Hospital Appeal Board
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DECISION NO. HAB-HA-20-A001(c)

In the matter of an appeal under section 46 of the *Hospital Act,* RSBC 1996, c 200

BETWEEN:	Katherine Puchala	**APPELLANT**
AND:	Northern Health Authority	**RESPONDENT**
BEFORE:	A Panel of the Hospital Appeal Board: Cheryl Vickers, Panel Chair Dr. Anita Molzahn, Panel Member Sandra Pullin, Panel Member	
DATE:	Conducted by way of oral hearing and written submissions concluding December 17, 2021	
APPEARING:	For the Appellant: Katherine Puchala, Self-Represented	
	For the Respondent: Melissa Perry, Counsel Lindsey Wilson, Counsel	

Decision on the Merits of the Appeal

INTRODUCTION AND ISSUES

[1] The Appellant, Katherine Puchala, is a Registered Midwife with the British Columbia College of Nurses and Midwives (the "College"). Midwifery is the health profession in which the professional provides prescribed services during normal pregnancy, labour, delivery, and the postpartum period. It is a self-regulated health profession, regulated by the College. As with other self-regulated health professions, the College establishes criteria for registration as a midwife, sets practice standards and ensures accountability of practicing midwives to the public.

[2] To provide intrapartum services, which are services during labour and delivery, a midwife must have hospital privileges. Privileges are the permit to practice in a facility and involve an appointment to the Medical Staff of a facility. Without hospital privileges, a midwife's license to practice midwifery is limited to antepartum (pre-natal) and postpartum services.

[3] Midwives consult and collaborate with other health care practitioners to work safely within their scope of practice. It is a midwife's professional responsibility to consult with appropriate health professionals when an indication for consultation, as set out in the College's professional standards, is identified.

[4] In 2018, Ms. Puchala applied to the Respondent, Northern Health Authority ("Northern Health"), for privileges at Mills Memorial Hospital ("MMH") in Terrace,

Kitimat Hospital and Health Centre ("KHHC") in Kitimat, and Wrinch Memorial Hospital ("WMH") in Hazelton, all operated by NHA. The NHA Board of Directors (the "Board") denied the Appellant's application in June 2019. Ms. Puchala appealed the June 2019 decision, and in a decision dated October 23, 2019 (the "Board Decision"), the Board affirmed its June 2019 decision denying Ms. Puchala's privileges.

[5] Pursuant to section 46 of the *Hospital Act,* this is Ms. Puchala's appeal to the Hospital Appeal Board ("HAB"), of the Board Decision confirming the denial of her privileges.

[6] The Board's stated reasons for upholding its original decision to deny privileges include:

a) neutral or negative verbal references;

b) fit with the existing group providing obstetrical care in Terrace; and

c) professionalism concerns.

[7] The Board noted that of Ms. Puchala's three professional references, two were interpreted as negative and the third was neutral. The Board commented that the lack of positive references is "unusual and raises red flags about the appropriateness of the applicant for membership on the Medical Staff".

[8] As to "fit", the Board noted that Ms. Puchala had worked in the community providing limited obstetrical services to the extent permitted by her license while her application for privileges was on hold. In view of feedback collected from the existing group of obstetrical care providers in Terrace, the Board expressed concern "that the addition of Ms. Puchala will upset the existing cohesiveness of that group and, as a result, have an adverse impact on patient care."

[9] Ms. Puchala initiated the appeal to the HAB on the grounds that the privileging process used in assessing her application was "not conducted accurately, fairly or in good faith". As the HAB process is a *de novo* process[1], allowing for procedural defects in the privileging process to be cured, concerns about procedural fairness do not raise valid grounds of appeal[2].

[10] The criteria for membership to the Northern Health Medical Staff are set out in the Northern Health Medical Staff Bylaws (the "Bylaws") and the Medical Staff Rules (the "Rules"). The Bylaws provide that an appointment to medical staff is "dependent on the human resource requirements of the facilities and programs operated by Northern Health and on the needs of the population served" (Bylaws, Article 3.1.5).

[11] While the granting of privileges is dependent on service needs and the ability of Northern Health to provide adequate resources and staff to support such privileges (Rules, Article 2.2.3), the facility based privileging process is also

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[1] *Hospital Act*, RSBC 1996, c 200 at section 46(2.3).
[2] *Figurski v Interior Health Authority*, Decision No 2015-HA-001(a) (January 9, 2017) at para 42; *Ng v Richmond Health Services Society*, Hospital Appeal Board, February 6, 2003 at p 10; *Fox v. Kelowna General Hospital*, Hospital Appeal Board, July 18, 1997.

intended to ensure that the recommended candidates are not only filling a service need but also have "the appropriate skills and personal qualities to practice effectively and safely in that facility or community cluster" (Rules, Article 2.5.1.1).

[12] On an appeal from the denial of privileges, the HAB is mandated to sit in the shoes of the Board and to consider the evidence adduced as though that evidence had been originally considered by the Board[3]. It may consider evidence not originally available to the Board[4]. In doing so, it must consider the privileging application in accordance with the requirements of the Bylaws and Rules.

[13] As such, broadly speaking, the issues in an appeal from the denial of privileges often concern whether there is a need in the community or communities served by the facilities to which an applicant has sought privileges for the services to be provided by the applicant, and whether the applicant has the appropriate skills and personal qualities to meet that need.

[14] Northern Health's position on this appeal is that there is no need for a midwife to provide intrapartum services in the communities served by MMH, KHHC or WMH, and if the HAB finds there is a need, that Ms. Puchala is not the appropriate candidate. Northern Health asks the HAB to affirm the Board's decision. In the alternative, Northern Health submits that if the HAB finds there is a need for an additional practitioner to provide intrapartum care, that a vacancy should be declared and posted for open competition.

[15] We disagree with Northern Health's narrow characterization of the "need" issue as a need specifically for intrapartum services. Ms. Puchala sought privileges to enable her to practice as a midwife with a full scope midwifery practice. Midwives are not permitted to provide intrapartum care, whether at home or in a hospital or birthing centre without privileges being granted to a facility. But while privileges are required to enable the Appellant or any midwife to provide intrapartum care, analyzing the "need" issue solely as a need for an intrapartum care provider fails to recognize the nature of midwifery as a profession and the provision of midwifery care as a care option for expectant mothers.

[16] One of the core principles of midwifery care is continuity of care during pregnancy, labour, birth, and the postpartum period on a 24 hour on-call basis. Ideally, clients develop a relationship with a midwife, or midwives in a group practice, before labour. That relationship extends though the provision of postpartum care for mother and newborn following birth.

[17] Midwives practice in a range of settings including clinics, client's homes, hospitals, and other community based settings. Midwifery care is provided in a setting chosen by the client, in consultation with the midwife, and appropriate to the client's level of risk.

[18] Another core principle of midwifery is that of informed choice, including choice of birthplace. To successfully facilitate informed choice, midwives ensure adequate discussion time with clients in the prenatal period and provide complete,

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[3] *Figurski*, supra note 2 at paras 36-43; *Fahmi v Board of Fernie District Hospital*, Medical Appeal Board, October 1978.
[4] *Aitken v Penticton Regional Hospital*, Medical Appeal Board, April 15, 1986.

relevant, and objective information to clients along with their professional recommendations.

[19] Although Ms. Puchala can and does provide antepartum and postpartum care to women without privileges, to approach the question of whether she should be granted privileges to simply address a need for intrapartum care, as suggested by Northern Health, fails to recognize that a privileged midwife with the ability to provide intrapartum care provides expectant mothers with the opportunity to choose to receive midwifery care and support throughout their pregnancy and labour and into the postpartum period from an individual with whom they have developed a relationship for that purpose. Midwifery is not just about birthing babies. It is about working in partnership with women (whose risk profile is appropriate) to provide support, care and advice throughout pregnancy, labour, birth, and the postpartum period. The absence of privileges at a particular facility means a midwife cannot provide full scope midwifery care and that women served by that facility are denied access to full-scope midwifery care without leaving their home community.

[20] The "need" issue in the context of a privileging application from a midwife is not whether there is a need in the community served for another intrapartum care provider, but whether there is a need in the community served for a midwife to provide full scope midwifery care including intrapartum care in the context of a full scope midwifery practice.

[21] Consequently, the issues in this appeal are:

1) Is there a need in the communities served by MMH, KHHC and WMH for a midwife capable of providing full scope midwifery care;

2) If there is a need, in one or all of those communities, is Ms. Puchala the appropriate person to fill that need; and

3) If Ms. Puchala is the appropriate candidate to fill the need, what is the appropriate remedy?

BACKGROUND

The Appellant

[22] Ms. Puchala graduated from the midwifery program at Laurentian University in 2013. After graduation, she worked as a midwife in Collingwood, Ontario for just over two years, then in Brampton, Ontario until October 2016, and then as a locum in Hay River, NWT until late 2017.

[23] In 2017, Ms. Puchala became aware through AS, a former classmate and friend then practicing midwifery in Hazelton, that there was no midwife practicing in Terrace. AS encouraged her to come to Terrace and start a midwifery practice. Ms. Puchala initiated the process to become registered in British Columbia, passed the necessary exam, and decided to move to Terrace to start a practice.

[24] While awaiting privileges, as is usual, the College restricted Ms. Puchala's license to practice to exclude intrapartum care as a primary caregiver. She was permitted to provide antepartum and postpartum care, and intrapartum care as a

second midwife only if she maintained current certification in neonatal resuscitation and cardiopulmonary resuscitation.

