SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Janice Sze Wei Lam (CPSO # 90556)
(the Respondent)

INTRODUCTION

The Complainant delivered her stillborn daughter by emergency Caesarean Section (C-Section) performed by the Respondent. The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct.

COMPLAINANT'S CONCERNS

The Complainant is concerned about the intrapartum care the Respondent provided to her resulting in a stillborn delivery in May 2018. Specifically, she was concerned that the Respondent:

- **lacked medical management by failing to monitor the fetal heart rate (FHR) and delayed in performing a C-Section;**
- **failed to assess and communicate the urgency to the other team members causing a delay in care; and**
- **lacked professionalism by making inappropriate comments and jokes with an uncompassionate demeanor when she attended post partum.**

COMMITTEE'S DECISION

An Obstetrical Panel of the Committee considered this matter at its meeting of September 13, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to her failure to act appropriately on the abnormal fetal heart rate tracing and to communicate the urgency of the situation. They also accepted an undertaking from the Respondent, in which she agreed to engage in professional education, including courses (covering both effective team interactions and obstetrical care, particularly fetal heart rate surveillance), individualized instruction in communication, and a review and summary of College policies and fetal heart surveillance guidelines.

COMMITTEE'S ANALYSIS

Failed to monitor the FHR and delayed in performing a C-Section

- The Committee shared the Complainant's concerns regarding the Respondent's management. The Complainant presented with an abnormal FHR tracing, which along with other factors made for a concerning situation. It was unclear how long the baby had been in distress prior to the Complainant's attendance at the hospital, but the record demonstrated that the FHR tracing was abnormal during the entire triage assessment period. The Committee noted that even when the Respondent became aware of the persistent tachycardia and a prolonged FHR deceleration, she simply advised the Complainant of the possibility of an operative delivery. It was not until the second prolonged deceleration that she called for an urgent C-Section.

- In the Committee's opinion, the Respondent demonstrated a critical error in judgment in this case. There was a serious lapse in her interpretation of the FHR tracing, and a failure to act appropriately on the tracing.

Failed to assess and communicate the urgency to the other team members causing a delay in care

- Once again, the Committee shared the Complainant's concern about the Respondent's failure to adequately and appropriately communicate the urgency of the situation, both to her team and to the anesthetist who performed the epidural. As it was, the anesthetist was unaware of the severity of the situation and moved on to another case. This resulted in a delay in the emergency C-Section due to the need to wait for the second anesthetist to attend. While the Committee could not know what impact, if any, this had on the outcome, it noted that it certainly added to the distress of the Complainant and, at least from the Complainant's perspective, contributed to the confusion and disorganization she witnessed in the OR.

Lacked professionalism by making inappropriate comments and jokes with an uncompassionate demeanor when she attended postpartum

- The Complainant described the Respondent's demeanour the day following her baby's passing as lacking compassion, cold and inappropriate. The Respondent denied being glib, as described by the Complainant, or lacking in empathy.

- In her response, the Respondent acknowledged that her communication was an area that needed to be addressed, and she set out educative steps she had undertaken or was planning to engage in. The Committee appreciated that the Respondent had reflected on this area of her practice, had acknowledged the need to address her

communications, and had taken steps to try to improve. However, this was a tragic and devastating outcome for the parents, and the Committee was struck by the Complainant's very negative description of her interactions with the Respondent and her perception of a total lack of empathy on the Respondent's part.

Conclusions

- As a result of this investigation, the Committee had concerns about the Respondent's obstetrical management in this case, and her communications with the Complainant and her family and other members of the care team (in terms of the urgency of the situation). As such, it accepted an undertaking from the Respondent to address the deficiencies identified and improve her future care and directed the caution in person set out above.