Summary of Adjudication Tribunal Decision

IN THE MATTER OF: **Dr. Krista D. Brown, Obstetrician/Gynecologist**
Practice address: 5 Paton Street, St. John's, NL

An Adjudication Tribunal of the College of Physicians and Surgeons of Newfoundland and Labrador has found Dr. Krista D. Brown guilty of professional misconduct in relation to a complaint filed by one of her patients. The Tribunal's written decision was released on August 10, 2022.

The Tribunal accepted a statement of facts that both the College and Dr. Brown had agreed on. This statement noted the following events, which took place in 2019. In summary:

> The complaint related to Dr. Brown's management of the patient's labour and delivery.
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> On January 10, 2019, for treatment of increased blood pressure, the patient (who had a complex medical history) was admitted to the hospital under the care of a different physician. At the time of admission, the patient was at 37 weeks plus 5 days gestation.
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> On January 14 and 15, in an effort to induce labour, the patient was prescribed vaginal Cervidil. On January 17, for the same reason, another prostaglandin was prescribed. Labour still did not begin. In further efforts to induce labour, an Oxytocin infusion was initiated later that evening. It was discontinued because it posed difficulty for assessing the patient's contractions. The fetal heart rate was recorded as normal throughout the attempts to induce labour.
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> Dr. Brown became involved in the patient's care on the morning of January 18. After assessing the patient, she ordered Oxytocin to be re-started. By midday, the patient's body temperature was slightly elevated and Dr. Brown began treating the patient for suspected chorioamnionitis.
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> Tachycardia was detected at about 6:00 p.m. on the evening of January 18. At 7:20 p.m., the fetal heart rate tracing was considered abnormal according to the applicable standards of practice. Dr. Brown attended at the patient's bedside and was made aware of the abnormal tracing and that the nursing staff was unable to capture the contraction pattern. Dr. Brown ordered an increased dose of Oxytocin medication but did not arrange for urgent delivery.
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> The patient reached full dilation at 11:00 p.m. and began pushing to deliver the infant. At 11:40 p.m., Dr. Brown was called to assess the patient and review the fetal heart tracing. The fetal heart rate was still abnormal with repeated complicated decelerations. At this point, Dr. Brown

determined that an urgent delivery was required. She recommended an attempted forceps delivery, which she assessed would result in a quicker delivery than a cesarian.

The patient was moved to an operating room and the infant was delivered by forceps 35 minutes after midnight on January 19. After the infant's head emerged, Dr. Brown identified that the baby had a mild to moderate shoulder dystocia. That resulted in a delay of less than 1 minute to complete the delivery.

The infant was immediately transferred to the neonatal intensive care unit's team for resuscitation, but the baby did not survive.

The patient did not learn of her infant daughter's death while Dr. Brown was present. Dr. Brown also did not visit the patient at any time during the patient's stay in the hospital.

The Tribunal accepted Dr. Brown's plea of guilty of "professional misconduct" in violation of section 4(h) of the College *By-Law No. 5: Code of Ethics*, which is conduct deserving of sanction under the *Medical Act, 2011.* The Tribunal found that Dr. Brown's care of the patient—in particular, her failure to appreciate the significance of the abnormal fetal heart tracing and the consequent need for urgent intervention—demonstrated errors in judgment that did not meet the standard of practice that is expected of an obstetrician/gynecologist, and that her failure demonstrated gross negligence or reckless disregard for the health and wellbeing of the patient and her infant daughter.

The Tribunal accepted a submission for sanctions that was jointly prepared by the College and Dr. Brown. It then ordered that:

1. The Tribunal issue a reprimand to Dr. Brown.
2. Dr. Brown successfully complete professional development courses covering "appropriate management of labour and delivery" and "effective communication with patients" within four months of the date of the Tribunal's Order.
3. Dr. Brown pay the hearing costs of the College in the fixed amount of $10,000.
4. The College Registrar publish a summary of the Tribunal's decision and the sanctions ordered.

Tanis Adey, MD
Registrar, CPSNL
September 12, 2022