[25] Now, because of the length of time that has passed since Ms. Puchala has been licensed to provide intrapartum care, Ms. Puchala will be required to undergo a recertification process involving a period of supervised practice approved by the College to ensure her skills meet the requisite standards before she can be licensed to provide primary intrapartum care.

[26] Ms. Puchala has provided and continues to provide antepartum and postpartum care in Terrace and surrounding area.

Northern Health

[27] Northern Health is a regional health authority established by the *Health Authorities Act*[5].

[28] Northern Health is responsible for the delivery of health care to the approximately 300,000 residents of northern British Columbia as divided into three Health Service Delivery Areas ("HSDA"), namely, Northwest, Northern Interior, and Northeast. Northern Health owns and operates various hospitals and health centres, including those to which Ms. Puchala sought privileges located in the Northwest HSDA.

[29] The Northwest HSDA serves a population of approximately 85,000 people over a vast geographic area. The central corridor of the Northwest HSDA, which includes the cities of Kitimat and Terrace, has a population of approximately 31,000 residents, with 13,000 to 14,000 people residing in the Terrace area.

The Privileging Process Generally

[30] The criteria and process for membership on the Northern Health Medical Staff are set out in the Bylaws and Rules. The *Hospital Act Regulation*[6] and the Bylaws stipulate that the Board is the final decision maker in respect to applications for appointment to the Northern Health Medical Staff.

[31] The "normal" process for bringing on Medical Staff involves multiple steps. The first step is to identify needs and contribute to a workforce plan[7]. The workforce plan is a "best estimate" of what Medical Staff may be needed with the understanding that things change. If a particular community needs a particular type of practitioner, they come with a request that is discussed with the Chief Operating Officer. An Urgent Priority List ("UPL") is created, endorsed by the Chief of Staff, and voted on by the Northern Health Medical Advisory Committee ("NHMAC"). From that document, the Medical Director will create postings that define a particular position. Applicants submit their applications for posted positions through an online portal. Verbal reference checks and interviews are conducted, and one or more

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[5] *Health Authorities Act*, RSBC 1996, c 180.
[6] *Hospital Act Regulation*, BC Reg. 121/97.
[7] The witnesses and all the evidentiary documents refer to this as a "manpower plan". We prefer the gender neutral term workforce plan and will use that term throughout.

successful candidates will be invited for a site visit to be introduced to the relevant clinical group. The Chief of Staff will make a recommendation with respect to the onboarding of a particular candidate and a letter of offer will then follow. Once signed by the candidate, the position is solidified and then the candidate is invited to apply for privileges. Applications for privileges are reviewed by the Privileges and Credentials Committee (the "Committee") who makes a recommendation to the NHMAC. The NHMAC, in turn, makes a recommendation to the Board and the Board makes a final decision.

[32] We heard evidence that the process described above is the "normal" process for the onboarding of medical staff at Northern Health and is typically the process followed when onboarding physicians. We also heard evidence that outside of the larger cities in British Columbia, midwife positions are rarely, if ever, posted. Midwives often start a practice then apply for privileges despite that no posting for a midwife has been created.

[33] There is no question that Ms. Puchala's application did not follow the "normal" process. While any failures in the process will be cured in a de novo appeal to the HAB, it is nevertheless helpful to set out what happened in Ms. Puchala's application to understand the context of the appeal.

The Appellant's Application

[34] Prior to her arrival in Terrace, Ms. Puchala requested an application for privileges and was advised that she would need to have a discussion with the local obstetrician gynecologist first. When she arrived in Terrace, she followed up and met with Dr. VR on December 18, 2017.

[35] There was not an advertised position for a midwife in Terrace when Ms. Puchala arrived.

[36] Dr. VR is the Chief of Staff at MMH and an obstetrician gynecologist. When Ms. Puchala and Dr. VR met, Dr. VR expressed concerns that a midwife practicing in Terrace was not part of the existing workforce plan and expressed concerns about how a practicing midwife would impact the existing group of doctors providing obstetrical services in Terrace. He was nevertheless supportive of incorporating midwifery and agreed to give Ms. Puchala a tour of the facilities.

[37] Ms. Puchala toured MMH briefly with Dr. VR on December 21, 2017, and met Dr. F, the Medical Director of the Northwest HSDA. Dr. F outlined to Ms. Puchala the application process and requirements for appointment to the Medical Staff as a midwife with privileges at MMH, including the submission of the names and contact information for professional references for the purpose of conducting confidential verbal reference checks. He asked that the referees be persons in a similar position to his, namely Chief of Staff, at their respective facilities.

[38] Both Dr. VR and Dr. F indicated to Ms. Puchala that midwifery had not been incorporated into the existing workforce plan for MMH. They explained that the obstetrical service needs of the community served by MMH were being met by a group of primary care physicians and a sole obstetrician and gynecologist, namely, at the time, Dr. VR.

[39] On January 12, 2018, as requested by Dr. F, Ms. Puchala provided Northern Health Medical Affairs with three names and contact details for her professional references so Dr. F could conduct confidential verbal reference checks. Dr. F did not conduct verbal reference checks at this time. It is not clear from the evidence when Northern Health contacted the referees to ask them to complete a written confidential reference form, but the three referees completed written reference forms on March 20, April 3, and April 15, 2018. All three written references were positive and recommended Ms. Puchala for appointment to the Medical Staff.

[40] In early March 2018, Ms. Puchala received a link to the online application for privileges. Her initial application for privileges is dated March 12, 2018. The application was not complete and could not be processed until April 17, 2018, as all the application requirements prescribed by the Medical Staff Bylaws were not yet met. This delay was not attributable to Ms. Puchala, but rather to an error on her professional liability certificate, and delay on the part of her referees to fill out written reference forms.

[41] On March 24, 2018, Ms. Puchala accompanied an intrapartum patient to MMH and facilitated the delivery of the patient's baby, as the on-call physician did not arrive in time for the precipitous birth. These activities fell outside the scope of Ms. Puchala's existing temporary scope license to practice midwifery in British Columbia and were undertaken without hospital privileges at MMH (the "Incident").

[42] Between March 26 and April 10, 2018, Ms. Puchala communicated with Dr. VR and Dr. F about the Incident. By letter dated April 18, 2018, Dr. F informed Ms. Puchala that her application was complete but that she had not yet been granted privileges. He also advised her that he had reported the Incident to the College in accordance with his duty to report and that processing of her application would be suspended pending the outcome of the College's investigation.

[43] The College did not render its decision respecting Dr. F's complaint until January 10, 2019. The Panel investigating the complaint "accepted the allegation as written that Ms. Puchala acted as a primary care provider for her part in delivering the baby in a facility where she does not hold privileges; however, the Panel considered the conduct and competence of the midwife to be reasonable given the circumstances." The Panel concluded that many steps were taken to avoid the situation, the client was well informed, and "the precipitous delivery required Ms. Puchala to take action to provide the safest care to this client and her baby". The College reminded Ms. Puchala that certain activities performed by her during the Incident were considered intrapartum care.

[44] On January 29, 2019, Dr. F met with Ms. Puchala. At that meeting, Dr. F advised Ms. Puchala that Northern Health wanted to incorporate midwifery at MMH and that a review of midwifery services had been initiated. He also told her that he had presented her application to the Committee and that her privileges would likely be in place "before the weekend". He asked Ms. Puchala to check in the following day with his assistant.

[45] Ms. Puchala made a contemporaneous audio recording of this meeting without advising Dr. F in advance or obtaining his consent.

[46] Ms. Puchala checked in with Dr. F's assistant as asked on January 30, 2019. On January 31, she received an email from Dr. F's assistant confirming her

privileges were in the final stages of sign off. The assistant advised that once signed off, temporary privileges would be in place until the application went to the Committee for approval, and then to the Board for approval. She advised that temporary privileges were the same as Board approved privileges.

[47] Having heard nothing, Ms. Puchala followed up again with Dr. F's assistant on February 6, 2019. The assistant advised that Dr. F had reached out to GY for a reference check but had been unable to connect and asked Ms. Puchala to get GY to call her. Several more emails ensued between Ms. Puchala and Dr. F with respect to contacting her referees.

[48] Between February 14 and February 29, 2019, all three of Ms. Puchala's professional references were contacted for a confidential verbal reference check.

[49] In addition to conducting confidential verbal reference checks with the referees that Ms. Puchala had provided, Dr. F sought input through Dr. VR from the existing practitioners providing obstetrical care in Terrace. Dr. VR reported to Dr. F that the feedback from the existing practitioners was not supportive of Ms. Puchala's application. There is no documentation of the feedback.

[50] Dr. F confirmed to Ms. Puchala by email on March 4 that he had connected with all the referees and presented a recommendation to the Committee.

[51] Ms. Puchala sent emails to Dr. F on March 15, and to Dr. F and Dr. VR on March 25, 2019 inquiring about the process. Dr. F's assistant emailed Ms. Puchala on April 5 to set up a meeting.

[52] On April 8, 2019, Ms. Puchala met with Dr. F, Dr. VR, and Dr. F's assistant. Ms. Puchala made a contemporaneous audio recording of this meeting without advising the others in attendance in advance or obtaining their consent.

[53] At that meeting, Dr. F informed Ms. Puchala that her confidential references were not favourable and that he would not be recommending her application to the Committee. Dr. F further advised Ms. Puchala that she had two choices: proceed with the processing of her application with the knowledge that it would proceed with a negative recommendation, or withdraw her application for appointment. This advice was confirmed in a letter dated April 10, 2019, and minutes from that meeting prepared by Dr. F's assistant were sent to Ms. Puchala on April 26, 2019.

