COLLEGE OF PHYSICIANS AND SURGEONS OF NOVA SCOTIA

SUMMARY OF DECISION OF INVESTIGATION COMMITTEE "D"

Dr. Amy Wambolt
License No. 017287
August 3, 2022

PROCESS

This matter was initiated by a letter from the Complainant, received on September 8, 2021. A response from Dr. Amy Wambolt was received on October 15, 2021.

Dr. Amy Wambolt is a physician, licensed to practise medicine in Nova Scotia in the specialty of Family Medicine.

Investigation Committee D, formed in accordance with the *Medical Act* of Nova Scotia, 2011, was responsible for the investigation of this complaint.

In addition to correspondence from the Complainant and respondent, the Committee considered:

- an interview with Dr. Wambolt held on March 8, 2022; and
- an external review report as requested by the Investigation Committee.

SUMMARY

Key points as reported by the Complainant

The Complainant took a pregnancy test on June 14, 2021 and called Dr. Wambolt's office. During that initial call, she let Dr. Wambolt know she was experiencing some brown spotting/discharge. Dr. Wambolt reassured her that some women spot/bleed during their first trimester and not to worry. The Complainant was booked for an appointment with the nurse practitioner for June 25, 2021 and spotted brown discharge on and off until June 25, 2021.

The Complainant was nervous because of the duration of spotting and voiced that the bloodwork she would receive that day would hopefully reassure her of proper development of the pregnancy. She was informed by both Dr. Wambolt and her NP that the bloodwork they were sending her for would not include checking HCG levels and was only to create a baseline for her own bloodwork. They said they did not request HCG tests unless they thought she was having a miscarriage or if the pregnancy was high risk. The Complainant voiced her concerns again about spotting and Dr. Wambolt offered to send a referral in for an ultrasound to ease her concerns. She did warn her that it was, "super early, and they may not be able to see anything".

The Complainant went for regular bloodwork that same day and then got a call from Cape

Breton Regional Hospital to go in for an ultrasound that afternoon at 2:00pm.

She was told the results would be sent to the doctor by the end of day. The Complainant did not hear from Dr. Wambolt until Tuesday, June 29, 2021. Dr. Wambolt said the ultrasound did not show a fetal sac anywhere, and that they checked her fallopian tubes as well. She said the next step was to check the HCG levels, but the ultrasound results most likely determined she was having a miscarriage as they would expect at least a fetal sac at six weeks.

The Complainant was away for work until July 2, 2021, so her first bloodwork appointment was scheduled then. She was to have it repeated on July 5, 2021 as well.

When she went to the first blood draw on July 2, 2021 the hospital had not received the referral. Dr. Wambolt's office does not have a receptionist on Fridays. The Complainant had to call on July 5, 2021 for them to send the referral and send a second one for July 7, 2021.

The first HCG level came back at 17,000 (roughly) and Dr. Wambolt's receptionist said it was a positive result and the next blood draw would be a better indicator of what was happening.

The second HCG level came back at 17,500 and Dr. Wambolt called to say it did not go up enough to confirm pregnancy and it was leaning towards a miscarriage diagnosis.

Dr. Wambolt requested a third HCG check, this time 5 days after on July 11, 2021. This blood draw came back with an HCG level of 17,000. Dr. Wambolt stated this confirmed a miscarriage and to wait to start bleeding.

Dr. Wambolt said it could take a couple of weeks before this happened and to call her office after she stopped bleeding to get a referral to repeat her HCG to confirm everything was expelled from the uterus. The Complainant reported a continuation of the original brown discharge, a more consistent volume of it and a small amount of thicker, stringy material.

The Complainant states Dr. Wambolt explained to her that it was common for the bleeding portion of a miscarriage to be delayed until what would have been the 12th week of the pregnancy, and that some women do not even know they are miscarrying until they start bleeding at the end of the first trimester. She said at this point all she could do was wait and see when she would start fully passing the products of conception.

The Complainant asked when she should repeat her bloodwork and was told to wait until after she bled fully and no longer had spotting. There was no mention of repeat bloodwork the following week, which would have been around July 20, 2021.

The Complainant noticed brown spotting around July 16, 2021 which got a little heavier and then stopped on July 23, 2021. She called the following week for a bloodwork referral for July 30, 2021 assuming she had finished bleeding.

