night. He emphasized that Dr. McCubbin is a good physician and a caring one. He pointed out that despite the devastating clinical outcome, the positive that has come from this case is that clinical team processes in the labour and delivery room were changed to decrease the likelihood of similar events happening again.

Questions from the Tribunal

24. Dr. McCubbin clarified that the parent was admitted to the hospital the day prior to going into labor to receive Cervidil. After receiving Cervidil the parent was transferred back to the antepartum unit. The parent was transferred to the case room at about 0315 AM.

25. Dr. McCubbin clarified that while on call, she is responsible for the obstetrical outpatient unit, post-partum unit, gyne unit, and labor and delivery unit.

26. Dr. McCubbin recalled that on the evening of the parent's delivery, it was a very busy night in the labour and delivery room where she had several other C-sections that night. She stated it was so busy that night that she only was personally assessing patients if the nurses asked her to for a specific reason.

27. Mr. Boyer stated that the considerable time which passed between when the parent was transferred to the case room and the time Dr. McCubbin personally assessed the parent reiterated the criticism the College's expert outlined in their opinion.

28. Mr. Hembroff stated the case is analogous to airplane flight where Dr. McCubbin is the pilot, and the labor and delivery nurses are air traffic control. Dr. McCubbin relies on the nurses to provide her with accurate information about patients so that she can act

accordingly, and this reliance is heightened on a busy shift. Mr. Hembroff stated that this does not lessen Dr. McCubbin's responsibility to a patient, but only wanted to highlight the issue in this case was one of communication amongst team members.

29. Mr. Hembroff stated the Grey Nuns Hospital has since taken steps to improve communication amongst care team members in the labour and delivery room. He objected to the implication that the on-call obstetrician typically rounds on all patients in the case room. He stated the more accurate scenario is a patient in the case room is seen by the obstetrician when the need arises.

30. Dr. McCubbin clarified that while the parent was transferred to the labour and delivery room at 0315 AM, it took until about 0415 AM for her epidural to be applied, all of the monitors to be connected and for the parent to get comfortable and settled.

31. The Complainant used the chat function in the virtual hearing to offer to provide further details. The Hearing Tribunal solicited the input of the parties in regard of these. The parties expressed concerns with receiving this information without prior notice or understanding of what it would relate to and suggested it may have the effect of amounting to a rejection of the agreement on facts and sanction. The Hearing Tribunal considered these arguments and determined it would not seek any comments from the Complainant.

VI. FINDINGS

32. Given Dr. McCubbin's admission to the Allegation, the Hearing Tribunal considered the submissions from the parties along with evidence presented in Exhibit 1 to determine if the evidence supports the admission.

33. The Hearing Tribunal adjourned to consider this matter, it took care to review all the evidence and the submissions from the parties. It concluded the allegation was factually proven as the evidence did support Dr. McCubbin's admission to the allegation and that the admitted conduct did represent unprofessional conduct.

34. Given the highly specialized nature of Dr. McCubbin's specialty, the Hearing Tribunal relied heavily on the expert opinions for the College and Dr. McCubbin to help make its findings.

35. An expert opinion for the CPSA concluded Dr. McCubbin in this case did not provide care that met the minimum standard expected of an obstetrician in Alberta. The CPSA expert opinion pointed out issues in the care provided to the parent including: attributing an abnormal fetal tracing to entirely the effect of medications given to the parent, interruption of fetal heart rate monitoring at crucial points during the parent's labor, no fetal monitoring performed after the parent was transferred to labour and delivery when there already had been an abnormal fetal tracing, and starting oxytocin when the fetal heart rate tracing was abnormal. Several areas of concern were cited as actions contrary to Society of Obstetricians and Gynecologists of Canada guidelines.

36. Dr. McCubbin retained an expert opinion who agreed with the assessment from the CPSA expert opinion but also pointed out the catastrophic outcome of the case was the result of a series of problems and propagation of inaccurate information borne from inaccurate assessments of the status of parent's unborn child. This expert stated the result was due to this multifactorial contribution from several healthcare providers and that each had their role in the outcome.