[54] The application for privileges includes a section to be completed by the appropriate Medical Staff leader to either recommend all requested privileges, recommend privileges with conditions or modifications, or not recommend privileges. Dr. F completed and signed Ms. Puchala's application form and dated it April 30, 2019. Dr. F did not recommend privileges and provided the following explanatory note: "I do not recommend granting privileges based on the obstetrical group recommendations + unfavourable references".

[55] After the April 8, 2019 meeting, Ms. Puchala contacted her professional references to advise them that her application for privileges had been denied, her understanding of the reason for the denial of her application (i.e. unfavourable references), and to ask them directly about any concerns they may have had regarding her as a midwife, a team member or as a person.

[56] On May 10, 2019, Ms. Puchala asked that the Committee proceed with her application. On May 27, 2019, the Committee informed Ms. Puchala by letter that it would not be endorsing her application for appointment.

[57] The NHMAC unanimously voted to recommend that the Board reject Ms. Puchala's application for Medical Staff membership in Northern Health in midwifery, with privileges at MMH.

[58] Following the NHMAC Meeting, Dr. C, the VP of Medicine for Northern Health, prepared a briefing note dated May 30, 2019 (the "Briefing Note") for the Board. As to the unfavourable references, the Briefing Note advises that verbal reference checks had been conducted over the phone of Ms. Puchala's references and that of the three professional references, "two were negative, both stating when asked that they would not hire Ms. Puchala if given the opportunity to do so" and that the "third reference was neutral with a limited history of an on-site working relationship with Ms. Puchala". The Briefing Note says:

> The lack of positive reference from professional references put forward by an applicant is unusual and raises red flags about the appropriateness of the applicant for membership on the Medical Staff. On that basis Dr. [F] made the decision not to recommend the applicant for appointment. However, he remains supportive of having a midwife with hospital privileges practicing in the community served by MMH.
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> In addition, over the past year, Ms. Puchala had been working in the community providing limited obstetrical services to the extent permitted by her license. Dr. [F] has sought out the input of the group of practitioners in the community providing obstetrical services. His overall impression of that input is that she is not a good fit in the existing group of obstetrical care providers. Dr. [VR] has also provided a letter to the Northern Health Credentials Committee…to the effect that he has never committed to be supportive of her application and that – on the basis of Ms. Puchala's references, "several red flags" over the past year, and feedback from local obstetrical care providers – he is not supportive of Ms. Puchala's application for appointment.

[59] On June 9, 2019, the Board denied Ms. Puchala's application.

[60] The Board heard an appeal of the application on October 23, 2019, at which time Ms. Puchala was given an opportunity to persuade the Board to reconsider its decision to deny her privileges.

[61] On November 18, 2019, the Board issued reasons for its appeal decision to uphold its June 9, 2019, decision to deny Ms. Puchala's application.

[62] Ms. Puchala filed this appeal to the HAB on February 14, 2020.

EVIDENCE AND ANALYSIS

Is there a need for a midwife in Terrace, Kitimat or Hazelton?

Obstetrics and Midwifery in the Northwest HSDA

[63] Most of the evidence respecting need focused on Terrace.

Terrace

[64] Planned birthing services are available at MMH in Terrace for low risk obstetrical care for Terrace and the immediate surrounding area, and high risk obstetrical care for communities west of Burns Lake, excluding Haida Gwaii, the Coastal Tsimshian Communities and Prince Rupert, which are served by other hospitals and health centres. Terrace has the highest concentration of specialists in the Northwest HSDA. It is used as a base to serve the whole of the Northwest HSDA and is where most of the high risk obstetrical patients in the Northwest HSDA go.

[65] Annually, there are approximately 300 deliveries in Terrace, with an average of about 220 vaginal births between 2017 and 2021.

[66] Midwifery is not part of the workforce plan for Terrace. There is no midwifery leadership at MMH.

[67] Currently, there are seven practitioners with active or provisional privileges at MMH to provide obstetrical care to the residents of the community served by MMH: four primary care physicians who provide maternity services and hold core obstetrical privileges, including one who is trained to provide caesarian sections; two obstetrician gynecologists; and one midwife. One of the physicians was recently added to the team and another physician will be joining the team in the summer of 2022. Practitioners have their own clients but also provide maternity and obstetrical services to women through the Women's Wellness Group (the "WWG"). Women may be referred to the WWG by their family physicians who do not provide obstetrical care. They may also be self-referred, particularly if they are without a family physician or "unattached".

[68] In 2020, the WWG received an award of excellence for team based rural maternity care from the Rural Coordination Centre of BC.

[69] Ms. Puchala, along with a number of local primary care physicians who do not have hospital privileges, assists the seven practitioners with hospital privileges at MMH to provide pre-natal (antepartum) care and supports in the community served by that site. Ms. Puchala also offers postpartum care to her antepartum clients, as well as supportive care upon request during labour, and stand-alone postpartum care by referral to assist with a gap in postpartum care caused by many patients being "unattached". She also receives referrals for postpartum care from physicians.

[70] Ms. Puchala's evidence was that she has provided antenatal and postnatal services to over 150 families over the past four years. She continues to get referrals, both by word of mouth and from local physicians, and her income from her midwifery practice has grown year by year. Ms. Puchala definitely sees a demand in the community for midwifery services.

[71] When Dr. VR initially met with Ms. Puchala in December 2017, he expressed concerns that a midwife practicing in Terrace was not part of the existing workforce plan and expressed concerns about how a practicing midwife would impact the existing group of doctors providing obstetrical services in Terrace. Dr. VR's evidence was that despite these concerns, he was nevertheless supportive of incorporating midwifery in Terrace as there were "expressed needs".

[72] Dr. VR's evidence was that he has requested that midwifery be incorporated into human resource planning for the next five years, but is not sure whether that will happen.

[73] Dr. F gave evidence about the challenges of ensuring capacity and capability for obstetrical care in mid-sized hospitals like Terrace where the number of deliveries make maintaining capacity and competency more tenuous. He gave evidence about the difficulty in recruiting and maintaining physicians in northern communities. His evidence was that sometimes to attract primary care physicians with interest in pursuing a practice that includes both obstetrics and other needed care such as paediatrics or emergency, it is necessary to make obstetrical exposure available to be able to recruit.

[74] In his evidence, Dr. VR expressed concerns about maintaining clinical competency as the group only does about 300 deliveries a year. He believes continuing to add practitioners will make existing practices unsustainable.

[75] Dr. VR expressed concern that if Ms. Puchala was working independently from the group as a community midwife, she would compete with the group. He said "there is always a need for midwifery" but said there were also other needs. There are many competing priorities, and most roles are filled by physicians who are general practitioners. He said Northern Health's "mantra" was to do nothing to destabilize primary care and they had to focus on longitudinal primary care. He suggested deciding whether to incorporate midwifery was not about whether midwifery was good or bad but about how it fit with all the other services. He believes there is a place for midwifery but thinks it will be difficult to incorporate without destabilizing other services. He said, "adding five more midwives might be great for antenatal care but will destabilize other programs delivered by GP's". He provided the example of the recent onboarding of two physicians wanting to provide obstetrical care that could also provide other needed services such as pediatrics and longitudinal family care. He said incorporating midwifery was imperative – it just had to be done responsibly and without destabilizing other services.

[76] In the fall of 2018, Ms. Puchala applied for and received a grant from the Rural Support Program of the Midwives Association of BC to assist with starting a midwifery practice. Ms. Puchala sought letters of support from members of the obstetrical group practicing in Terrace. Dr. VR wrote a letter in support of Ms. Puchala's application for this grant.

[77] The midwife working with the WWG, BN, started a practice in Terrace at the end of September 2019. She started conversations about privileges in the winter of 2019 and was granted provisional privileges at MMH in February 2020. BN is currently on a temporary leave of absence for an undetermined time.

[78] BN has a low volume solo practice, offering full scope care to low risk patients but does not offer home births, although she would like to do so if she had a practice partner. BN works collaboratively with the other obstetrical practitioners in Terrace backing up the low risk call group and providing primary call 24 hours one day a week. The call group covers for her when necessary. Through the WWG, BN provides postpartum care for patients without a family doctor and for self-referrals. There have been challenges with enabling BN to provide antenatal care to

patients of the WWG largely because of billing issues with MSP. The nature of BN's practice requires her to enter into an alternative practice arrangement with the College and the College has granted the necessary permission.

[79] BN would like to see more midwives practicing in Terrace and would like to have a practice partner; however, she is not interested in partnering with Ms. Puchala. She has had to turn people away from her practice and agrees there is room for another midwife to work in Terrace.

[80] Dr. G is a family physician with privileges at MMH and part of the obstetrical group. She provides antenatal care to her patients and works at the WWG. She is part of the call group providing intrapartum care. She sees her own patients for postpartum care as well as other "unattached" patients and sees mothers and babies for breast feeding consults.

[81] Dr. G's evidence was that things are working well and there is no desire for things to change.

[82] Dr. G spoke of many shortfalls in health services for women in Terrace. While she indicated support for midwifery, when asked to provide a letter of support for Ms. Puchala's application for a grant, she did not feel so strongly about midwifery that she needed to advocate for Ms. Puchala to be part of the group or that "midwifery was the one thing we should be fighting for".