The Complainant went on July 30, 2021 for bloodwork and expected to hear from Dr. Wambolt's office the following week, but still had not heard by August 4, 2021. She was going

to call on August 4, 2021 but started a period-like bleed, and this lasted from August 4-8, 2021.

The Complainant rebooked bloodwork for August 13, 2021 but when she called on August 10, 2021 to get the referral, it went to voicemail which stated the office was on vacation and to call back after August 23, 2021 to make an appointment.

On Monday, August 16, 2021 around 6:30pm, the Complainant started experiencing sharp, shooting pains through her abdomen, accompanied by fainting when she opened her eyes or stood-up, and waves of extreme heat. She was rushed to the Cape Breton Regional Hospital Emergency Department. She was rushed into a trauma room based on very low blood pressure.

After an abdominal exam, bloodwork and ultrasounds, the gynecologist determined she was going through an ectopic pregnancy. The pain she was experiencing was caused by her right fallopian tube rupturing and her abdomen was filling with blood. She required emergency surgery to repair or remove the damaged fallopian tube and potentially the right ovary as well.

The Complainant was in surgery for an extended period because the gynecologist had to fully open her abdomen up due to the amount of bleeding.

In the days following, the Complainant learned there were "red flags" that were missed by Dr. Wambolt which should have been followed up on.

The loss of the right fallopian tube and the need for extensive surgery could have been avoided. The Complainant was close to losing her life over simple mistakes and things that should have been double checked. The Complainant is lucky she was home and not driving or somewhere she could not get to medical help quickly.

The Complainant states her knowledge of "expectant management" of a miscarriage is that after a heavy bleed occurs, the expected BHCG level should be under 5. She holds this view due to a previous conversation with Dr. Wambolt at the end of January 2021, when she went through a first miscarriage after a chemical pregnancy. This conversation took place after she had already started bleeding and passed products of conception. Dr. Wambolt placed emphasis on wanting to ensure her BHCG levels returned to normal after she stopped bleeding, to ensure all products of conception had been passed and if they had, then she would expect to see a level lower than 5.

The Complainant' current physician requested bloodwork, including a BHCG, after she was discharged from the hospital in August 2021. He wanted to make sure the BHCG level had returned to normal (under 5) and that if it had not, it would have to be further investigated.

The Complainant states that if her ultrasound on June 25, 2021 showed there was no evidence of an "intrauterine or ectopic pregnancy", and her BHCG bloodwork levels, performed 10 days later, were at 17,081.6 and increased by even the small amount to 17, 548.2 two days later, there had to be something producing these levels if there was no evidence of a pregnancy during the ultrasound, even if it was only a small increase.

The Complainant questions why a second ultrasound was not ordered to confirm placement of the embryo. The Complainant states all other medical professionals she spoke with around the time of her hospital stay and discharge, voiced their disbelief that BHCG was not included in her original bloodwork on June 25, 2021, especially when miscarriage was a concern, to create a baseline of where the BHCG levels were from the start.

Dr. Wambolt cannot say that miscarriage was not a concern at that point, otherwise she would not have sent her for an ultrasound.

The Complainant states there is a lack of communication from Dr. Wambolt and her office regarding bloodwork results, which she requested in the first place.

The Complainant did not contact her office the week of August 2-6, 2021 because she (wrongfully) assumed Dr. Wambolt would contact her if her levels were not back to normal.

Key points as reported by the Respondent

Dr. Wambolt extends her deepest sympathy to the Complainant for her pregnancy loss. She is disappointed she was unhappy with her care. She remembers the events leading to her pregnancy loss and believes the care was appropriate.

The Complainant contacted Dr. Wambolt's office on June 14, 2021 by telephone. She told Dr. Wambolt she had taken a pregnancy test at home five days earlier and it was positive. She was having some brown spotting. Dr. Wambolt told her spotting in early pregnancy is common but it can also be an early sign of Spontaneous Abortion (SAB). Dr. Wambolt told her she needed to schedule an in-office visit for an initial pre-natal assessment.

The Complainant was seen on June 25, 2021, initially by the family practice nurse and then Dr. Wambolt. She reported she had been experiencing spotting. Dr. Wambolt ordered an ultrasound to be performed the same day so she could assess viability of the pregnancy.

