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. Deborah Penava (CPSO #67864)
(the Respondent)

INTRODUCTION

The Complainant was referred to the Respondent for assessment and management of abnormal uterine bleeding. The Respondent performed endometrial ablation and fibroid removal on the Complainant in October 2019. During the surgery, the Respondent noted uterine perforation and aborted the procedure. The Complainant developed hypotension and bradycardia in the post-anesthesia care unit (PACU). She was transferred to another hospital where she underwent tests that identified a bowel perforation. The Complainant went on to require multiple procedures, including total abdominal hysterectomy, colorectal repair and ileostomy.

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent:

- **Failed to identify the surgical complication and treat it in an appropriate and timely manner**
- **Failed to disclose harm that occurred during the Complainant's initial surgery**
- **May not have supervised her residents during the surgery or in the recovery room**
- **May not have been competent in her skills in performing the surgery**
- **Communicated in an unprofessional manner.**

COMMITTEE'S DECISION

An Obstetrical Panel of the Committee considered this matter at its meeting of July 17, 2020. The Committee required the Respondent to attend at the College to be cautioned in person with respect to communication with families and the importance of providing in-person care rather than providing patient care through residents. The Respondent also provided an undertaking to the College that included her agreement to complete professional education in the areas of recognition and management of complications of hysteroscopic surgery, including as a result of electrocautery, and recognition and management of sepsis, as well as individualized instruction in communication with an instructor selected by the College.

COMMITTEE'S ANALYSIS

Failed to identify the surgical complication and treat it in an appropriate and timely manner

The Respondent identified the uterine perforation at the time it occurred but made the clinical decision not to proceed with laparoscopy to explore the abdomen for further injury. The Respondent told the College that it was her judgement that the perforation occurred at a time when she was placing the hysteroscope, not when electrocautery was in use.

The Respondent made some incorrect assumptions at the time of the uterine perforation. As electrocautery had been used by that point in the surgery, diagnostic laparoscopy was then indicated. There is a difference between perforation occurring with a blunt dilator and perforation that occurs with a hysteroscope's electrocautery loop. Thermal injury might or might not have been visualized; however, it is clear that the delayed diagnosis resulted in subsequent bowel perforation and sepsis.

The Respondent left the hospital after the Complainant's procedure. Hospital staff advised her as she was driving home that the Complainant was hypotensive. The Respondent ordered a fluid bolus and some initial investigations and contacted a resident to attend to and assess the Complainant.

The Committee was not comfortable with the Respondent's decision not to return to the hospital to see the Complainant when her condition began to deteriorate in the PACU. The Respondent did not appear to recognize the seriousness of the complication. She should not have managed the post-operative care from a distance via the resident.

It appears the Respondent was satisfied that it was appropriate to provide care to the Complainant via the resident on the basis that the Complainant was not showing signs of sepsis; however, one would not have expected the Complainant to show an immediate septic response to the injury. In regard to the Respondent's suspicions about air embolus as the cause of the Complainant's hypotension in the PACU, bowel injury was a more likely explanation than air embolism in light of the recognized uterine perforation.

May not have supervised her residents during the surgery or in the recovery room

The Committee saw no information to support the concern that the Respondent failed to supervise the resident in the operating room. It appeared to the Committee that the Respondent also adequately supervised the care the resident provided to the Complainant in the PACU; however, she supervised at a distance. As indicated above, once there were signs of a complication that might necessitate hospital transfer, the Respondent should have considered returning to the hospital to support the resident in person and reassure the Complainant.

Communicated in an unprofessional manner

The Committee took no further action on the concern that the Respondent failed to disclose the harm that occurred during the Complainant's initial surgery; however, the Respondent acknowledged that her communication with the Complainant during this exchange was not optimal. She also recognized other shortcomings in her communication, including her failure to speak directly with the Complainant when she was in the PACU.

Given the issues regarding the Respondent's management of the Complainant's post-operative complication, an undertaking was obtained, as set out above. In regard to the issues with the Respondent's communication and her failure to attend the Complainant in the PACU, the Committee decided to require the Complainant to attend at the College to be cautioned.