[83] Dr G is unsure if she wants more midwives in the community. She said she wants midwifery, but she wants other things too. She is worried that a new family physician needs to do a certain number of deliveries to be a competent provider and that if there are multiple midwives providing care to low risk patients, then the family physicians will not be getting the patients. While there are no specific standards set for number of births to maintain competency, Dr. G believes she would need a minimum of 40 births per year. She currently does about 50 births a year. She suggested that for someone new to a practice, 2 deliveries a month would probably be the minimum.

[84] Ms. Puchala provided evidence of a petition commenced in the summer of 2018 in support of bringing midwifery services to Terrace, as well as several newspaper articles speaking to the shortage of doctors and the need for midwifery services in Terrace and surrounding communities.

[85] Ms. Puchala provided copies of numerous thank you notes from clients expressing their gratitude for her services. Some expressed the desire that she be able to provide care during labour and delivery or the desire not to have to leave Terrace to receive midwifery care in a home setting for labour and delivery. She also provided client satisfaction forms that rated her care highly and also identified the desire for intrapartum midwifery care.

[86] Midwife AS, who suggested to Ms. Puchala that she start a practice in Terrace, previously had privileges in MMH as well as at WWH. She gave up privileges at MMH in 2015 because she found it too far to travel from Hazelton. She believed that giving up her privileges in Terrace created a gap.

Kitimat

[87] Planned birthing services are available at KHHC for low risk obstetrical care for Kitimat and the immediate surrounding area. Those services are provided by seven general practitioners with core obstetrical privileges at that site including one who is trained to perform caesarian sections. All seven practitioners share in the on-call obligations of that site. These providers deliver care in shared practice arrangements, and their functional FTE is that of four practitioners. There are no midwives with privileges at KHHC.

[88] Between April 1, 2017, and May 27, 2021, the number of births in Kitimat has ranged between 47 and 57 births per year, with the number of vaginal deliveries ranging between 33 and 39.

[89] Some of the same practitioners providing obstetrical services in Terrace also provide services in Kitimat. Ms. Puchala also has clients in Kitimat. Dr. F `s evidence was that Terrace and Kitimat were closely aligned.

Hazelton

[90] WMH is a small community hospital located in Hazelton. WMH does not have the resources and infrastructure to support a birthing centre. WMH does not have local access to any practitioners trained to perform a caesarean section. A limited number of planned low-risk deliveries take place at WMH; those deliveries are facilitated by two local midwives with hospital privileges at WMH supported by local physicians as back up. Dr. F indicated that a third midwife would be added soon.

[91] As there are often difficulties securing sufficient trained nursing staff to support planned low-risk deliveries at WMH, patients are commonly diverted to the Bulkley Valley District Hospital ("BVDH") in Smithers, which is the designated birthing centre for patients from Hazleton. Patients needing a caesarian section go to Smithers, but high risk obstetrical patients go to Terrace.

[92] AS was one of the midwives practising in Hazelton until 2020. Her evidence was that the two midwives did about 35-40 births a year between them. The midwives in Hazelton are paid through a contract with Northern Health. AS's evidence was that without this contract providing financial support, it would not be financially sustainable for two midwives to practice in Hazelton.

[93] BA is a solo midwife practicing in Smithers. She has about 40 to 50 clients and in the past year received 75 requests for midwifery care. She takes clients from as far away to the west as Prince Rupert, Kitimat, and Terrace, as well as clients from Burns Lake. She is not able to accommodate all the requests she receives for midwifery care. AP has shared clients with Ms. Puchala, where Ms. Puchala provides the antenatal care, the patient goes to Smithers for the birth, and then returns to Terrace to receive postpartum care from Ms. Puchala.

Findings Regarding Need

[94] We are satisfied that there is a need for a midwife with a full scope practice in Terrace and Kitimat. Hazelton is well served by midwives whereas there is no midwife with a full scope midwifery practice in either Terrace or Kitimat. Even when

BN is practicing in Terrace, her practice does not provide women with choice of birthplace.

[95] The fact that there was no posting when Ms. Puchala originally applied and that there is no current posting for a midwife is not indicative that there was or is no need. We heard evidence that the "normal" privileging process is often not followed with midwives. Midwives throughout the province, and particularly in smaller communities, have had to apply in the absence of postings and convince hospital administration of the need for their services.

[96] Dr. F and Dr. VR acknowledged the need for midwifery and have expressed support for its incorporation. We find their hesitancy with incorporating midwifery into Terrace has more to do with concern about its impact on the existing practitioners than on the lack of need for midwifery service.

[97] Dr. VR was originally supportive of granting Ms. Puchala privileges and Dr. F was initially willing to support her privileges. When Dr. F spoke with Ms. Puchala on January 29, 2019, he advised her that he had presented her application to the Committee and that her privileges would be in place "by the weekend". His willingness at the time to proceed with her application demonstrates a recognition and acceptance of the need to have a midwife practicing in Terrace.

[98] The Board did not deny Ms. Puchala's privileges on the basis that there was no need for midwifery services.

[99] The subsequent privileging of BN also demonstrates an acceptance of the need for midwifery services. The presence of BN in the practice group, however, does not fully meet the need for full scope midwifery services, and BN has limited her practice so as not to offer home births. Women who chose a home birth must still leave their home communities of Terrace or Kitimat for that service.

[100] The fact that Ms. Puchala's practice is growing and that some of her patients seek intrapartum care from midwives outside of Terrace also demonstrates need for full scope midwifery services in Terrace.

[101] We are not satisfied that privileging a midwife will significantly negatively impact the practices of the other practitioners currently providing low risk obstetrical services in Terrace. It is possible that the physicians and the midwife currently providing service to low risk patients in Terrace will perform fewer deliveries, but we are not satisfied that the addition of a midwife will reduce the numbers of deliveries by the other practitioners so as to make their practices unsustainable. An average of approximately 220 vaginal deliveries a year, allows seven practitioners approximately 30 births annually, the number Ms. Puchala and Dr. G agreed was reasonable to maintain skills and competency. Of the seven practitioners currently practicing in Terrace, three handle higher risk deliveries and caesarian sections. The majority of the low risk vaginal births are handled by 4 practitioners. Women who now have to leave Terrace to birth outside the community with the services of a midwife would be able to give birth in Terrace increasing the number of births annually in Terrace.

[102] Not all women will want midwifery care, and not all women will have an appropriate risk profile for midwifery care, in particular during labour and delivery. The physicians practicing in the obstetrical group will still serve the higher risk

patients and those low risk patients who do not choose midwifery care, and will still be required to consult as necessary.

[103] We acknowledge the challenges Northern Health has in recruiting and retaining physicians and the desire to accommodate physicians wanting a maternity practice when they bring other needed skills to the community, and we acknowledge that sometimes choices have to be made to ensure needed services are available even at the expense of other needed services. We do not accept, however, that adding a midwife to the obstetrical practitioners in Terrace or Kitimat will have the effect of making the physicians' practices unsustainable.

[104] Saying we have enough practitioners providing intrapartum care fails to understand that midwifery, while also providing intrapartum care, offers a different model of care. Limiting intrapartum care in a community to that provided by physicians fails to meet the needs of many women for the alternative model of care offered by midwives.

[105] We note that most of the midwives with privileges in the Northwest NSDA are practicing in communities that are not well served by physicians providing maternity care, such as Hazelton and Haida Gwaii. Northern Health clearly supports the incorporation of midwives into Medical Staff where obstetrical needs are not being met by physicians. Despite its stated support for midwifery, Northern Health seems less enthusiastic to incorporate midwifery into communities where obstetrical care is being provided by physicians for fear of the impact midwifery will have on the practices of those physicians. The lack of midwifery leadership in Northern Health enables physician dominance of the practice setting.

[106] Privileging midwives ought not to be a competition between midwives and physicians. Decisions about privileging midwives are not about whether one or another model of care is "better" for expectant mothers. Decisions about privileging midwives, however, must recognize that midwives offer a different model of care and options to women that are not generally available to women accessing obstetrical services from a physician. The fact that intrapartum services are being provided by physicians does not obviate the need for expectant mothers to be able to choose, if they want and if it is appropriate, the alternative model of care provided by midwives. Nor will the provision of midwifery care obviate the need for women to be able to access the care that is provided by physicians whether by choice, the level of risk involved with their pregnancy, or unforeseen emergency circumstances associated with the labour and birth requiring the attendance of a physician.

[107] We are satisfied that the preponderance of evidence supports the need for a midwife to have privileges at MMH and KHHC.

Is the Appellant an appropriate candidate for midwifery privileges in Terrace and Kitimat?

[108] There has never been an issue with Ms. Puchala's skills or competence as a midwife. Her practice was limited by the College because she did not have privileges, not because she was not competent to provide intrapartum services. If her privileges had been granted earlier, the restrictions on Ms. Puchala's license would have been removed.

[109] Now, because of the length of time that has passed since Ms. Puchala last provided intrapartum services, Ms. Puchala will need to undergo a period of supervision for the College to be satisfied she continues to have the requisite skills.

[110] Northern Health says Ms. Puchala is not a good "fit" with the existing group of obstetrical practitioners. Whether Ms. Puchala will be a good fit or, using the terminology in the Rules, has the appropriate "personal qualities to practice effectively" in a facility or community cluster is a difficult question.