The Complainant was also given a requisition to have pre-natal bloodwork done which she had previously arranged herself for the same day as her appointment.

The ultrasound was done on June 25, 2021. Dr. Wambolt got the ultrasound report on Monday, June 28, 2021 and had her assistant arrange a virtual appointment with the Complainant.

The ultrasound report offered a conclusion of, "no intrauterine or ectopic pregnancy demonstrated".

The radiologist also recommended serial quantitative BHCGs for follow up purposes. The differential diagnoses at this point included SAB or early pregnancy/inaccurate dating.

Dr. Wambolt spoke with the Complainant on June 29, 2021 and informed her of the result of the ultrasound. She advised her she could order serial quantitative BHCGs, to be performed two days apart. She also indicated they expected a doubling of BHCG in a viable intrauterine pregnancy

while a decline can suggest an SAB.

A stable BHCG can be a sign of both a viable and non-viable pregnancy.

After the conversation, Dr. Wambolt immediately faxed the requisition for quantitative BHCGs.

The Complainant was away for work and could not arrange to have her bloodwork obtained until Friday, July 2, 2021. Given the plan to have her first bloodwork drawn on Friday (July 2), she could not have another lab drawn until Monday (July 5).

Unfortunately, on July 2, 2021 the Complainant was told by the lab it had not received the requisition. Dr. Wambolt works in her office Friday mornings but does not have a receptionist available to answer the phone during this time.

The Complainant had her BHCG performed on July 5 (17, 081.6) and July 7 (17,548.2).

Dr. Wambolt called the Complainant on July 8, 2021. She noted there was no doubling effect to suggest a viable pregnancy or significant decline in levels to suggest an obvious SAB.

The Complainant denied any red flag symptoms including pelvic bleeding or pelvic cramping/pain which made ectopic pregnancy unlikely.

Dr. Wambolt recommended the Complainant recheck her BHCG level the following day. Dr. Wambolt also recommended she continue to monitor for potential symptoms of SAB such as heavy vaginal bleeding, abdominal and/or pelvic pain, fever or other signs of infection. The requisition was sent, and the Complainant was told it could be used as a recurring requisition.

Unfortunately, the Complainant did not attend for additional testing until July 13, 2021. Dr. Wambolt cannot comment on the reason for the delay.

Dr. Wambolt spoke with the Complainant on July 14, 2021 to inform her of the result (17,430.1). During the call, the Complainant reported she had experienced bleeding since Saturday (July 10), that was “not heavy”, as well as passing “stringy” material since that date. She denied any pain or cramping. Dr. Wambolt advised her that she was probably passing products of conception.

They agreed they would proceed with expectant management and continue to watch for potential symptoms of SAB including heavy vaginal bleeding, abdominal and/or pelvic pain, fever, or other signs of infection. Most SABs do not require medical intervention.

The Complainant was asked to follow up with Dr. Wambolt for any worsening symptoms. In the absence of hemodynamic instability or infection, expectant management can proceed for up to eight weeks. They also agreed to proceed with another BHCG in one week to confirm that it was down trending and therefore consistent with SAB in conjunction with her symptoms.

The Complainant did not have her next BHCG test until Friday, July 30, 2021. The result was 3,592.

Dr. Wambolt had not heard from the Complainant during the interim (July 14 - July 30, 2021).

After receiving the July 30, 2021 result on August 3, 2021, Dr. Wambolt assumed the Complainant had suffered a SAB because she had passed products of conception since July 10, 2021, had the July 30, 2021 test results (3592), and did not contact Dr. Wambolt during the interim.

Dr. Wambolt was out of the office on vacation from August 9 to August 15, 2021 and returned to work on August 16, 2021 to find out the Complainant had presented to the ED with worsening symptoms and had a subsequent surgical intervention for a ruptured ectopic pregnancy on August 16, 2021.

BHCG levels are not diagnostic of a viable pregnancy.

On June 25, 2021 Dr. Wambolt felt that an ultrasound was more appropriate as it is the preferred standard of care to confirm a viable intrauterine pregnancy with fetal heart tones. She recognized if the ultrasound is obtained too early or prior to six weeks gestation, then a viable pregnancy cannot be confirmed. Serial quantitative BHCGs were ordered after the ultrasound was performed.

