

**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. Graeme Neil Smith (CPSO #65616)
(the Respondent)**

INTRODUCTION

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

The Patient has a history of severe pre-eclampsia toxemia during her first pregnancy which resulted in an urgent caesarean section (C-section). She was referred to the Respondent for care during her next pregnancy.

At the Respondent and Patient's last visit, which occurred at 36 weeks gestational age, the Patient's blood pressure was 168/93. At that time, the Patient was taking medication for gestational hypertension. The Respondent reviewed the results of a recent ultrasound, which were normal, and the Respondent moved up the date of the Patient's planned C-section.

Four days later, the Patient attended the hospital with severe abdominal pain, elevated blood pressure, and intrauterine fetal demise. The Patient underwent an urgent C-section, and a large placental abruption was identified.

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of October 10, 2025. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to conducting appropriate investigation when a patient presents with escalated blood pressure and a previous history of severe pre-eclampsia and maintaining appropriate medical record keeping for Ontario Perinatal Records (OPR) entries.

COMMITTEE'S ANALYSIS

Given the Patient's prior history of severe pre-eclampsia, the Patient's elevated blood pressure should have triggered the Respondent to provide further maternal and fetal evaluation at their last visit.

The Committee was concerned that the Respondent failed to conduct or direct further investigations at their last visit, his assertion in his response to the College that there

was no need to check the fetal heart rate at this visit, and the sparseness of the Respondent's documentation in the OPR.

The Committee's concerns were heightened by the lack of insight in the Respondent's response, specifically that he did not consider what he might have done differently or how the events of the case might change his future practice.

Given the Committee's significant concern about the Respondent's care, the potential impact of this approach to care on future patients, and the Respondent's lack of insight, the Committee was satisfied that it was appropriate to caution the Respondent.