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. George Arnold (CPSO #56716)
(the Respondent)

INTRODUCTION

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care of the Patient following a total abdominal hysterectomy with bilateral salpingo-oophorectomy in January 2010. The Respondent was the Patient's on-call obstetrician/gynecologist on the Patient's second post-operative day.

The Respondent did not have any in-person interaction with the Patient and instead had two phone calls with nursing staff regarding the Patient. First, he was contacted about the Patient's increasing pain. He was advised that the Patient's vital signs and urine output were normal, and he ordered a stat (immediate) complete blood count (CBC). Later, he was informed of the CBC results, including a hemoglobin level of 80 g/L. The Respondent ordered a repeat CBC test for the next morning. However, a few hours later, the Patient's condition deteriorated, and she was transferred to the intensive care unit (ICU).

The Patient, sadly, passed away on the fourth post-operative day, after developing rapid atrial fibrillation, hypotension, aspiration pneumonia, coagulopathy, metabolic acidosis, and acute renal failure.

COMPLAINANT'S CONCERNS

The Complainant is concerned regarding the care provided to the Patient by the Respondent. Specifically, that the Respondent:

- **failed to appropriately manage the Patient's decrease in hemoglobin; and,**
- **failed to assess the Patient.**

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of November 9, 2022. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to the management of postoperative patients presenting with pain, pallor and decreasing hemoglobin levels.

COMMITTEE'S ANALYSIS

The Respondent advised the Committee that on the night he was the Patient's most-responsible physician, he was busy in the labour and delivery and emergency department (ED). He also believed that the Patient was clinically stable based on the information he obtained from nursing, and since no staff, who saw the Patient in person, alerted him to any concerns.

The Committee was concerned that once the Respondent was aware that the Patient was in pain and had a decreasing hemoglobin level following surgery, the Respondent did not consider the possibility of an intraabdominal bleed. Even in the context of a busy labour and delivery unit and ED work, the Respondent should have been concerned by the information he had, and he should have either assessed the Patient in person or investigated further by following up with other involved staff.

In addition, the Committee had concerns that the Respondent was not particularly insightful in his response to the College, nor did he consider what he might have done differently.

Given the concerns about the Respondent's care of a post-operative patient who has pain and decreasing hemoglobin levels, the Committee determined that it is appropriate to caution the Respondent. The caution was intended to address the Committee's concerns in these areas and to discuss ways in which such concerns can be prevented in future.