[111] Ms. Puchala's privileges were denied because of negative references and a concern that she would "upset the existing cohesiveness" of the group and consequently have an adverse impact on patient care. The Board accepted the evidence before it that Ms. Puchala's references were unfavourable and that the existing group had provided feedback that she would not be a good fit. We heard evidence from Dr. F and Dr. VR with respect to the reference checking process and their perceptions of what the references said. We also heard evidence from the referees themselves with respect to what they said and their perceptions of their participation in the verbal reference process. As we are sitting in the shoes of the Board, we may review and consider all of the evidence now available to us respecting Ms. Puchala's fit and personal qualities.

The Written References

[112] As previously indicated, Ms. Puchala provided contact information for three references. Each of those referees completed a written reference form and returned the completed forms directly to Northern Health. The written reference form asks the referee to provide information about the referee's working relationship with the candidate then asks the referee to provide an evaluation of the candidate, on a scale from "Never" to Always", with respect to a lengthy list of criteria including performing clinical skills competently, exhibiting reliable behaviour, exhibiting professional and ethical practice, demonstrating effective interpersonal communication skills, demonstrating patient centered care, and accepting responsibility. The form then asks the referee to provide commentary on particular matters. Ultimately, the referee is asked to check a box indicating whether they would: recommend the applicant "highly and without reservation"; recommend the applicant "as qualified and competent"; recommend the applicant "but with some reservation"; or not recommend the applicant.

[113] The written reference completed by SM is dated March 20, 2018. SM is a midwife practicing in Brampton and Georgetown. Ms. Puchala was a student in SM's practice and then did a locum with the practice in 2016.

[114] SM provided an "Always" rating for all the listed criteria she was able to rate. Commentary includes a note that SM's experience was over a six month period and that Ms. Puchala "would have been invited to stay with our group longer if we were in a position to offer a permanent position." SM recommended Ms. Puchala as qualified and competent.

[115] The written reference completed by GY is dated April 3, 2018. GY is the Chief obstetrician gynecologist at Collingwood Hospital. Ms. Puchala worked in the midwifery program in Collingwood for just over two years following her graduation in 2013.

[116] GY provided an "Always" rating for all the listed criteria she was able to rate. Commentary includes the notes, "Communication is a strength" and "No concerns about the ability to practice midwifery in a low risk setting." GY recommended Ms. Puchala highly and without reservation.

[117] The written reference completed by BG is dated April 15, 2018. BG is an obstetrician gynecologist working in Yellowknife. He consults with the midwifery group in Hay River. Ms. Puchala did two locum stints in Hay River in 2017.

[118] BG provided an "Always" rating for all the listed criteria he was able to rate. Commentary includes the notes, "Excellent midwife, a pleasure to work with!" and "Worked well and does well in a collaborative collegial environment". BG recommended Ms. Puchala highly and without reservation.

The Verbal Reference Process

[119] As indicated earlier, it was not until after Dr. F's meeting with Ms. Puchala on January 29, 2019, where he told Ms. Puchala her privileges would be in place "before the weekend", that Dr. F conducted verbal reference checks with the three references provided by Ms. Puchala.

[120] Dr. F could not recall why he did not contact Ms. Puchala's references for a verbal check in 2018. He indicated that at that stage there was still preliminary work to be done about how to recruit, that none of the process had been followed, they were "trying to come to terms with what was happening", what engagement had been like and trying to have members of the obstetrical practice group sign a Memorandum of Understanding ("MOU"). He said he did not have approval to complete the process without a "green light from the team", there was no service model in place, and that they were "blindsided" and trying to come to terms with where they were and "wanting to proceed with due process and caution". It was not until the end of the process that they realized they still had to do verbal reference checks and that they could not skip that step. He acknowledged it was "something that should have happened at the beginning but was now happening at the end".

[121] Dr. F described medical reference checking as "one of the most important components of recruiting any practitioner". He indicated reference checks were vital to learning about work history, competency, weaknesses, psychological concerns, and anything about fitting into a team. His evidence was "nothing is not open to discussion". If there is any doubt, more scrutiny needs to be applied and more references checked. He said the process is applied consistently "without exception" and is well documented for every practitioner.

[122] Members of Northern Health do not receive any training in conducting verbal reference checks. The person conducting a verbal reference check completes a Verbal Reference Check Form that provides space for free form comments, two check boxes: "Recommended by Referee" and "Not Recommended by Referee", and places for the signature of the "Medical Leader Who Telephoned the Reference" and the date.

[123] Dr. F's practice when checking references is to describe the position and the environment to try and find out if the candidate, typically a physician, can function independently – "how will he fit in?" – "how will he cooperate and collaborate?". He

asks the referee what they can tell him about the candidate, lets them talk, and follows up from what information is offered. He asks whether the referee would hire this candidate again and asks about how well the candidate fit into their team.

[124] Dr. F spoke about the importance of confidentiality in the reference checking process indicating referees may not speak frankly if they think what they say can be scrutinized or be subject to subpoena or sanction.

[125] Dr. F reiterated that he cannot defend an application if reference checking discloses a concern.

The Verbal References

[126] Dr. F was initially confused about which of Ms. Puchala's references he had contacted, and which Dr. VR had contacted, and which reference had been contacted first. He initially testified to contacting GY and to Dr. VR contacting SM but later corrected his testimony and said he had contacted SM first, then asked Dr. VR to contact GY. They both contacted BG.

[127] After conducting the first verbal reference check Dr. F asked for Dr. VR's assistance with the next check. His evidence was after the first verbal reference check he was concerned about "red flags". He told Dr. VR he had received a negative reference and that he did not feel comfortable doing the next reference check in case of unconscious bias. He felt he needed someone else who could do the reference check with a clear mind.

[128] Dr F. spoke with SM for a verbal reference. The Verbal Reference Form is dated February 14, 2019. Dr. F completed and signed Northern Health's Verbal Reference Check form and checked the box "Not Recommended by Referee". The comments read:

- [S] didn't work with Katherine in a large team and didn't feel she could meaningful [*sic*] comment.
- Didn't hear about specific competency issues.
- [S] felt Katherine [*sic*] collaboration could've been better evaluated if she was a permanent midwife in their group.
- When asked if there was a group of midwives to select from, if Katherine would be their first pick, she said no.

[129] Dr. F's evidence is that he wrote those free form comments.

[130] When she testified before us, SM's evidence was that Dr. F seemed to put a fair bit of emphasis on fit, leaning a bit more to personality than competency. She said she told him she had heard no complaints and had no concerns about Ms. Puchala's fit in her practice, and that she did not have a social relationship with Ms. Puchala. She said Dr. F asked if she had any reservations and she said "no". SM's evidence was that she felt Dr. F was trying to get at something she could not answer, and she felt uncomfortable at the end of the interview.

[131] SM's evidence was that she felt Dr. F had a bias against Ms. Puchala. SM's evidence was that when Dr. F asked her if she would hire Ms. Puchala if she applied tomorrow, her answer was, "If the time was right, we would." When Dr. F pushed

for "tomorrow" she said, "that's not how it works", that their case load was full, and they can't take on another midwife. If we could take on another midwife, they would review it at the time. Her evidence was that she "certainly did not say 'no' we would not consider hiring [Ms. Puchala] again".

[132] When asked about how Ms. Puchala worked in the team, SM said she was always present when expected to be, she attended meetings when she was off, she contributed, she worked beyond what was expected of a locum, was approachable and came when called for backup.

[133] With respect to the third bullet in the comments on the Verbal Reference Form completed by Dr. F, SM said she was not sure what Dr. F meant by that comment. She said he kept referring to a good fit and involvement on hospital committees. She stated that Ms. Puchala attended meetings she was expected to attend and joining committees was not expected of locums. He asked about getting along with obstetricians and she said she had never heard of any problems – "obviously, the longer someone is with you, the longer you have to get to know them".

[134] With respect to the last bullet, SM stated that is not what she said. The comment that she was not the first pick was not what she was asked and was not her response. She said she was concerned that if Ms. Puchala applied tomorrow, she could not give her a job because there was no job to give. She said, "I should have just said yes, because that's what I felt."

[135] When asked if she would hire Ms. Puchala tomorrow, SM's answer was "Yes, we have spots" and she "wouldn't hesitate".

[136] Dr. VR spoke with GY. The Verbal Reference Form is dated February 28, 2019, but we find the actual call did not take place on that date. By email dated February 6, 2019, Dr. F's assistant asked Ms. Puchala to have GY contact Dr. F. By email dated February 18, 2019, Ms. Puchala asked for a progress report and advised that GY had let her know that she had connected by text message with Dr. F to set up a reference call. Dr. F responded on February 19 that he had connected with GY and one of her other references but was having trouble connecting with the third reference. It is likely that Dr. VR's conversation with GY occurred sometime between February 14 and February 19, 2019.

[137] While Dr. VR spoke with GY, he did not complete the Verbal Reference Form. Dr. F completed and signed the Verbal Reference Form and checked the box "Not Recommended by Referee". The comments read:

- Worked with Katherine in a group setting with a large number of midwives and did express concerns about collaboration and working in a group setting when I referenced the group composition at MMH.
- Emphasized her ability to practice midwifery in a low risk setting.
- Had concerns about consistency of referrals.
- When asked – [G] said she would not hire Katherine as part of their group again
- Stated that she was relieved to see her leave

[138] Dr. F's evidence was that he wrote the comments after a discussion with Dr. VR and that they are an accurate reflection of what Dr. VR communicated to him.