The Complainant's BHCG levels presented as consistent with a spontaneous abortion. Her clinical presentation did not include right-sided pain, pain of any kind, cramping, or hemodynamic instability.

As of July 10, 2021, she reported passing stringy material which Dr. Wambolt felt was consistent with products of conception.

Given the Complainant's clinical picture, she felt it was more reasonable to obtain serial BHCG levels as they are used therapeutically to trend resolution of an SAB. This was the intent of this testing.

The result of the July 30, 2021 BHCG indicated that no further medical intervention was required unless the Complainant became symptomatic. Although closed loop communication is desirable, it was not required given the ongoing plan of expectant management. Results that required further action would have been reported to the Complainant in a timely manner. Unfortunately, the office closure interrupted the Complainant's access to follow up with the office, but all patients are instructed to present to the Emergency Department in their absence, which she did.

Dr. Wambolt states when an abdominal ultrasound is performed in conjunction with an HCG greater than approximately 5000, an intrauterine pregnancy ("IUP") should be visualized. The most common reason no IUP is identified is dating error, meaning the ultrasound was conducted too early. A dating error occurs due to variation in ovulatory cycles. Approximately sixty-five percent of women ovulate midcycle while thirty-five percent ovulate within four to five days from midcycle, which alters the current gestational age and subsequent estimated due date.

Despite the Complainant's reported careful monitoring of her ovulation cycle, it is not unusual to not have a visualization so early in a pregnancy.

Dr. Wambolt ordered a BHCG to verify her queried SAB. The ultrasound report and chart notes both confirm there was no sign of ectopic pregnancy at the time. Had the Complainant reported symptoms of heavy bleeding or cramping, Dr. Wambolt would have ordered a second ultrasound to find the cause.

In the Complainant's case, the pregnancy was producing HCG, but it was not rising at the levels she would expect of a viable pregnancy.

As is reflected in the HCG chart, from July 5, 2021 an HCG of 17,000 would indicate a gestational age of 6-8 weeks, and the HCG should double every 48 hours in a viable pregnancy.

The chart notes from July 8, 2021indicated that there was "no doubling effect". Although there was a slight increase in her HCG levels over the course of 48 hours, this is a negligible change. Given the lack of visual on the ultrasound and the stagnant BHCG, Dr. Wambolt felt this was a SAB and proceeded accordingly. The difference in BHCG from 17,081.6 to 17,548.2 is not enough to cause concern or dictate a change in management.

In her July 30, 2021 blood test results, the Complainant's HCG levels demonstrated a significant down-trending to 3,592, which continued to support a finding of a routine SAB.

The Complainant notes that BHCG should be below five after a heavy bleed occurs. Again, no new symptoms were reported to Dr. Wambolt, including no indication of heavy bleeding, and therefore there was no indication for change in management. Dr. Wambolt also felt that this did not warrant an update since she was not making any changes to the current recommendations.

Preliminary Investigation

Pursuant to Section 88 (1) of the *Medical Practitioners Regulations*, an investigator was appointed to conduct a preliminary investigation of this complaint.

CONCERNS/ALLEGATIONS OF COMPLAINANT

The Complainant alleges Dr. Wambolt:

- performed inadequate testing after she voiced her concerns about her spotting early pregnancy (i.e. running her HCG levels sooner);
- did not provide appropriate follow up after determining she was having a miscarriage;
- did not request a second ultrasound; and
- did not provide appropriate follow up after her July 30, 2021 bloodwork.

DISCUSSION

The Committee reviewed the complaint, response, and medical record. The Committee interviewed Dr. Wambolt.

Interview

During her interview Dr. Wambolt reiterated she is disappointed the Complainant was unhappy with her care but in reviewing her medical record, believes the care provided was appropriate. The Complainant's ultrasound did not show a pregnancy anywhere.

Dr. Wambolt was asked what she did to reassure herself that either the products passed, were somewhere in the uterus but too early to show or could potentially be ectopic. Dr. Wambolt told the Committee these questions were on her radar, and candidly stated she considers now whether she may have been, "just biased by the original report".

When the subsequent beta was 17,000, Dr. Wambolt thinks at the time she reflected on the original ultrasound and assumed it had just been too early, and it did not pick up on the pregnancy vs. instead of [thinking about] confirming the pregnancy again.

