

SUMMARY

DR. MARIO BYRON JARMUSKE (CPSO# 64085)

1. Disposition

On March 16, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required plastic surgeon Dr. Jarmuske to appear before a panel of the Committee to be cautioned on failing to directly observe and supervise a resident performing carpal tunnel release surgery, and on failing to ensure that the resident had the necessary skill to perform the surgery, in accordance with the College's policy #2-11, *Professional Responsibilities in Postgraduate Medical Education*.

2. Introduction

Patient A, who had symptomatic carpal tunnel syndrome, underwent carpal tunnel release (CTR) surgery. A resident physician, Dr. X, performed the surgery. According to Patient A, her daily function has been limited, as she now experiences pain, burning and swelling, and the ends of her fingers feel like sandpaper.

Patient A complained to the College that Dr. Jarmuske did not do the surgery himself and poorly supervised Dr. X, and was not present during the surgery. Patient A also complained that Dr. X's skill was poor and that patient communication was "non-existent".

Dr. Jarmuske responded that Dr. X was a third-year resident who had done 17 procedures in the clinic, including three CTR surgeries. He believed that Dr. X had demonstrated suitable competency in performing CTR surgery during these earlier cases.

Dr. Jarmuske explained that while Dr. X was starting the CTR surgery on Patient A, he left the room to see one or two other patients in adjacent rooms. He indicated that he came back 10

minutes later and advised Dr. X to proceed with routine closure of the incision. Dr. Jarmuske further stated that he reviewed the operative note, as dictated by Dr. X, which described a very standard CTR procedure.

With respect to communications, Dr. Jarmuske indicated that he reviewed the basic principles of the surgery, including the need for local anesthetic, sterile prepping and draping of the hand, as well as the basic steps of the operation with Patient A. Dr. Jarmuske stated that they also talked about the risks of the surgery, which were both general (such as, pain swelling, bruising/bleeding and possible infection) and specific (such as, injury to the nerve or its branches, as well as potential recurrence). According to Dr. Jarmuske, after their discussion, Patient A indicated that she wanted to proceed with the surgery that same day and signed a consent form.

3. Committee Process

A Surgical 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 Committee noted that the record confirmed that Dr. X performed Patient A's surgery, which was unfortunately complicated by an injury to a sensory nerve (the palmar cutaneous branch of the median nerve) and a motor nerve (the motor branch of the median nerve to the thenar eminence).

The Committee found that the fact that Dr. X performed Patient A's surgery was not in and of itself inappropriate. Staff physicians can and do allow residents to perform procedures, such as CTR surgery, because residents need to be given opportunities to observe and actively participate in clinical interactions in order to acquire the knowledge, skills, and judgment required for future practice. However, the Committee noted that, in doing so, staff physicians must ensure that they fulfill their responsibilities as outlined in the College's policy, *Professional Responsibilities in Postgraduate Medical Education*, including adequately supervising residents (e.g., ensuring residents do not compromise care, seeing patients as required, etc.).

In this case, the Committee was of the view that Dr. Jarmuske failed to appropriately supervise Dr. X in accordance with the College's policy. As Dr. Jarmuske himself acknowledged, he left the room to assess other patients while Dr. X was starting Patient A's surgery. By the time Dr. Jarmuske came back 10 minutes later, Dr. X had already completed the surgical decompression. The Committee was of the opinion that Dr. Jarmuske should have ensured that Dr. X placed the initial incision correctly, and that the motor branch of the median nerve to the thenar eminence was consciously identified, released and protected.

The Committee noted that there was some degree of involvement of the thenar muscles, i.e., explicit exploration of the motor branch was indicated, as there might have been a band other than the transverse carpal ligament (TCL) causing compression. However, the Committee was concerned that no mention of the motor branch was made in the operative report. That is, the record suggested that Dr. X did not reasonably assess the potential complications of surgery. In the Committee's view, this was troubling, as certainly the motor branch must always be consciously protected.

Furthermore, upon careful review of the investigative record, the Committee was of the opinion that the incision in Patient A's hand extended a bit further distally than it should (the incision should extend no further than to the superficial palmar arch and the distal edge of the TCL). The Committee also remarked that it is not necessary to cross the wrist crease proximally,

which generally leads to some degree of hypertrophic scarring, as the photograph of Patient A's palm suggested.

The Committee concluded that the complications that resulted in this case, while known risks of CTR surgery, were significant and could have been minimized by proper technique. Given the junior status of Dr. X, the Committee was of the view that Dr. Jarmuske failed to fulfill his obligations by not supervising Dr. X carefully and directly (i.e., by not being present when Dr. X performed the procedure), or ensuring that Dr. X had the requisite skill to complete Patient A's surgery successfully. In the circumstances, the Committee believed that it would be appropriate to caution Dr. Jarmuske to impress upon him the importance of directly observing and supervising residents performing CTR surgery, and of ensuring residents have the necessary skill to perform such surgery.

With respect to communications, the Committee noted that while it was clear Patient A did not fully understand the extent of the possible complications that could result from the surgery, it was limited to a paper review only. In the absence of documentation regarding this discussion or independent information confirming one party's version of events over the other, the Committee concluded that it was unable to determine with any certainty what Dr. Jarmuske said to Patient A. In the circumstances, the Committee did not take any action on this aspect of the complaint, other than to state its expectation that physicians document consent discussions, with specific mention of more common complications.