SUMMARY

DR. JEREMY PAUL FENNELL (CPSO# 88416)

1. Disposition

On July 14, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") ordered physiatrist Dr. Fennell to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Fennell to:

- complete six months of clinical supervision in the performance of block of medial branch of cervical nerves, management of cardiac arrest, and record-keeping (including documenting explicit informed consent for procedures), and the supervisor is to directly observe procedures as well as complete a chart review;
- complete an Advanced Cardiovascular Life Support (ACLS) refresher course; and a relevant course on nerve blocks acceptable to the College (for example, the course offered by the Spine Intervention Society on "Imaging Anatomy for the Spine Interventionalist");
- complete self-directed learning on the performance of block of medial branch of cervical nerves and management of cardiac arrest; and
- undergo a reassessment, approximately six months after completing the educational program.

The Committee also required Dr. Fennell to appear before a panel of the Committee to be cautioned with respect to performing a procedure, in which patients are at risk of adverse outcomes, without knowing and/or applying the ACLS protocol, and not ensuring the facility was adequately equipped, or staff adequately trained, to respond to emergency situations.

2. Introduction

The College received information raising concerns about Dr. Fennell's sports medicine practice. In particular, a patient became unresponsive after Dr. Fennell performed a nerve block. CPR was initiated and the patient was transferred to hospital. After admission to the intensive care unit (ICU), the patient was found to have experienced anoxic brain death, and later passed away. Subsequently, the Committee approved the Registrar's appointment of investigators to conduct a review of Dr. Fennell's practice.

Dr. Fennell responded that he has reflected on this case and the report of the Medical Inspector. He has implemented an office policy with respect to ACLS certification, such that in addition to himself, there are two ACLS-certified staff present for all procedures. He has also instituted a written consent form. He has attended a seminar on spinal intervention and intends to complete an upcoming course in this area as well.

3. Committee Process

As part of this investigation, the Registrar appointed a Medical Inspector to review two of Dr. Fennell's patient charts, and submit a written report.

A Surgical Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the investigation. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Medical Inspector concluded that the care Dr. Fennell provided to the patient was below standard; that he lacked skill, knowledge, and judgement; and posed a risk of harm. The Committee agreed with the Medical Inspector and had serious concerns about Dr. Fennell's care of the patient. Given the risks associated with the procedure performed, Dr. Fennell should have known the ACLS guidelines and been prepared to implement them. Neither Dr. Fennell nor his staff showed adequate preparation to handle the cardiac arrest. While the patient experienced a known complication, the technique Dr. Fennell used is more likely to lead to such a complication and he should have considered using the coaxial technique (that is the needle approach should be coaxial to the fluoroscope). Dr. Fennell also should have obtained written consent for the procedure, and documented the consent discussion with the patient.

While the Committee had concerns about the care Dr. Fennell provided to the patient, the Committee also appreciated that he has shown insight into his deficiencies and taken appropriate steps to update his practice and skills. The Committee was also reassured by the fact that the Medical Inspector reviewed the care Dr. Fennell provided to another patient, and found that Dr. Fennell met the standard, except for the fact that he did not obtain written consent.