The Complainant went on to have her beta HCGs and the two serial ones were in 17000s and a very slight difference a few days later. Dr. Wambolt was asked if she thought at the time it might be reasonable to get an ultrasound. She again confirmed she suspects she was biased by the original ultrasound. She, "wasn't shooting for the ectopic because the ultrasound said no ectopic". She acknowledged again it may have been too early to identify.

Dr. Wambolt chose to proceed with a third beta. When she had the third beta results, by that time, the Complainant became symptomatic, and Dr. Wambolt thinks at that point, that was biasing her decision, because, "now we've got symptoms that are consistent with passing tissue and a negative ultrasound and this, you know, possibly a plateau of her betas and, then again, unpredictable declines in beta".

Dr. Wambolt was reassured the Complainant had passed the products of conception because she had bleeding and she had used the term "stringy" and was bleeding enough that it was consistent with at least a period. The word "stringy" to Dr. Wambolt, "really just meant tissue because what else could it be". At no point in time did her symptoms really change. She was "feeling fine". Dr. Wambolt suggests she may have been surprised a little the Complainant was not really having pain when she reported her July 10, 2021 symptoms and Dr. Wambolt may have presumed things to be consistent with a routine spontaneous abortion.

Dr. Wambolt was asked if there was any point as she was following the process that would make her consider whether should just get an ultrasound to see if there were retained products or if there was anything there that might be a reason for why the spontaneous abortion was seeming to be a little longer. Dr. Wambolt thinks that would have been dependent on the symptoms. If she was just bleeding normally and then suddenly complained of worsening bleeding or heavy bleeding or if she had a fever that would certainly prompt her to get an ultrasound sooner.

Dr. Wambolt acknowledged that obviously in hindsight, an ectopic would have been a consideration, and she is not sure why it was not. She reiterated she was biased by that statement

in the first ultrasound that it did not identify an ectopic. She also acknowledged that as a physician, she must look at the whole picture and manage everything.

Dr. Wambolt talked to the Committee about how in other aspects of medicine she has reviewed findings with the radiologist if something does not seem right. She stated in this case that would have been helpful as well.

External independent opinion

The Committee reviewed an external independent opinion. It indicated in this situation the standard of practice was not met.

The external reviewer noted on the initial prenatal visit that the lab order did not include the quantitative beta HCG. When a female presents with a positive urine pregnancy test it is assumed she is pregnant and confirmation with serum beta HCG is not actually required. A positive urine pregnancy test is rarely a false positive.

This was not a straightforward new pregnancy. This patient had vaginal spotting. When a patient in early pregnancy presents with spotting/bleeding of any amount there are a few things a physician must consider. A patient can be having a miscarriage or threatening to have one. She can be having an implant bleed. The bleeding can come from pathology separate from the pregnancy such as the vagina or cervix. Very uncommon is an ectopic pregnancy, however, this diagnosis can be life threatening and should always be top of mind.

The external opinion noted in the case of the Complainant, she was in the category of early pregnancy bleeding thus more astute investigation was required.

On the day of presentation for her first prenatal visit an early pregnancy ultrasound was urgently obtained. The external reviewer noted this was excellent care.

The external reviewer noted the result of, “no intrauterine or ectopic pregnancy demonstrated” did not completely rule out with 100% certainty an ectopic pregnancy.

The Complainant’s LMP (last missed period) was May 10, 2021. At the time of the ultrasound she was 6 weeks 4 days gestational age. The lack of a gestational sac should be a signal that an ectopic pregnancy is possible and not excluded. Had the Complainant’s gestational age been less than 6 weeks or dating was in question, then the lack of gestational sac would not necessarily be unexpected. It is simply too small to visualize. The quantitative beta HCG result may have been another clue this was a possible diagnosis depending on the result and it is reasonable the beta HCG should have been ordered when the patient presented with early bleeding in pregnancy to assist in clinical assessment in conjunction with the ultrasound results.

