SUMMARY

Dr. Deborah Anne Penava (CPSO# 67864)

1. Dispositions

On February 17, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") ordered obstetrician and gynecologist Dr. Penava to attend the College to be cautioned with respect to her management of the patient's labour and her documentation.

2. Introduction

A patient expressed concerns about the care Dr. Penava provided to her during her labour and delivery. The patient stated that Dr. Penava failed to adequately supervise the residents caring for her; failed to provide adequate intrapartum care; failed to expedite her delivery by Cesarean Section (C-Section) due to fetal heart rate (FHR) concerns; and failed to advise the patient of concerns in her labour and involve her in decision making. The patient was also concerned that Dr. Penava said that she would write a reprimand letter for the resident's file and provide her with a copy, which Dr. Penava did not do. The patient reported that her son's shoulder got stuck during the delivery, and he was subsequently diagnosed with a severe brain injury due to lack of oxygen at birth, resulting in severe global motor and intellectual delays, seizures and a shortened life expectancy.

Dr. Penava responded that the residents involved in the patient's care had sufficient skill and expertise to manage her situation, and that they kept her up to date with the patient's progress. She stated that she also checked with the charge nurse for any concerns, and reviewed the FHR tracing remotely on the computer system to ensure there were no concerns with fetal health. Dr. Penava explained that her practice is to continue with induction (oxytocin) as long as the fetus demonstrates health on monitoring and there are no maternal contraindications to continuing. She said that they did not recommend a C-Section to the patient as it was not indicated, and they continued to follow her progress. She stated that if they had felt that there was fetal distress they would have acted. Dr. Penava noted that while the FHR tracing 20 minutes prior to the birth could be classified as "distress", she was present and actively involved in facilitating the birth at that time, and she had the neonatal intensive care unit (NICU) team available. She confirmed that

there was a shoulder dystocia at birth and the NICU responded to the baby's needs, pursuant to their protocol.

Dr. Penava recalled speaking with the patient the morning after the birth about her concerns regarding the resident, and stated that she urged the patient to put her thoughts and feelings into a letter that she could review with the resident, which the patient did not do. She indicated that she did meet with the resident, however, to review the patient's case and the concerns that the patient had verbally expressed.

3. Committee Process

An Obstetrical Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. 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 Committee was left with the overall opinion that the second stage of the patient's labour was not managed appropriately, and was not supervised by Dr. Penava as closely as one would have expected in the circumstances. The Committee noted that while it is clear from the information Dr. Penava and the residents provided to the College that Dr. Penava was in contact with the residents during the course of the patient's labour, she was not physically present to assess the patient and personally assist in the labour until late in the process. The Committee was of the view that Dr. Penava should have attended to assess the patient earlier, and more frequently, in these particular circumstances (i.e. a very prolonged labour with slow progress).

The Committee noted that neither the residents nor Dr. Penava documented the discussions that they said took place between them about the patient's management, nor were there any notes by Dr. Penava or the residents regarding the second stage of labour or Dr. Penava's involvement with the patient and her family following the delivery.

The Committee pointed out that the College's policy entitled *Professional Responsibilities in Postgraduate Medical Education* sets out the responsibilities of the supervising physician and the trainees under his/her supervision, including ensuring proper documentation of the patient's care in the medical record. As is noted in the policy, the delivery of care in the postgraduate environment relies on supervisors and trainees fulfilling each of their obligations.

The Committee noted that in this case, the lack of physician documentation during the prolonged second stage of labour (for which Dr. Penava was ultimately responsible) was concerning and very problematic, as it made it much more challenging for the Committee to obtain a clear understanding of how events unfolded and the quality of the care that the patient received. The Committee observed that Dr. Penava was in the patient's room for the last 40 minutes of her labour (and her delivery); however, Dr. Penava did not document her findings or her thought process in this period of time, when it was clear that the FHR tracing was progressively abnormal.

The Committee acknowledged that it is a matter of judgment in terms of how to manage a patient in these circumstances, but indicated that it had concerns about the FHR tracing and questions about Dr. Penava's decision not to intervene earlier as a result of those concerns. The Committee was specifically concerned that when Dr. Penava visited the patient just before the start of the second stage of labour, she did not examine the patient, did not make a determination as to why the labour was progressing so slowly, and did not document a clear plan. Dr. Penava did not return to see the patient for five hours, and the Committee felt that she should have returned much sooner to assess the patient.

Overall, the Committee found it concerning that Dr. Penava failed to be more personally involved in the management and supervision of the residents who were providing care to the patient, given the unusually long first and second stages of labour. As noted above, they were also troubled by the lack of documentation of the second stage of labour, including Dr. Penava's discussions with the residents and the patient, which made it difficult to ascertain how much information Dr. Penava provided to the patient about her situation and how much involvement the patient was allowed to have in the decisions regarding the management of her labour.

The Committee noted that there were clear abnormalities on the FHR tracing in this case, which Dr. Penava herself acknowledged, and that it would have expected to see careful documentation of her interpretation of the tracing, and her thought process, including a consideration of whether it was appropriate to proceed to a C-Section in the circumstances.

In terms of the patient's concerns regarding Dr. Penava's failure to place a letter on the junior resident's chart, the Committee is satisfied that Dr. Penava did adequately address the verbal concerns that the patient expressed to her, by meeting with the resident to discuss the situation (which they felt was adequate feedback appropriate to the resident's level of training).