SUMMARY

DR. JANICE SZE WEI LAM (CPSO# 90556)

1. Disposition

On August 12, 2016, the Inquiries, Complaints and Reports Committee (the Committee) required obstetrician/gynecologist Dr. Lam to appear before a panel of the Committee to be cautioned with respect to failing to attend a patient, failing to communicate with colleagues if she was too ill to attend a patient, and providing inadequate intrapartum care and management.

2. Introduction

The patient attended the hospital in the early stages of labour at just over 41 weeks' gestation. Approximately seven hours later, Dr. Lam performed a Caesarean section (C section). The baby was stillborn.

The patient and her spouse complained to the College that Dr. Lam failed to appropriately monitor the patient's labour (including the fetal heart rate [FHR]) and delayed in performing a C section; failed to keep them informed about the situation as it changed during the labour and after delivery; failed to provide explanations about the death of their baby, and asked them to sign an incorrect death notice.

Dr. Lam responded that after she initially attended to the patient to review the FHR tracing (which demonstrated some abnormalities) and perform an artificial rupture of membranes, she planned to return in 30 minutes to reassess the situation, but she developed symptoms from food poisoning, which prevented her from doing so. She indicated that she was unaware that the FHR tracing had worsened until she received a call from a nurse approximately two hours after she had initially assessed the patient, at which point she notified the nurse to prepare the patient for an emergency C section. Dr. Lam noted that she had shared her findings (of abnormalities in the FHR tracing and thick meconium) with the patient and her spouse at the time of her initial assessment, and had told them that it was possible that the patient would need to undergo a C section. Dr. Lam acknowledged that she did not speak to the patient and her spouse outside the recovery room (because she was advised to give them some "private time"), and indicated that

she did not realize the patient had been asked to sign an incorrect death notice, as it had been completed by another physician.

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 identified concerns with the intrapartum care Dr. Lam provided to the patient and the judgment she displayed in managing the patient's labour. In particular, the Committee felt Dr. Lam demonstrated a lack of judgment when she chose not to proceed with a C section after she first attended the patient and noted concerns with the FHR tracing and thick meconium. The Committee also found that Dr. Lam's attendance during the patient's labour was severely lacking, in that she was not physically present to monitor the patient's labour (despite the concerns noted above), or take the lead and expedite the process once she felt that the patient needed to undergo an urgent C section (which again, was a decision that the Committee felt Dr. Lam ought to have made earlier).

In the Committee's view, it was a misstep for Dr. Lam to assume that the nurse would contact her if the FHR tracing worsened, as it was Dr. Lam's responsibility to follow up with the nurse to ensure that the patient's labour was progressing properly. The Committee also found that Dr. Lam displayed a lapse in judgment when she failed to arrange for coverage when she felt ill, and noted that it was her responsibility to inform her team that she could not fulfill her duties if she was indeed too sick to attend to the patient properly.

Finally, the Committee expressed concern that Dr. Lam failed to speak with the patient and her spouse outside the recovery room following delivery, as it was incumbent on Dr. Lam to make sure that she made herself available to meet with them to provide a proper explanation about the

circumstances surrounding the death of their baby. The Committee felt that the patient and her spouse were deserving of better care and support, and a greater level of compassion than Dr. Lam demonstrated here.

The Committee did not have concerns regarding the incorrect death notice, as it appeared that Dr. Lam was not the physician who prepared the form.