SUMMARY

DR. NICHOLAS VIVIAN JOHN PAIRAUDEAU (CPSO# 27748)

1. Disposition

On November 2, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required obstetrician and gynecologist Dr. Pairaudeau to appear before a panel of the Committee to be cautioned with respect to his management of the Patient's second stage of labour.

2. Introduction

The Patient complained to the College about Dr. Pairaudeau's management of her labour and delivery. After a prolonged labour, the Patient delivered her infant girl via forceps delivery performed by Dr. Pairaudeau. The infant required resuscitation. Due to the infant's deterioration and poor prognosis, the decision was made to withdraw care and she passed away that evening.

Dr. Pairaudeau stated that he did provide appropriate care during the Patient's labour and delivery, which he detailed in his letter of response to the complaint.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider (IO provider) who specializes in obstetrics and gynecology. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

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 Patient received prenatal care from Dr. Pairaudeau and he was also the most responsible physician during her labour and delivery. The Patient had a relatively uneventful prenatal course, with normal test and ultrasound results.

The IO provider concluded that Dr. Pairaudeau managed the first stage of the Patient's labour in an appropriate fashion, and the Committee agreed. However, the IO provider and the Committee identified errors in judgment by Dr. Pairaudeau during the second stage of labour. Specifically, they were concerned that Dr. Pairaudeau left the hospital to see patients in his office, and that he delayed in attending the hospital after he was notified by nursing staff of a lack of progress and informed the nursing staff that he would attend "ASAP". The IO provider stated that Dr. Pairaudeau's main responsibility was to attend and manage the situation sooner that he did (given the poor progress, the prolonged second stage, the uncertain fetal position, and the intermittent fetal heart rate changes). The IO provider was of the view that in failing to do so, Dr. Pairaudeau failed to maintain an appropriate standard in his management of the Patient's labour and delivery.

The Committee stated that while there was no indication that Dr. Pairaudeau demonstrated a lack of knowledge or skill, he showed poor judgment in choosing to leave the hospital and return to his office at 3:00 pm and to manage the Complainant's labour remotely. Then, even after he was called, he failed to arrive at the hospital for 40 minutes, and after arriving and being informed about significant fetal bradycardia, he delayed another five or six minutes in delivering the infant (11 minutes after the sustained severe bradycardia).

The Committee noted that Dr. Pairaudeau has been practicing obstetrics for more than 40 years and has not had a previous complaint to the College raising similar issues regarding his obstetrical care. As the IO provider noted, the outcome in this case, although tragic, appeared to be an outlier, and the IO provider was not of the opinion that the Respondent's clinical practice, usual behaviour and conduct are unlikely to expose his patients to harm or injury or put his patients at risk.

The Committee also noted that there were several factors at play beyond Dr. Pairaudeau's lack of judgment in this case, including a broader issue relating to the hospital's policy of allowing physicians to deliver their own patients when not on-call (which has since changed), and issues of communication involving the nursing staff.

In the circumstances of this case, the Committee determined that it was most appropriate to require Dr. Pairaudeau to attend for a caution as set out above.