[139] Dr. VR's evidence respecting the telephone call with GY is that he introduced himself, explained the reason for the call, asked about the role that the applicant played in their facility, briefly sketched the practice in Terrace, expressed thanks for the written reference and asked if there were any questions or comments they did not elaborate on or any concerns about the applicant functioning in the described role. The "sketch" was that it was a new service for Terrace working with a primary care group with an expectation to work closely and provide appropriate referrals for high risk patients. Dr. VR said of his conversation with GY that this was the only time he has asked a referee if they would hire again, they have responded "no".

[140] In a letter dated May 22, 2019, to the Committee, Dr. VR wrote about his involvement with checking references and the result as follows:

> I personally phoned one of the references and was present when Dr. [F] spoke to another referee. The reference check performed by myself was certainly not positive. In reply to the question whether they would hire Ms. Puchala again in future, the answer was NO.
>
> The referee also mentioned that she feels terrible because she knows that Ms. Puchala would expect a positive reference and that she felt this was indicative of a lack of insight.
>
> As Chief of Staff I cannot in good conscience support privileges for a candidate with neutral or negative references – the stakes are simply too high.

[141] As to her conversation with Dr. VR, GY remembered talking about impacts of midwifery care on a small hospital. She recalls being told they did not have midwifery at the hospital at the time and they spent a long time talking about her experience of how the introduction of midwives impacted the physicians' ability to care for babies. She said most of the conversation was about obstetrics and midwifery in general and not Ms. Puchala in particular.

[142] With respect to the first bullet in the comments on the Verbal Reference Form, GY did not recall expressing concerns about Ms. Puchala's ability to collaborate or work in a group setting.

[143] With respect to the second bullet, GY said midwifery is for low risk patients and she did not recall Ms. Puchala not being able to take care of low risk patients.

[144] With respect to the third bullet, GY said sometimes Ms. Puchala "did stuff" then would call to let them know. Other midwives called earlier. She said that was "not bad", but that is how she felt about Ms. Puchala's practice.

[145] With respect to the fourth bullet, she said she did not recall being asked if she would hire Ms. Puchala. She didn't have the ability to hire Ms. Puchala; she approved privileges. When asked if she would grant privileges, GY said she "would not say no".

[146] With respect to the fifth bullet of the comments, GY said she could not recall making that statement. She remarked that "the people who call you at the last minute are more stressful than those that call early, but I wouldn't say I was

relieved". When asked if she was relieved when any midwife left, she responded that there were some things she really liked about midwifery and some things that "drove her crazy" and "make it a challenge to practice". She expressed that one of the reasons she came to the hospital where she practices is because initially there were no midwives.

[147] Dr. F conducted a verbal reference check with BG in the presence of his assistant and Dr. VR on February 28, 2019. Neither of the recommendation boxes is checked, but a check mark appears in between the two boxes. The comments read:

- Didn't work side by side in a clinical team but took calls from Katherine regarding patients. The calls seemed appropriate but couldn't see the clinical outcome as he was not onsite.
- No comment on the level of collegiality of her practice.
- When asked if he would hire her as part of his team he didn't commit himself.
- Not aware of any red flags but doesn't have any specific comments.
- Cannot assess collaboration.
- Overall impression – neutral with limited onsite working relationship.

[148] Dr. F's evidence was that the comments reflect the collective notes of him, his assistant and Dr. VR, and that the comments are in accord with the discussion. He said the check mark indicated the referee did not commit one way or the other. Dr. F's evidence was BG did not provide a firm recommendation, but they did not feel comfortable assigning a negative assessment. Their impression was it was a neutral opinion.

[149] BG gave evidence about his conversation with Dr. F. He was not aware that Dr. VR and Dr. F's assistant were also present. He said Dr. F reviewed the written reference form he had completed, and he stood by what he had written.

[150] BG recalled being told that Ms. Puchala had applied for a midwifery position in Terrace, and that he had the sense it would be new and that they were trying to develop a collaborative practice. BG thought Ms. Puchala would be a good person to do that.

[151] BG told Dr. F. that Ms. Puchala was a good, competent midwife and he had no problems working with her. He remembers trying to paint Ms. Puchala in a very positive light. He remembers being asked about problems with staff and that he told Dr. F he had never noticed that Ms. Puchala had any problems with staff.

[152] BG was surprised by Dr. F's concern about Ms. Puchala getting on with people and he remembers after the telephone conversation with Dr. F going back to the midwives who worked in Hay River and asking them if they had any concerns. They said they had not had any concerns working with Ms. Puchala.

[153] BG was surprised by the comments on the Verbal Reference Form. His evidence was that he thought he had described Ms. Puchala's work as excellent and he would not hesitate in having her come back. He agreed that he did not strictly work side by side with Ms. Puchala but there was enough telephone communication that he could tell she had a good understanding, asked the right questions, and followed advice. He said he would have been aware of any poor clinical outcomes

and there weren't any. He said that at meetings, they discussed recent deliveries and he thought he had made it clear in his conversation with Dr. F that Ms. Puchala was collegial and would discuss patients in a positive manner. He said he didn't know where Dr. F got the idea he wouldn't hire Ms. Puchala, that there were no red flags that gave him concern, and that he was surprised that his reference would be characterized as neutral.

[154] BG recalled being asked by Dr. F if he would hire Ms. Puchala again and he said he would. He has asked Ms. Puchala if she would consider returning to Hay River and would ask her again.

Group Feedback

[155] Dr. F's evidence was that after completing the verbal references, he asked Dr. VR to find out how other members of the obstetrics team had experienced interactions with Ms. Puchala to that point. He said he needed to see if the group experience was congruent with the references. Dr. F's evidence was that Dr. VR reported to him that the group without exception were not favourable about their professional interactions with Ms. Puchala and did not feel positive about collaboration with her.

[156] Dr. VR's evidence was that after the verbal reference checks Dr. F sought some feedback from the physician group. Dr. VR was involved in obtaining the feedback. His evidence was the group was supportive of incorporating midwifery. He described the feedback question as "because the reference checks were not positive, did we want to continue onboarding Ms. Puchala?" His evidence was "there were enough red flags that the rest of the group felt we should not proceed" and that Ms. Puchala "would not be a good fit". He said the feedback was not written down, but the "overall sense" was that people were "not comfortable with their interactions" with Ms. Puchala. He said when there is a red flag it makes it difficult to proceed and that was the sense from the group; they didn't feel comfortable continuing to support the application.

[157] Dr. VR did not provide evidence of any specific feedback relating to any particular interaction causing concern, nor did he provide any detail as to what the "red flags" were.

[158] In his May 22, 2019 letter to the Committee, Dr. VR says his letter of support for the grant Ms. Puchala applied for "should not be misrepresented as a recommendation to approve privileges" as it had transpired before he had the opportunity to speak to her referees. The letter confirms that in his first meeting with Ms. Puchala in January 2018 he had committed to be supportive of incorporating midwifery into a collaborative practice although he thought it might be challenging "given the fragile state of provision of care that is dependent on a small group of practitioners".

[159] In his letter, Dr. VR referred to "several red flags" during the course of the year that indicated that Ms. Puchala was "not an appropriate choice to achieve this goal of collaborative care". Again, the letter does not elaborate as to what the "red flags" were.

The Practitioners' current views on "fit"

[160] Dr. F expressed concern that the obstetrical team in Terrace would disband if Ms. Puchala obtained privileges through this appeal process. He said the team had expressed concerns about collaboration and trust. Dr. F thought privileging Ms. Puchala would have implications for currency of competency for other obstetrical care providers. He indicated adding another midwife into the team at this point "will tip the fine balance of this high functioning award winning team". He believes Ms. Puchala will not fit in this group. He described the group as "robust on the one hand and fragile in the other" and is worried the team will break down. He described the group as "a vital care delivery group" that "is cohesive and functioning" and "a cohesive intimate team". He said, "threatening this group is incomprehensible" and said he is "very concerned about preservation of this highly functioning health ecosystem."

[161] Dr. F's evidence was that upon learning Ms. Puchala had recorded the meetings he did not feel respected or trusted by Ms. Puchala. He said he sometimes records meetings, but always declares when he is doing so and makes a transcription available. Now that he knows about the recordings, he sees them as part of a larger body of concerns. To Dr. F, the recordings are congruent with other behaviours and the opinions of the group and contribute to the body of evidence that makes him anxious about recommending privileges for Ms. Puchala.

[162] Dr. F also expressed that he found the fact that Ms. Puchala had contacted her references after the fact concerning.

[163] Of the current members of the obstetrical team, we heard evidence about Ms. Puchala's "fit" from Dr. VR, Dr G., and BN.

[164] Dr. VR feels that Ms. Puchala's recording of the meeting of April 29, 2019, signifies a "complete lack of trust". He said it is impossible to provide good care if you do not trust the team members. He believes that Ms. Puchala is distrustful of him, and he doesn't know whether he can trust her as a colleague. He indicated that as obstetricians can sometimes become involved at the last minute in an emergency situation, they can feel like they are being set up for failure before they even start if there is lack of trust.

[165] Dr. VR. does not think it will work trying to integrate Ms. Puchala into the existing group because there has been "such a breakdown in trust". He is worried patients will get "caught in the middle".

[166] Dr. G gave evidence that she thought there was an unhealthy dialogue in the community pitting midwifes and doctors against each other. She suspects Ms. Puchala was contributing to this dialogue although she had no specific evidence of such contribution. She said she had to leave a maternity care discussion group because of the dialogue where midwives expressed they were being "witch hunted". She said she didn't know where the "splitting narrative" was coming from, but it was "exhausting and hurtful". The maternity care discussion group is not specific to Terrace.

