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. Karima Ben Omran (CPSO #71893)
(the Respondent)

INTRODUCTION

The Complainant arrived in hospital by ambulance and was diagnosed with pre-eclampsia with abnormal fetal tracing. The Respondent (Obstetrics/Gynaecology) was the on-call obstetrician who managed the Complainant's labour and performed a Caesarean section (C-section) delivery of her baby.

The Complainant's baby was transferred to a tertiary care centre for management and died several days later.

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 that the Respondent fell short of her professional obligations in the management of her childbirth delivery, resulting in the death of her baby. Specifically, the Respondent:

- **delayed in attending to and operating on the Complainant in a timely manner, despite knowing that she and her baby were not coping well and were under distress;**
- **failed to consider and account for oxygen deprivation to the baby, despite recognizing that the baby's oxygen would be impacted by the Complainant's contractions, pre-eclampsia and high blood pressure and despite the fact that the Complainant was herself experiencing difficulty breathing (and had been experiencing severe symptoms for a week), and did not act in a timely manner;**
- **failed to transfer the baby to a tertiary care centre in a timely manner despite knowing the urgency of the situation and the risk of decreased oxygen supply to the baby; and**
- **did not act in a timely manner given the Complainant's extremely high blood pressure.**

COMMITTEE'S DECISION

An Obstetrical Panel of the Committee considered this matter at its meeting of April 16, 2021. The Committee required the Respondent to attend at the College to be cautioned in person on the management of patients with hypertensive disorders in labour and monitoring of atypical fetal heart rate tracing.

The Committee also accepted an undertaking from the Respondent.

COMMITTEE'S ANALYSIS

Re: delayed in attending to and operating on the Complainant in a timely manner
-AND-
Re: failed to consider and account for oxygen deprivation to the baby
-AND-
Re: did not act in a timely manner given the Complainant's extremely high blood pressure

The Committee had several concerns with the Respondent's management of the Complainant.

When the Complainant arrived in hospital, the Respondent did not complete a thorough assessment or consider pre-eclampsia but rather treated the Complainant for threatened preterm labour only. The Respondent's notes were brief and did not identify the Complainant's elevated blood pressure upon admission or address the primary concerns of pre-eclampsia and fetal distress.

The Committee noted the record documented numerous elevated blood pressure readings while the Complainant was in triage. The Respondent told the College that nursing staff did not inform her of the Complainant's high blood pressure. Even if the Respondent was completely unaware of the severity of the situation earlier, once she was aware of the atypical fetal heart tracing she did not act promptly. The Respondent should have ordered a stat (immediate) C-section. Once the concerning fetal heart tracing was identified, the Respondent still did not consider hypertension or order anti-hypertensive medication prior to the C-section to ensure the Complainant was stable.

The Committee noted that the Respondent has a history of College complaints, including where concerns were identified with her clinical care, albeit regarding different issues. This further elevated the Committee's concern in this case.

As a result of this investigation, the Committee had concerns about the Respondent's management of patients with hypertensive disorders in labour and monitoring of atypical fetal heart rate tracing. In addition to cautioning the Respondent on these

subjects, the Committee accepted an undertaking from the Respondent, with terms to include six-month clinical supervision, professional education on fetal health surveillance and hypertensive disorders of pregnancy, and a reassessment of the Respondent's practice.

With regard to the concern of failing to transfer the baby to a tertiary care centre, the Committee did not take any action as once a baby is delivered, a pediatrician, not the Respondent, was responsible for the care and transfer decisions.