

SUMMARY

DR. GWENDOLYN JOY GOODROW (CPSO# 70139)

1. Disposition

On April 13, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required Dr. Goodrow (Obstetrics and Gynecology) to appear before a panel of the Committee to be cautioned on failing to recognize and react to a fluid imbalance during surgery, and on failing to have early recognition of the potential for perforation of the uterus.

2. Introduction

Dr. Goodrow performed a hysteroscopic myomectomy on Patient A. The operative note indicates that Dr. Goodrow was able to resect four fibroids, but that at the end of the case, there was three litres of unaccounted glycine (including approximately one litre of fluid on the floor). Ultimately, a bowel injury was noted and Patient A required an ileostomy.

Patient A and Patient A's family member complained to the College that Dr. Goodrow made a routine surgery mistake that almost killed Patient A, did not take Patient A's multiple sclerosis (MS) into account in providing Patient A with treatment, and continuously lied after the mistake and had other doctors take over Patient A's care.

Dr. Goodrow responded that she resected approximately four fibroids, which was as much as could safely be done at that time. Dr. Goodrow also indicated that she always took Patient A's MS into account when she was involved in Patient A's care. She explained that Patient A's prolonged hospitalization was complicated by the MS, and she sought the involvement of the Neurology, Psychiatry, Social Work and Physiotherapy teams to help Patient A get better. Finally, Dr. Goodrow stated that she never lied to Patient A or Patient A's family; rather, she continuously endeavoured to have open communication and relay the appropriate information

at the appropriate time. She also explained that Patient A's care was complex and evolving, and required numerous medical teams.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider (IO provider) who specializes in obstetrics and gynecology. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

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 IO provider opined that Dr. Goodrow's care fell below the standard of practice, that she demonstrated a lack of skill and judgment, and that her practice may potentially expose her patients to harm. Among other things, the IO provider noted that:

- While uterine perforation at the time of hysteroscopic myomectomy is a known complication of this sort of surgery, the question is how a potential perforation should be dealt with.
- In this case, even taking into account the large amount of fluid on the floor, the discrepancy of glycine was still approximately two litres, which was above the accepted fluid discrepancy.

- At this time, Dr. Goodrow should have considered that there may have been a perforation and that the fluid was entering Patient A's abdomen and not being re-circulated out.
- Once such a large fluid balance was demonstrated, Patient A should have taken an alternative measure to see if there was a perforation.

In her response to the IO report, Dr. Goodrow explained that nursing staff had not been advising her as each bag of fluid was hung during the procedure (as was her expectation), and that she terminated the surgery when she requested an update on the fluid balance and became aware that the discrepancy was approximately two litres. Dr. Goodrow also indicated that she did consider the possibility of a perforation, but believed that the fluid discrepancy could be accounted for by the amount visualized on the floor and the amounts lost while she was changing instruments at the beginning of the procedure. She advised that she has since changed her practice to ensure she is properly apprised of the fluid balance throughout her procedures, and that her index of suspicion for potential perforation is now heightened.

The Committee considered, and agreed with, the IO provider's conclusions. That is, the Committee noted that regardless of the cause, perforation is a recognized risk associated with hysteroscopic myomectomy. Perforation does not, in and of itself, indicate that a physician failed to meet the standard of care. Unfortunately, there is no guarantee of positive results with any surgery, even with the best of care. Indeed, Dr. Goodrow maintained in her response that her view during the procedure was acceptable, and the Committee concluded that there was no information before it to confirm otherwise.

That said, the Committee was very troubled by Dr. Goodrow's failure to react to the large fluid imbalance, as a three litre (or even two litre) deficit is significant, as it means that two or three litres more fluid went in than came out. The Committee found that Dr. Goodrow's explanations (outlined above) did not excuse her failure to account for the fluid imbalance or to recognize the likelihood of injury in this case. The Committee was of the opinion that it would have been wise for Dr. Goodrow to consider a laparoscopy and/or to admit Patient A for further

observation. Moreover, the Committee noted that the failure of Dr. Goodrow to attend post-operatively was a concern, if post-operative care was left to the anaesthetist.

In light of the above, the Committee required Dr. Goodrow to attend at the College to be cautioned with respect to the above-mentioned aspects of her care.

With respect to Patient A's MS, the Committee noted that while it might have impacted Patient A's recovery, the fact that Patient A had MS was not relevant to Dr. Goodrow's decision to operate (i.e., it was appropriate for Dr. Goodrow to try this minimally invasive procedure even though Patient A had MS). Furthermore, the Committee found that the record demonstrated that Patient A's MS was generally considered throughout the course of her treatment. In the circumstances, the Committee decided to take no further action on this aspect of the complaint.

In regards to communications, the Committee found that it was limited to a documentary review and could not determine with any certainty whether Dr. Goodrow told Patient A or Patient A's family anything that was not true. However, the Committee did note that, aside from the complaint letter, there was no information before it indicating that Dr. Goodrow lied at any time.

Finally, the Committee was satisfied that it was reasonable and appropriate for other physicians to take over Patient A's care. In the Committee's view, Patient A's case was complicated and beyond Dr. Goodrow's scope as an obstetrician-gynecologist, and therefore required a multi-disciplinary approach (for example, Patient A required the specialized care of a surgeon to perform a bowel resection and deal with the post-operative complications, as this was beyond Dr. Goodrow's scope of practice). Dr. Goodrow successfully ensured all of the appropriate medical specialties were involved in Patient A's care in this case. As a result, the Committee also took no further action in this regard.