The Complainant proceeded to have three lab tests in a row to measure her beta HCG. The labs were drawn 10, 12 and 18 days after the ultrasound completed on June 25, 2021. The results demonstrated a stable/stagnant level of 17000 IU/L give or take a few hundred units. This demonstrates there is no doubling of levels which is expected of this lab result in early pregnancy every 48 hours. This suggests a likely non-viable pregnancy. The levels do not indicate if it is ectopic or intrauterine. The expected normal results of levels are quite

varied numerically week to week, however a level of 17000IU/L can suggest a pregnancy of 6-8 weeks. A level of this value is more than adequate to be for a fetus to be visualized on ultrasound. (As a rule, a patient must have a level of minimum 1500IU/L before an early prenatal ultrasound can be ordered.)

The external reviewer noted the second result on July 5, 2021 did not demonstrate any doubling effect. In conjunction with The Complainant' report of no symptoms of bleeding, this does suggest a likely non-viable pregnancy. This would now be considered a missed pregnancy loss.

However, confirmation of an intrauterine pregnancy had not been established. It is reasonable care to order another ultrasound at this point to ensure/establish the intrauterine pregnancy.

The first ultrasound without a beta HCG result was not completely conclusive. A second ultrasound would have been useful to monitor the progression especially now that there was a pattern of lab results available.

On July 30, 2021 the Complainant had another lab draw. The result of this beta HCG of 3594.6 IU/L were not communicated, and the office was subsequently closed for vacation.

Dr. Wambolt reasoned these results were in keeping with the diagnosis of a spontaneous abortion as they were much less than the previous results and it had appeared that products of conception were passed on July 10, 2021. This is reasonable clinically. Not hearing from the patient appeared to reassure Dr. Wambolt that no new symptoms of concern had presented.

The external reviewer noted there did not seem to be any further plan in the chart notes or in the letter from Dr. Wambolt to the Complainant to follow up on the lab work. The standard of care would suggest the beta HCG levels be followed until undetectable. It is noted that the Complainant experienced a miscarriage in December 2020, and this was the approach provided.

The external reviewer stated without the initial beta HCG results, Dr. Wambolt did not have the entire clinical picture at the time of the initial ultrasound. The results of the ultrasound stated there was no ectopic pregnancy visualized. This result was held on to and possibly created a bias clinically with Dr. Wambolt (which she acknowledges).

The external reviewer noted the ultrasound also did not show an intrauterine sac and therefore an ectopic pregnancy could not be completely ruled out without further clinical data. While a positive urine test confirms a pregnancy, a pregnancy with first trimester bleeding indicates that a beta HCG is required for further clinical evaluation.

It is also noted the Complainant had a previous miscarriage and understood the role of the quantitative beta HCG and requested this lab work at her first prenatal appointment on June 25, 2021. It is not entirely clear why this would be declined. She was going for lab work for the other routine screening, so it is more than reasonable to add the beta HCG to minimize future lab draws for the patient. It is reasonable care to always order a quantitative beta HCG in all pregnant patients as the standard of care. Even without a presentation of bleeding in early

pregnancy, as more and more pregnancies are dated with ultrasounds and beta result is required at a minimal level to enable booking the ultrasound.

With beta levels of consistently over 17000 and persistent bleeding the standard of care would have been to arrange another ultrasound. The presence of "stringy" material may or may not have been products of conception. The external reviewer noted a physician would want to verify the diagnosis and would be considering an ectopic pregnancy as an uncommon possibility. The external reviewer also noted a physician would want to verify the intrauterine pregnancy, and if it was not viable, then could discuss options of management with the patient which would include expectant, medical or surgical management.

The lack of heavy bleeding in this situation suggested the Complainant had not yet completed the possible miscarriage. A persistent elevation in the beta HCG, with ultrasound results of an intrauterine non-viable pregnancy would have likely required referral to gynecology for further management. The uncommon result of an ectopic at this point would have been identified in this instance as well and management would have been referred to gynecology urgently.

The presence of the ovarian cyst is a very common radiological and clinical finding in females. The size of 10mm x 6 mm is not particularly large for an ovarian cyst and the radiologist stated that the ring of fire sign was absent suggesting that there was not hypervascularity (increased blood flow) that could indicate an adnexal ectopic pregnancy. Of note as well the radiologist also states there is no double decidual sign to indicate there is no evidence of an early intrauterine pregnancy, thus the recommendation of serial beta HCG was recommended.