37. Concerns were also raised about Dr. McCubbin's lack of communication with the parent and her partner about the possible implications of a non-reassuring tracing and what that might mean for delivery options. Such communications should have also been documented.

38. The Hearing Tribunal does acknowledge the specific clinical dynamic present in the labour and delivery room setting where the obstetrician is reliant on clinical information relayed to them by the case room nurses to inform their clinical decision making and that this reliance is likely amplified in a busy labour and delivery shift such as the evening of the events of this case.

39. The Hearing Tribunal also appreciated the fact that two of the nurses involved in the parent and patient's care were disciplined by their regulatory body for their part in the catastrophic outcome of this case.

40. However, the Hearing Tribunal understood from the evidence that the parent's pregnancy was complicated, and she required several hospitalizations to manage pregnancy-related issues leading up to her delivery. Given this and the presence of some signs on

the fetal tracing that suggested the delivery may not have been evolving smoothly and safely, the Hearing Tribunal found the ultimate responsibility would have been on Dr. McCubbin to ensure the safety and well-being of the parent and her unborn child. Dr. McCubbin's actions fell short of this, and the result was catastrophic.

41. The Hearing Tribunal contemplated the College's Standard of Practice regarding the requirement of a physician to follow and abide by the Canadian Medical Association's Code of Ethics and Professionalism. Specifically, this code states that a physician must commit to the well-being of the patient and provide appropriate care and management across the care continuum.

42. In this case, the Tribunal found that Dr. McCubbin did not provide appropriate care and management for the parent during her labor, as outlined above.

43. The Hearing Tribunal found that the proven Allegation constituted unprofessional conduct under section 1(1)(pp)(i) of the HPA as follows:

> ***1(1)*** *In this Act,*
>
> *(pp) "unprofessional conduct" means one or more of the following, whether or not it is disgraceful or dishonourable:*
>
> *(i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;*

VII. SUBMISSIONS ON SANCTION

44. The parties presented the Hearing Tribunal with a Joint Submission Agreement following the finding of unprofessional conduct that was marked during the hearing as Exhibit #2. The parties presented their submissions on the agreed sanction.

45. The joint submission on sanction included the following terms:

a. Dr. McCubbin shall receive a reprimand;

b. That Dr. McCubbin shall, at her own expense, take and complete by June 30, 2022 the following professional development courses;

i. The online course, TeamSTEPPS Canada Essentials, by the Canadian Patient Safety Institute, and

ii. The online Institute for Healthcare Improvement Open School modules on Quality Improvement (QI 101 to QI 105) and Patient Safety (PS 101 to PS 105).

c. That Dr. McCubbin shall provide proof of completion of the professional development courses to the Complaints Director by September 1, 2022.

d. That Dr. McCubbin shall be responsible for two-third of the costs of the investigation and hearing, up to a maximum of $15,000.

Counsel for the Complaints Director

46. Mr. Boyer presented the sanction agreement. He also highlighted points from the Brief of Law on Joint Submissions which states that joint submissions should be given considerable deference and should not be rejected unless the decision-maker finds that it is manifestly unjust and would be inappropriate to accept.

47. Mr. Boyer stated that the key principle in determining sanctions from *Jaswal v. Medical Board of Newfoundland* is that sanctions have a two-fold purpose: to provide deterrence to both the individual and the profession at large and rehabilitation. He explained an appropriate sanction should strike a balance of these two purposes. He submitted the agreed sanction strikes an appropriate balance between deterrence and rehabilitation.

48. Mr. Boyer pointed out that in this case several different health professionals who were part of the labour and delivery team for the parent failed to meet the standard of care for their profession. Therefore, he submitted that as a deterrent, a reprimand would be appropriate for Dr. McCubbin. He pointed out that the outcome of this case was the result of the actions of several health professionals including Dr. McCubbin and therefore a deterrent on the low end of severity in the spectrum of potential sanctions available under section 82 of the *Health Professions Act* would be most appropriate.

