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. Amel Henein Fahim Sadek (CPSO #81889)
(the Respondent)

INTRODUCTION

The College received information raising concerns about the death of a 17-day old infant (the Patient) who had been under the Respondent's care. Subsequently, the Committee approved the Registrar's appointment of investigators to conduct a review of the Respondent's care of the Patient.

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of March 24, 2022. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to the poor diagnosis and management of progressive dehydration in a newborn. The Committee also accepted an undertaking from the Respondent, which included professional education in the assessment of newborns, including with respect to the adequacy of breastfeeding, detecting dehydration, and timely reassessments; and a reassessment of the Respondent's practice by an assessor selected by the College within three months of completing the professional education.

COMMITTEE'S ANALYSIS

As part of this investigation, the Registrar appointed an independent Assessor to review the Patient's chart, interview the Respondent, and submit a written report to the Committee.

The Assessor concluded that the Respondent's care in this case failed to meet the standard of practice. The Assessor was of the opinion that the Respondent displayed a lack of skill in that her clinical notes indicate normal clinical examinations despite the significant weight loss at each visit; and that the Respondent displayed a lack of judgment, in that she did not initiate an urgent investigation into potential causes of the Patient's weight loss, and did not act on her perception that the Patient's mother's consumption of cannabis and nicotine products during pregnancy and breastfeeding was contributing to the Patient's decline. The Assessor was of the opinion that the Respondent's clinical practice, behaviour or conduct exposes or is likely to expose her patients to harm or injury.

The Respondent accepted that the degree of weight loss warranted urgent medical attention, and she expressed regret for her errors in this case. She disagreed with some of the Assessor's conclusions and she disagreed that she exposed her patients to harm or injury.

The Committee shared the Assessor's concerns and conclusions. It noted that the significant drop in weight from the first to the second visit in itself was a red flag and should have prompted more than a recommendation about adding formula to the breastfeeding schedule. There was clear indication to refer the Patient to specialty care for further assessment. It was important in this context to have arranged closer follow-up, and with the increased weight loss at the time of the second visit, to have given advice to attend the Emergency Department.

The Committee noted that the Respondent had reflected on the case and had provided information about education/remediation she planned to pursue to improve her practice. It also noted she had no prior history with the College raising similar issues.

While the Respondent contended that her examinations were appropriate, the Committee shared the Assessor's opinion that it is unlikely that there would have been completely normal examinations at the visits, given the significant weight loss and the Patient's serum sodium level at the time of her admission to hospital.

The Committee was satisfied that a caution was warranted, as set out above, in addition to an undertaking as outlined above.