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. Jerzy Sternadel
(CPSO #73345)
(the Respondent)

INTRODUCTION

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

The Respondent assessed the Complainant in hospital following a spontaneous vaginal delivery after which her placenta was noted to be ragged and she experienced continued heavy bleeding.

COMMITTEE'S DECISION

A Panel of the Committee considered this matter at its meeting of August 16, 2024. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned to refrain from deferring and postponing care for patients with compromised vital signs in the setting of post-partum hemorrhage and consider transferring care when requested, and to demonstrate accountability and insight in cases where improvement is needed.

COMMITTEE'S ANALYSIS

According to the Complainant, when she had continued heavy bleeding postpartum, the Respondent failed to:

- respond promptly to consult requests from midwives, leading to a delay in the transfer of care;
- adequately perform a manual exploration for retained products of conception, leading to a persistent post-partum hemorrhage; and
- actively manage a post-partum hemorrhage, leading to severe postnatal anemia requiring blood transfusion.

The Respondent told that College that he assessed the Complainant twice and advised the midwives that he would speak to the oncoming obstetrician on-call to make a plan for the Complainant's transfer of care, since his shift was ending soon thereafter.

The Committee was of the view that, given the Complainant's compromised vital signs and high blood loss, the Respondent's decision to wait for the next on-call obstetrician for transfer of care was unreasonable. Given the Patient's presentation, a manual

exploration for retained products of conception was indicated. The Respondent should not have deferred and postponed care for a patient with compromised vital signs and should have transferred care when requested and indicated.

Additionally, the Committee's concerns were heighted as the Respondent demonstrated a lack of insight and accountability in a case where areas of improvement are notable.

On this basis of the above, the Committee decided to caution the Respondent.