

SUMMARY

DR. AUBREY GEROME KASSIRER (CPSO# 71330)

1. Disposition

On December 15, 2017, the Inquiries, Complaints and Reports Committee (the Committee) required Dr. Kassirer (Family Medicine) to appear before a panel of the Committee to be cautioned with respect to second stage management of labour and operative vaginal delivery, including considering the appropriateness of a vacuum-assisted delivery, ensuring there is a back-up plan if the vacuum fails, and recognizing atypical fetal heart rate patterns. The Committee also required Dr. Kassirer to reflect on this case and submit a written report with respect to how he would manage a similar situation in the future.

2. Introduction

The patient complained to the College about the care and conduct of Dr. Kassirer during her labour and delivery admission to hospital (which included an unsuccessful vacuum-assisted delivery). Specifically, the patient expressed concern that Dr. Kassirer failed to appropriately manage, intervene and consult on the length of her second stage of her labour and the fetal heart rate (FHR) monitoring concerns resulting in her infant son's brain injury and death; failed to take the nurses' comments about fetal position seriously; and communicated in an unprofessional manner through conversations with others in the labour room (i.e., that he told the nurses and intern that he preferred not to give an epidural because it can hinder the patient's ability to push).

With respect to care, Dr. Kassirer responded that he consulted with an obstetrician-gynecologist (Dr. X) when there was no downward movement of the baby's head despite excellent pushing. He stated that together they decided against an assisted vaginal delivery and proceeded to a Caesarean section (C/S). He stated that while there were no concerning changes

in the FHR, in hindsight, he recognizes that there was some delay during the second stage of labour. He also outlined a number of changes he made to his practice.

Dr. Kassirer denied that he failed to consider the nurses' comments about the baby's fetal position. Dr. Kassirer also indicated that he compared different cultures of obstetrics practices in Oshawa and Port Perry, but that the discussion was not intended to cast any judgment on epidural use.

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 was troubled by the manner in which Dr. Kassirer managed the patient's care. Specifically, the Committee found that Dr. Kassirer: failed to make an adequate assessment of station, caput or pelvic adequacy; failed to suspect that there was an issue when he was unable to catheterize the patient; and failed to ensure he had a back-up plan if the vacuum failed. Dr. Kassirer also waited to consult Dr. X until seven minutes after the last attempt with the vacuum had elapsed, which was inappropriate, and failed to document the number of vacuum applications, pop-offs, pressure, descent, etc. Furthermore, Dr. Kassirer's assessment appeared to be lacking, as when initially consulted Dr. X had the impression that the baby's head was on the perineum. While the Committee was not in a position to opine on what caused the baby's death, the Committee was of the view that it was not appropriate for Dr. Kassirer to attempt a vacuum delivery in the circumstances.

The Committee was similarly concerned by the fact that Dr. Kassirer failed to recognize that there were concerning FHR tracings in the patient's second stage of labour; had Dr. Kassirer noticed these abnormal FHR tracings himself, perhaps he would have realized that this was not an appropriate case to attempt a vacuum delivery.

While the Committee acknowledged as a positive step Dr. Kassirer's efforts to improve his labour and delivery practices, the Committee remained of the view that it would be beneficial to meet with Dr. Kassirer in person to caution him with respect to the deficiencies identified in this complaint.

The Committee found that there was no information indicating that Dr. Kassirer disregarded the nurse's comments, and accepted as reasonable Dr. Kassirer's explanation that he felt the baby was in an occiput anterior position after he performed a vaginal examination on the patient. The Committee took no further action on this aspect of the complaint.

The Committee was unable to determine what, exactly, Dr. Kassirer said to the patient about epidurals, nor was it able to come to a conclusion about his manner or tone. Given that the patient perceived Dr. Kassirer's comments to be upsetting, however, the Committee stated its expectation that physicians communicate around patients in a professional manner at all times.

In the course of reviewing the record, the Committee noticed that Dr. Kassirer's documentation of informed consent (regarding the risks of vacuum-assisted delivery) was signed two days after the procedure. The Committee remarked that, going forward, it was important for Dr. Kassirer to contemporaneously document such consent discussions.