49. Mr. Boyer explained the two required courses for Dr. McCubbin are aimed to improve skills in the team approach of working in a clinical care team and patient safety. He stated the specific courses were identified by the Complaints Director (Dr. Hartfield) who has worked as a pediatrician providing in-hospital care and also has expertise and leadership experience in patient safety, quality improvement and quality assurance.

50. Mr. Boyer explained that one required course deals with teamwork and this would address the concern of team communication and the breakdown in team communication that occurred in this case. The other course deals with patient safety, and this is appropriate given how the system put the labor and delivery team in a very difficult situation which enhanced the likelihood of error. Mr. Boyer submitted this course would address specific steps to take to improve patient safety.

51. Mr. Boyer pointed out that the Grey Nuns Hospital has already implemented process changes within the labour and delivery unit and that Dr. McCubbin has made changes in her personal practice as a result of this case. The required courses in the sanction will supply Dr. McCubbin and her team with more tools to ensure accurate communication amongst the team and ultimately improved patient safety.

52. Mr. Boyer submitted that partial costs imposed upon Dr. McCubbin as part of the sanction is consistent with previous college decisions.

53. Mr. Boyer referred to the Brief of Law and pointed out that in *R. v. Anthony-Cook*, 2016 SCC 43, the Supreme Court of Canada set out the test against which to measure the acceptability of a joint submission. The bar is high to reject a joint submission on penalty. The Hearing Tribunal should accept a jointly proposed penalty unless the proposed penalty would bring the administration of justice into disrepute or is otherwise contrary to the public interest.

54. Mr. Boyer concluded that the joint sanction agreement does achieve an appropriate balance of deterrence and rehabilitation. He stated a reprimand is the most appropriate deterrence for Dr. McCubbin and the rehabilitation component of the sanction aims to improve some of Dr. McCubbin's skills such that she is a more resourced physician. He stated the proposed timeline gives Dr. McCubbin ample time to complete the required courses.

Counsel for Dr. McCubbin

55. Mr. Hembroff agreed with Mr. Boyer's assessment of the law and the purpose of sanctions.

56. Mr. Hembroff explained that they provided the College a list of courses that Dr. McCubbin has completed since 2017 including fundamentals of fetal health surveillance (2017 and 2019) and shared that she was a member and now the Chair of the Grey Nuns Hospital Perinatal Mortality and Morbidity Committee.

57. Mr. Hembroff stated that Dr. McCubbin is a physician who is engaged in educating those around her and in the assessment of safety and quality control. He explained that the two courses in the agreed sanction were determined in the context of all the continuing education Dr. McCubbin has already completed. He suggested that Dr. McCubbin has gone above and beyond with her personal efforts in obtaining continuing education in safety and quality control assessment.

58. Mr. Hembroff stated the proposed costs was an agreement borne out of considering factors including Dr. McCubbin not contesting the allegation and providing an admission, Dr. McCubbin's co-operation with the complaints process and working together to provide a joint admission, and Mr. Boyer's estimate of costs incurred to date.

59. Mr. Hembroff stated Dr. McCubbin understands the need for a deterrent and feels that that a reprimand in this case is appropriate as opposed to a suspension. As previously submitted the outcome of this case was the result of domino effect of a series of inaccurate information propagated through a clinical team. He submitted if not for other events occurring leading up to Dr. McCubbin's ultimate clinical decisions in this case, Dr. McCubbin's conduct would not have fallen below the expected standard of care. He pointed out that Dr. McCubbin has provided an admission that her own conduct in the care provided to the parent fell below accepted standards and Mr. Hembroff suggested the reprimand is appropriate in this matter.

Questions from the Tribunal

60. The Hearing Tribunal asked for further details as to changes Dr. McCubbin has incorporated into her practice since the events in this matter.

61. Dr. McCubbin summarized the various changes in the processes within the obstetrical unit at Grey Nuns hospital and in her own personal practice that have resulted from this case.