[167] Dr. G gave evidence about conversations with nurses in emergency that expressed favour for midwifery care and in her view contributed to the splitting narrative.

[168] Dr. G said she was initially supportive of Ms. Puchala starting a practice in Terrace, but that support changed because of the divisive narrative that she was hearing and because of certain interactions. Dr. G gave an example of having been asked by Ms. Puchala to release a tongue tie on a newborn. Although she was still on holiday, she agreed to see the patient. She perceived that the mother did not want to see her. A few days later, a newspaper article appeared in the Terrace newspaper about Ms. Puchala being denied privileges. The mother and baby that Dr. G had just seen were featured in the article and the mother expressed her support for midwifery. Dr. G expressed feeling unappreciated.

[169] Dr. G's concerns about having Ms. Puchala being appointed to the Medical Staff at MMH are about her not being a positive and supportive colleague. While she said she doesn't "need everyone to be chipper all the time", it is a "small community with a small and fragile group of people who work hard to provide services".

[170] Dr. G agreed she and Ms. Puchala had worked collaboratively and collegially but indicated the relationship had broken down more recently. When Ms. Puchala was denied privileges in April 2019, Dr. G reached out with a text message to express how sorry she was for how things were working out and to offer "strength and positivity". Administration at Northern Health asked her not to communicate further with Ms. Puchala about the privileging process.

[171] BN gave evidence that Ms. Puchala came to her house when she was looking for pre-natal care. BN did not feel confident in Ms. Puchala's ability to get privileges before it was time for her to give birth. She was uncomfortable with Ms. Puchala's expressed confidence and determination to obtain privileges and with language used by Ms. Puchala in expressing her confidence and determination. Her evidence was that she always left conversations with Ms. Puchala feeling confused and that they each came away with different understandings of what had been said.

[172] Ms. Puchala's recollection of her first meeting with BN was different. Her evidence was BN had reached out to AS who had passed her information on to Ms. Puchala indicating BN had an appointment with the clinic and was not sure what she wanted to do. On the day they were to meet, Ms. Puchala received a message from BN saying she was not going to stay in the community to birth and didn't want to waste Ms. Puchala's time. Ms. Puchala responded that she wanted to meet her anyway, and that she met BN at her house, not as a potential client but as a midwifery colleague. Ms. Puchala does not recall expressing the strong feelings or using the language recollected by BN.

[173] BN's evidence was that she would not feel comfortable working with Ms. Puchala and that Ms. Puchala would not be a good fit with the group. She said it is essential to have good communication and a level of trust with practice partners and she did not perceive that in her relationship with Ms. Puchala.

[174] BN said she had received "hostile referrals" and late referrals from Ms. Puchala and that she did not receive referrals from public health. She had heard that public health was recommending patients would be better off with Ms. Puchala and was feeling undermined by Ms. Puchala. She said it breaks down trust when you don't know what is being said about you.

[175] BN expressed concern about Ms. Puchala's ability to communicate and does not see Ms. Puchala as being a good fit for her as a midwifery partner.

[176] Ms. Puchala's evidence was that she and BN stayed in touch and BN contacted her periodically inquiring about the privileging process. When Ms. Puchala applied for the rural program grant, she asked BN if she would be willing to serve as a second midwife for home births and BN said she would. BN's evidence was she did not remember making a commitment to supporting Ms. Puchala with home births. She does recall sharing with Ms. Puchala that families were excited about midwives in the community. She agreed that when Ms. Puchala reached out by text she generally responded and that she did her best to remain collegial although she did not always feel comfortable with the relationship.

[177] Ms. Puchala's evidence was that over time, BN became more reluctant to talk about her plans about whether she wanted to practice midwifery in Terrace and that she encouraged BN to do so. Both BN and Ms. Puchala spoke to the fact that the rural start up grant was not available to BN because it had already been received by Ms. Puchala.

[178] Ms. Puchala indicated that she was hearing for the first time during the hearing how much her relationship with BN had deteriorated.

[179] According to Ms. Puchala, BN has referred a client to her since taking her leave of absence.

[180] AS, the midwife who practiced in Hazelton with privileges at WWH from 2013 to 2020, gave evidence that when Ms. Puchala first moved to BC she worked with AS in Hazelton providing back up for home births. AS thought that she and Ms. Puchala worked well together and had no concerns about their interactions or with Ms. Puchala's interactions with patients.

[181] BA, the midwife in Smithers who has shared clients with Ms. Puchala, said she was pleased working with Ms. Puchala and that the clients also indicated pleasure. The transitions worked well, although the clients would have preferred to stay in Terrace. Her work with Ms. Puchala has been collegial and professional and she sees them being able to continue to work collaboratively.

Findings Regarding Fit

[182] Generally speaking, we are not comfortable with using a vague notion of "fit" to deny someone's privileges since the term "fit" is highly subjective. It can be used to make decisions based on personality traits or personal characteristics that are not important to the role. Ideally, organizations would objectively define in advance the aspects of fit that are important for the position. Some organizations provide training for committees to avoid unconscious bias in recruitment. Without discussion to identify important aspects of fit for the role, there is a risk of discrimination and bias.

[183] To deny someone's privileges on the basis of fit, there must be clear and convincing evidence that the person will not integrate well into a group of practitioners or work collaboratively with that group, or that a person's integration is likely to cause patient harm.

[184] It is difficult to reconcile all the conflicting evidence we heard respecting Ms. Puchala's "fit". Having considered the conflicting evidence, we find the evidence is not clear and convincing that Ms. Puchala will not be able to work collaboratively with the obstetrical practitioners providing care in Terrace and Kitimat.

[185] With respect to the conflicting evidence surrounding the verbal reference checks, we find the evidence provided by the referees themselves as to what they said in their respective interviews to be more compelling than the notes on the verbal reference check forms. We do not accept that the referees provided the negative references attributed to them.

[186] Northern Health submitted that we should give greater weight to the notes on the Verbal Reference Check Forms, however, we find there are several inconsistencies and incongruencies in the evidence of Northern Health respecting the reference checking process that we find make their evidence as a whole less reliable. Dr. F described the verbal reference checking process as "one of the most important components of recruiting any practitioner" and yet somehow that process got overlooked until after Dr. F told Ms. Puchala her privileges would be in place before the weekend. Dr. F was confused as to which reference he even spoke with that initially raised the "red flags" causing him to be concerned about Ms. Puchala's fit. After he spoke with the first reference, he asked Dr. VR to assist to avoid bias. But having told Dr. VR that the first reference was negative, creates the possibility of bias when Dr. VR then conducts a reference check.

[187] While Dr. VR conducted the verbal reference check with GY, he did not complete the Verbal Reference Check Form. The form was completed by Dr. F. Further, the evidence indicates that GY's verbal reference check took place between February 14 and 18, 2019, yet the form is dated February 28, 2019. The fact that the Verbal Reference Check Form was not completed by the individual who conducted the verbal reference check nor completed contemporaneously with the verbal reference check makes it an unreliable account of what transpired during the interview.

[188] We accept each of the three references versions of their conversations over Dr. F or Dr. VR's versions. While GY expressed some reservations to us about Ms. Puchala "calling late", she did not express any concerns about her "fit" or her ability to work collaboratively in a group. She gave no evidence of adverse outcomes as a result of poor collaboration on the part of Ms. Puchala. Both SM and BG's evidence was that Ms. Puchala consulted as appropriate and there were no issues with her working collaboratively in a group. Both BG and SM reported that they felt uncomfortable with Dr. F's questions regarding fit and wondered why so much attention was being placed on it and whether questions were being directed to a specific outcome.

[189] The concerns expressed about Ms. Puchala's "fit" are generally vague and without specifics. Both Dr. F and Dr. VR talked about "red flags" but neither provided any examples of behaviour or interactions that would raise a "red flag". Apparently, the entire group "without exception" provided Dr. VR with negative feedback about their interactions with Ms. Puchala, yet those conversations are undocumented and no specific examples of negative feedback were provided.

[190] We are also not convinced that Dr. F's request that Dr. VR elicit feedback from the group was anything more than an exercise in trying to support the conclusion they had already made that they did not think Ms. Puchala would fit with the group. Dr. VR described the feedback question as "because the reference checks were not positive, did we want to continue onboarding Ms. Puchala?". Advising the group that the reference checks were not positive was not likely going to elicit positive feedback.

[191] Other than Dr. VR, we only heard from two other members of the obstetrical group, namely Dr. G and BN. We did not hear from the other members of the obstetrical group who have been working in Terrace and who have interacted with Ms. Puchala. Ms. Puchala gave evidence that she has referred patients to Dr. S, Dr. G, and Dr. P. From Ms. Puchala's perspective, Dr. S has been a supportive consultant and they have a good collegial relationship. We heard no evidence from either Dr. S or Dr. P that their interactions with Ms. Puchala were not collegial, professional, or otherwise not in the best interest of patients.

[192] We are having trouble understanding how the less than positive interaction Dr. G spoke of in attending to a tongue tie for one of Ms. Puchala's patients provides sufficient concern for lack of fit. The patient's mother seemed unhappy to have to see Dr. G. Why that unhappiness was blamed on Ms. Puchala is not clear to us.

[193] There is no direct evidence to support the feeling or suspicion that Dr. G spoke about of Ms. Puchala contributing to divisiveness in the community pitting doctors and midwives against each other. The online maternity care discussion group where Dr. G experienced discussion pitting doctors and midwives against each other is not specific to Terrace and there is no evidence that Ms. Puchala was contributing in a negative way to that dialogue. On the other hand, the text messages between Dr. G and Ms. Puchala between 2017 and 2020 demonstrate collegiality and collaboration in seeking appropriate care for patients.

