

**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. Padma Lata Garisa (CPSO #88111)
(the Respondent)**

INTRODUCTION

The Complainant was admitted to hospital in labour. After delivery, the family physician who delivered the Complainant's baby consulted the Respondent (Obstetrics and Gynecology) because the Complainant was bleeding profusely. The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent failed to provide appropriate care to her when consulted for cervical tears. Specifically, the Complainant is concerned that the Respondent:

- **failed to recognize and repair the Complainant's cervical tears;**
- **argued with the other care givers about the plan and treatment;**
- **failed to recognize the critical situation and have an appropriate treatment plan leading to another physician having to take over care; and**
- **failed to explain what was happening to the Complainant.**

COMMITTEE'S DECISION

An Obstetrical Panel of the Committee considered this matter at its meeting of March 15, 2019. The Committee required the Respondent to attend at the College to be cautioned in person on failing to appropriately manage a post-partum haemorrhage, especially in light of the patient's possible vaginal and cervical trauma. The Committee also requested that the Respondent provide the Committee with a written report, approximately 2-4 pages in length, with respect to how she could have improved her care in this case, including:

- appropriate management of a post-partum haemorrhage;
- appropriate triaging and delegation, and calling in the second call if the unit acuity demands it;
- appropriate resuscitation in light of significant blood loss;
- appropriate and professional communications with colleagues in an emergency setting; and
- appropriate debriefing of a family after a critical event.

COMMITTEE'S ANALYSIS

Concern about the Complainant's cervical tears

-AND-

Concern about failing to recognize the critical situation and another physician having to take over care

The Committee found that the Respondent failed to appropriately recognize and repair the Complainant's cervical tear. The notes from the family physician who delivered the Complainant's baby demonstrated that she saw a cervical tear at 7 o'clock, but the Respondent did not address this in the delivery room.

The Committee also noted that the family physician, who was present at the time, was quite clear that the Respondent did not "walk" around the cervix and did not repair the tear when they were in the OR. The Committee expressed concern that it took another trip to the OR, and the intervention of another obstetrician, before the Complainant's tear was repaired.

It appeared to the Committee that the Respondent did not recognize how critical the Complainant's situation was. The Committee was of the view that the Respondent should have requested a second obstetrician for back-up as soon as the family physician became concerned about the Complainant's deterioration following the first examination under anesthesia.

Finally, the Committee was concerned that the Complainant was not resuscitated properly. It was clear to the Committee that the Complainant, who was both tachycardic and hypertensive, and very ill right from early on, did not receive appropriate care (i.e., resuscitation) in the circumstances.

Concern about arguing with other caregivers

The Committee noted that the Respondent acknowledged she had an argument with the family physician in front of the Complainant during the procedure in the OR.

The Committee was troubled that the Respondent was unable to maintain professional communications, especially given that this argument occurred in an emergency setting.

Concern about failing to explain what was happening

The Committee noted that the Respondent acknowledged she was not able to debrief or speak with the Complainant or her mother after the Complainant was in the OR because she had to

see another patient. As a result, the Complainant was only made aware of how serious and life threatening her situation was when the situation became critical in terms of discussion of hysterectomy for profound hemorrhage.

The Committee found that the Respondent should have ensured that the Complainant understood the gravity of her situation earlier – at the very least, after the Complainant’s first trip to the OR.

Concluding remarks

Given the deficiencies identified with respect to the Respondent’s care and communications, and considering the serious nature of this case with the high potential for harm were the second obstetrician not eventually called in to the unit, the Committee determined that it would be appropriate to caution the Respondent in person, and request that she provide a written report, as outlined above.