62. There is a new antepartum unit which is located closer to the case room and is staffed by their patient labour and delivery nurses as opposed to postpartum nurses. Well-trained charge nurses are consistently present on their shift which makes communication as a team much easier. All obstetricians and nurses have additional training in fetal heart monitoring. The unit is equipped with new faster fetal heart monitors.

63. The previous perinatal mortality committee has been expanded to include morbidity so that learnings can be gained from near misses in addition to deaths. Dr. McCubbin now Chairs this committee.

64. Dr. McCubbin has completed communications and disclosure courses as she acknowledges her communication with the parent and her partner was poor. She stated the team now communicates better in situations where a baby may not tolerate labour about what actions to consider and take.

65. Dr. McCubbin also expressed how this case and the result has affected her on a personal and psychologic level.

Order of the Hearing Tribunal

66. After adjourning to consider the submissions from the parties, the Hearing Tribunal determined that the proposed sanction order was appropriate and was consistent with the factors in *Jaswal v. Newfoundland Medical Board,* (1996), 42 Admin L.R. (2d) 233. The Hearing Tribunal was also mindful that much deference should be given to joint submissions.

67. The Tribunal considered the test of the appropriateness of a jointly proposed penalty as outlined in *R. v. Anthony-Cook*, and after considerable deliberation, accepted the joint submission as appropriate.

68. The Hearing Tribunal is satisfied that the proposed sanctions serve the dual goals of protecting the public interest and remediation of the Dr. McCubbin. The Hearing Tribunal did not find the agreed sanctions in any way unfit, unjust, or unreasonable.

69. The Hearing Tribunal found the proposed payment of a portion of the costs of the hearing appropriate. Dr. McCubbin was co-operative with the College throughout the investigation of the complaint and by admitting to the allegation, saved much time and cost of a longer contested hearing.

70. The Hearing Tribunal appreciated the specific dynamics of this case when considering the appropriateness of a reprimand. Dr. McCubbin's proven unprofessional conduct was not the result of any malicious or abusive behaviors towards her patient or actions that defrauded the healthcare system. Instead, her proven conduct was a result of her trusting inaccurate misinformation she obtained from other team members she was relying on during a busy on call shift. The Hearing Tribunal recognizes that this does not place all the fault onto Dr. McCubbin's nursing colleagues and found that Dr. McCubbin had the ultimate responsibility to ensure the safety of the parent and her unborn child, especially given the clinical circumstances of this case.

71. Therefore, the Hearing Tribunal accepted a reprimand as the appropriate deterrent portion of Dr. McCubbin's sanction.

72. In consideration of the appropriateness of the proposed sanction, the Hearing Tribunal was very mindful of the details of this particular case. Specifically, the Hearing Tribunal does recognize and acknowledge the devastating impact of the catastrophic end result on the parent and her partner and their families.

73. The Hearing Tribunal did appreciate that Dr. McCubbin expressed sincere remorse over the outcome of this case in her remarks to the Hearing Tribunal. The Hearing Tribunal acknowledges the self-reflection and efforts that Dr. McCubbin has already made to improve her personal obstetrical practice and her engagement in processes at the Grey Nuns Hospital to address systemic factors to lessen the chances of a similar outcome happening again.

74. Accordingly, the Hearing Tribunal accepts the joint sanction proposal and makes the following orders:

    a. that Dr. McCubbin shall receive a reprimand;

    b. that Dr. McCubbin shall, at her own expense, take and complete by June 30, 2022 the following professional development courses:

i. the online course, TeamSTEPPS Canada Essentials, by the Canadian Patient Safety Institute, and

ii. the online Institute for Healthcare Improvement Open School modules on Quality Improvement (QI 101 to QI 105) and Patient Safety (PS 101 to PS105);

c. that Dr. McCubbin shall provide proof of completion of the professional development courses to the Complaints Director by September 1, 2022;

d. that Dr. McCubbin shall be responsible for two-thirds of the costs of the investigation and hearing, up to a maximum of $15,000.

Signed on behalf of the Hearing Tribunal by the Chair:

Dr. Don Yee

Dated this 15th day of December, 2021.