The external reviewer noted the ultrasound result ultimately was non-diagnostic. The serial beta levels of 17000 in conjunction with the presence of a cyst again does not alter expected management in this case. However, the lack of a gestational sac in the uterus during the first ultrasound and the then subsequent beta HCG levels of 17000 were concerning and an additional ultrasound was indicated to further evaluate the status of the pregnancy.

Analysis

The Committee considered whether Dr. Wambolt's failure to order a second ultrasound warranted a licensing sanction and turned its mind to the type of sanction that might be warranted.

The leading judicial authority for sanctioning principles followed by Professional Regulators is *Jaswal v. Newfoundland (Medical Board),* [1996] N.J. No. 50. It sets out thirteen non-exhaustive factors to consider. These include:

- the nature and gravity of the proven allegations;
- the age and experience of the offending physician;
- the previous character of the physician and in particular the presence or absence of any prior complaints or convictions;
- the age and mental condition of the offended patient;
- the number of times the offence was proven to have occurred;

- the role of the physician in acknowledging what had occurred;
- whether the offending physician had already suffered other serious financial or other penalties as a result of the allegations having been made;
- the impact of the incident on the offended patient;
- the presence or absence of any mitigating circumstances;
- the need to promote specific and general deterrence and, thereby, to protect the public and ensure the safe and proper practice of medicine;
- the need to maintain the public's confidence in the integrity of the medical profession;
- the degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct; and
- the range of sentence in other similar cases.

The Committee observed that on August 16, 2021 the Complainant experienced severe abdominal pain and syncope. She was brought to the Cape Breton Regional Emergency Department. She was vomiting to the point of incontinence.

The Complainant was assessed and found to be hypotensive (53/29) and on assessment by the Emergency Department physician was found to clinically have signs of free fluid in her abdomen and a working diagnosis of a ruptured ectopic pregnancy was made based on presentation and recent medical history.

An ultrasound was completed and the gynecologist on call was consulted. The ultrasound confirmed a likely right ruptured ectopic pregnancy.

The Complainant proceeded to have emergency surgery. She required a midline laparotomy, right salpingectomy (removal of right fallopian tube) and removal of the hemoperitoneum (blood in abdomen), and removal of the ectopic pregnancy.

During surgery the Complainant's hemoglobin was 68 and she required four units of blood. She was stabilized and then recovered well in the postoperative period with stable vitals and hemoglobin.

The Complainant was discharged home on post-operative day two with plans for follow up with the gynecologist in six weeks' time.

The Committee noted the Complainant experienced a serious, life-threatening medical emergency. She required midline surgery and four units of blood. She lost a fallopian tube.

The Committee also observed Dr. Wambolt had multiple interactions with the patient, and opportunities to consider other diagnoses and order more investigations.

The Committee confirmed Dr. Wambolt is a relatively young physician, early in her career, with no complaint history at the College. She was candid with the Committee regarding how in hindsight she may have been biased by the statement that in the first ultrasound that it did not show an ectopic pregnancy. She also acknowledged that as a physician, she must look at the

whole picture and manage everything. This was a single patient, in an isolated situation. She was not a vulnerable patient. She was very well informed and a good advocate for her own care.

There was nothing to suggest this is a pattern of behaviour. The external reviewer observed that Dr. Wambolt provided otherwise excellent care, aside from this significant repeated miss. They were also reassured that this differential (ectopic) will now be considered by Dr. Wambolt at all future similar presentations.

DECISION

The Committee concluded in accordance with subclause 99(5)(f)(i)(A) of the *Medical Practitioners Regulations*, there is sufficient evidence that, if proven, would constitute a finding of professional misconduct in the context of a breach of the expected standards of practice. The Committee determined that pursuant to subclause 99(5)(f)(ii) the conduct in this case warrants a licensing sanction.

With the consent of Dr. Wambolt, the Committee orders the following pursuant to subclauses 99(7)(a)(i) and (ii) of the *Regulations*:

a) Dr. Wambolt is Reprimanded for failing to arrange a second ultrasound for a patient in circumstances where the patient had beta levels of consistently over 17000 and with persistent bleeding;
b) Dr. Wambolt agreed to contribute to the costs of the investigation.

Dr. Wambolt agreed to accept this disposition on August 3, 2022.

For further information related to the Nova Scotia Medical Act & Medical Practitioners Regulations, along with the College Standards and Guidelines, please visit our website at: www.cpsns.ns.ca