[194] Dr. VR and Dr. G expressed concerns about not knowing who was labouring in a community and then being asked to provide backup. But it is not clear from the evidence why they felt that would be so, even if Ms. Puchala practiced as a midwife independent of the obstetrical group. Midwives are required by the standards of practice established by the College to consult and collaborate to ensure appropriate care for their patients. In the absence of specific evidence to demonstrate that Ms. Puchala is either incapable of following the standards of her College or unwilling to follow them, of which there is no such evidence, fears about who would be labouring reflect a lack of trust in midwifery as a profession that are unfounded and ought not to be used to suggest Ms. Puchala will not fit with the group providing obstetrical care.

[195] There is no direct evidence to support BN's feeling that she was being undermined by Ms. Puchala and that public health nurses were recommending Ms. Puchala over her.

[196] We accept that BN and Ms. Puchala may have had difficulty communicating with each other. Ms. Puchala seemed unaware of the extent of BN's discomfort with their interactions. BN did not provide any specific examples however of clinical collaboration, acknowledging she did not work with Ms. Puchala. Ms. Puchala may

very well have to work on her communication skills in non-clinical settings. BN may not want Ms. Puchala as a midwifery practice partner – but that is not the position that Ms. Puchala is seeking. In any event, professionals that have to work collaboratively in a professional environment do not need to be friends as well.

[197] There is no direct evidence that Ms. Puchala is not able to work collegially and collaboratively in a clinical setting or that her communication skills in any way hampered working relationships or patient care. Quite to the contrary, the evidence from those that have actually worked with Ms. Puchala is that there were no issues with collaboration or communication. Further, the professionalism of the members of the obstetrical team should ensure that patient needs are addressed despite other interests or differences.

[198] The negative feedback relayed by Dr. VR from the group is not only hearsay but provides no specifics or examples of inability to collaborate or where collaboration actually caused harm. Without these examples we are left with the impression that the negative feedback from the group was more about personality and a concern for how their practices would be impacted than about any real experience with lack of collaboration.

[199] The constant use of the terminology "red flags" with no specifics as to the behaviour or interactions that caused "red flags" to be raised does not provide convincing evidence of lack of fit.

[200] Dr. F and Dr. VR also expressed concern that Ms. Puchala contacted her referees after being told she would not be recommended for privileges because of unfavourable references. GY acknowledged it was the first time she had ever been contacted by a reference after the fact. Neither SM nor BG seemed concerned by having been contacted.

[201] Ms. Puchala found herself in a precarious position. The references were the most senior people at each of the organizations with which she had previously worked. There is no doubt Ms. Puchala was expecting good references from them and she must have been concerned about how she would advance her career as a midwife if they had concerns about her performance. She asked each of her references if they would be open to sharing their thoughts and feedback to enable her to make improvements. There was certainly no obligation on any of the three references to respond. Ms. Puchala did not interfere with the reference checking process itself.

[202] Although contacting referees after the fact may be unusual, we do not think it was inappropriate in this case or raises significant concerns about Ms. Puchala's professionalism. How else was Ms. Puchala to move forward to establish herself as a midwife if she was not aware of concerns so that they could be addressed?

[203] Much was said about Ms. Puchala recording the meetings of January 29 and April 8, 2019, without revealing to those participating that she was doing so. The revelation that Ms. Puchala recorded those meetings has certainly further fuelled both Dr. F and Dr. VR's views that Ms. Puchala will not fit with the obstetrical group in Terrace.

[204] The Incident was an unfortunate intervening event and the length of time the College took to deal with Dr. F's complaint was also unfortunate and unhelpful to

Ms. Puchala's application. We do not fault Dr. F for either lodging the complaint or for suspending the privileging process while the complaint was outstanding. But we understand how these actions contributed to Ms. Puchala feeling unsupported. Dr. F revived the privileging application as soon as the College rendered its decision finding Ms. Puchala had acted appropriately in the circumstances.

[205] We do not condone Ms. Puchala's action in recording the meetings without disclosing that she was doing so. We understand how both Dr. F and Dr. VR feel about being surreptitiously recorded and how such an action impacts feelings of trust. On the other hand, we understand Ms. Puchala's frustration with time passing and feeling unsupported, and understand her feelings of desperation, especially when it came to the meeting of April 8, 2019. On January 29, Dr. F told Ms. Puchala that her privileges would be in place "before the weekend" and asked her to check back the following day. But when Ms. Puchala checked back, she learned that her references were being checked. Her confusion is entirely understandable, and we have no doubt that she would have been feeling extremely anxious when asked to meet on April 8.

[206] We also understand how Dr. F and Dr. VR now feel that there has been a breakdown in trust. But we are not convinced that as professional care providers working in the best interest of their patients, they will not be able to move beyond those feelings to engage professionally with Ms. Puchala.

[207] Aside from the recordings, we are pressed to find any evidence to support the "red flags" that both Dr. F and Dr. VR spoke of. While the act of recording surreptitiously is problematic, we are not prepared to let that be the act of unprofessional conduct that demonstrates Ms. Puchala will not be a good fit for providing midwifery services alongside the other obstetrical practitioners in the community.

[208] Subject to Ms. Puchala being successfully able to reinstate her license to provide intrapartum services, there are absolutely no concerns with Ms. Puchala's competence as a midwife or her clinical skills. Northern Health's concerns about fit have not been reliably established by the evidence and consequently, we find that Ms. Puchala, subject to license reinstatement, is an appropriate candidate for appointment to the Medical Staff of MMH and KHHC as a midwife.

What is the appropriate remedy?

[209] Northern Health submitted that if we found there was a need for a midwife that a vacancy be declared and posted for an open competition. In all of the circumstances, we are concerned that Ms. Puchala will not be given a fair opportunity in an open competition. We have found that the Verbal Reference Forms do not accurately reflect the views provided by the references. Dr. F is convinced Ms. Puchala will cause the group to disband and Dr. VR is feeling a complete lack of trust.

[210] We appreciate that Ms. Puchala is not currently licensed to provide intrapartum services because of the time that has passed since she last provided those services. The elapsed time is attributable not just to the privileging process and the intervening Incident and resulting College process, but also to this appeal process. The HAB adjourned hearing dates scheduled for the spring of 2020 on the

application of Northern Health resulting in further time passing. The right of a practitioner to appeal from a denial of privileges would be rendered meaningless if the time taken by the process ultimately results in the appellant no longer being qualified to practice. In all of the circumstances, we find Ms. Puchala should have the opportunity to endeavour to have her license reinstated, and if she is successfully able to do so, she should be granted privileges.

[211] If Ms. Puchala is granted privileges, all concerned will need to work at rebuilding relationships and rebuilding trust. Ms. Puchala will have work to do to reach out to the other care providers and ensure them of her willingness to be a trustworthy and collaborative care provider. Nothing less is required of Ms. Puchala by her College. The other members of the group will similarly need to work on being open to giving Ms. Puchala an opportunity to be a trusted and collaborative care provider in keeping with their professional obligations. Northern Health has a responsibility for overseeing the work environment and fostering collaborative interprofessional practice.

[212] The obstetrical group in Terrace are a highly skilled, high functioning cohesive team of professional care providers working in the best interests of their patients. The fact that they are a tight, cohesive, well-functioning team does not in itself mean there is not room or need for another member. Indeed, another physician is expected to join this team later this year and yet there are no expressed concerns that the newcomer will upset the cohesiveness of the team.

[213] The team has been working collaboratively to a limited extent with Ms. Puchala, and there is no reason to expect that they will not be able to continue to work collaboratively with Ms. Puchala, or that Ms. Puchala cannot work collaboratively with them if she is granted privileges. We have every confidence that the team will continue to provide a high level of care and continue to work in the best interests of their patients to ensure excellent outcomes.

[214] We are not convinced by the whole of the evidence before us that Ms. Puchala will not have the requisite skills and personal characteristics to practice effectively in Terrace and Kitimat and with the other practitioners providing obstetrical care in Terrace and Kitimat. We find, subject to Ms. Puchala being able to successfully complete any requirements placed on her by the College so as to be able to receive an unrestricted license to practice midwifery in British Columbia, that she should be given the opportunity to provide services in Terrace and Kitimat to meet the need for midwifery services in those communities and should be granted privileges to practice midwifery at MMH and KHHC, with MMH being her primary site.

ORDER

[215] Subject to the Appellant completing, within a year of the date of this order, any requirements imposed by the College to reinstate her license to provide intrapartum services, Northern Health shall, as soon as practicable, grant the Appellant provisional privileges (in accordance with the Bylaws) at MMH and KHHC, with MMH being her primary site.

[216] We strongly suggest that Northern Health engage a third party consultant to work with and coach members of the obstetrical team and Ms. Puchala on interprofessional collaboration.

[217] The HAB retains jurisdiction to resolve any issues relating to the integration of Ms. Puchala to the Medical Staff at MMH and KHHC.

"Cheryl Vickers"

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Cheryl Vickers
Panel Chair, Hospital Appeal Board

"Dr. Anita Molzahn"

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Dr. Anita Molzahn
Panel Member, Hospital Appeal Board

"Sandra Pullin"

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Sandra Pullin
Panel Member, Hospital Appeal Board

March 16, 2022