SUMMARY

DR. KARIMA BEN OMRAN (CPSO# 71893)

1. Disposition

On December 15, 2017, the Inquiries, Complaints and Reports Committee (the Committee) required obstetrician/gynecologist Dr. Ben Omran to appear before a panel of the Committee to be cautioned with respect to the management of acute post-operative hemorrhage.

The Committee also requested that Dr. Ben Omran provide the Committee with a written report, approximately 2-4 pages in length, with respect to the management of post-operative haemorrhage, the management of salpingectomy (including obtaining informed consent and considering risk factors), and reflection on her role as the most responsible physician and the need to thoroughly document the care she provides patients (including her consent discussions).

2. Introduction

The patient complained to the College that Dr. Ben Omran failed to provide adequate care and management during the patient's scheduled Caesarean section (C/S) which resulted in the patient's post-partum hemorrhage and post-operative complications.

Dr. Ben Omran responded that the patient opted for elective C/S and tubal ligation and declined a vaginal birth after a prior C/S. She stated that she counselled the patient on the potential risks of surgery, and that the surgery itself was uneventful. She pointed out that the patient's subsequent severe post-partum hemorrhage was appropriately managed by the Anaesthesia and ICU teams as well as the on-call obstetrician and herself.

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 noted that it was faced with conflicting information regarding the issue of the consent discussion around the tubal ligation component of the surgery given that the patient said this was a last-minute decision while Dr. Ben Omran stated it was discussed at an appointment a week prior to the surgery as well. Ultimately, the Committee found the documentation of consent to be deficient in several ways. Dr. Ben Omran did not document the specific details of her consent discussion with the patient. The form used did not specify the type of tubal ligation and nor was the slightly higher risk of bleeding documented anywhere in terms of a consent discussion.

The Committee also questioned Dr. Ben Omran's involvement in the patient's care with respect to the post-partum hemorrhage. The Committee noted that other physicians, not the obstetricians, were managing the patient's care at least for the first 90 minutes after the patient's hypotension started. The Committee stated that it was unusual for the obstetrician or on-call obstetrician not to be the lead physicians in the management of a post-operative complication. The Committee questioned the decision by Dr. Ben Omran and the on-call obstetrician not to take the patient back to the operating room to address the suspected intra-abdominal bleed, as such course of action should have been the main priority. Embolization is not the first choice of management in cases of suspected post-operative intra-abdominal

bleeding, as the procedure is not always successful, can sometimes involve significant time, and if the patient decompensates it is difficult to manage this in the Interventional Radiology suite.

The Committee found Dr. Ben Omran's response to the complaint troubling in that she demonstrated little insight by understating the significance of the patient's hemorrhage.

Given the Committee's concerns about Dr. Ben Omran's management of the patient's care, it issued the caution described above.

This summary was amended following a review and decision by the Health Professions Appeal and Review Board (HPARB), February 25, 2019, and the Committee's consideration of the matter on August 16, 2019.