

SUMMARY

Dr. Denise Schnider (CPSO# 52391)

1. Disposition

On May 11, 2018, the Inquiries, Complaints and Reports Committee (the Committee) ordered Dr. Schnider (General Surgery) to complete a specified continuing education and remediation program (SCERP). The SCERP requires Dr. Schnider to:

- Successfully complete the next available session of the following courses:
 - A formal continuing professional development program on management of palpable breast lumps (for example, the course at the American College of Surgeons Clinical Congress, *Oncoplastic Breast Surgery for the General Surgeon*)
- Review and submit written summaries of the following policies/guidelines:
 - The College's policy statement, *Disclosure of Harm*
 - The World Health Organization's Surgical Checklist

2. Introduction

A patient complained to the College about the care that she received from Dr. Schnider. Specifically, the patient was concerned that during surgery to remove a lump in her left breast Dr. Schnider made an incision at the "3 o'clock" position when the lump was at "8 o'clock", failed to remove the lump and left the patient with a larger than expected, unnecessary scar, failed to follow up with the patient in the recovery room after the surgery and left it to the patient's mother to discuss the surgical outcome with the patient.

Dr. Schnider responded that the location of the patient's left breast lump was noted in both her initial consultation notes and in the report from the patient's pre-operative ultrasound; however, at the time of the surgery, despite moving the patient's arm above her head and carefully examining the left breast, she could not find the lump. Dr. Schnider indicated that she paused during the surgery and reviewed the pre-operative notes, but that even on physically

re-examining the patient she still could not locate the lump. Dr. Schnider stated that since she could no longer find the exact location of the lump, she decided to make the skin incision first and then try to ascertain the lump's position; however, after making the incision she unfortunately still did not feel the lump and therefore she decided to abandon the procedure and simply closed the patient's skin. Dr. Schnider indicated that she visited the patient in the recovery unit but the patient was not awake. She said the patient's mother was in the unit with the patient post-surgery and that she spoke with the mother and advised her that she could not locate the lump. Dr. Schnider stated that she had an important family meeting to attend out of town thus she regrettably could not stay in the hospital and wait for the patient to wake up.

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.cpsso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee did not accept Dr. Schnider's response that she read the pre-operative records and made the 3 o'clock incision intentionally in order to find the lump in the 8 o'clock position. In the Committee's view, it would not have been easier to find the mass once a skin incision was made and it seemed that what transpired in this case was a matter of wrong-sited surgery. The Committee noted the fact that Dr. Schnider made the incision in the opposite quadrant from where her own consultation note and the ultrasound report stated the mass was located. The Committee found it unlikely that if Dr. Schnider had in fact read the pre-operative records, then she would have made a sizable skin incision nowhere near the tumour's actual location.

The Committee noted that the appropriate course of action would have been to mark the mass and was troubled by the fact that Dr. Schnider does not seem to mark non-palpable lumps. In the Committee's view, in addition to noting the tumour's location at the initial consultation, Dr. Schnider should have seen the patient prior to surgery and marked the lesion at that time. Moreover, Dr. Schnider could have used ultrasound during the surgery to locate the tumour.

The Committee noted that the patient sustained harm as result of Dr. Schnider's surgical error. The patient was not only left with a significant scar, but she had to undergo a second surgery. The College has a policy statement, *Disclosure of Harm*, which all physicians have to abide by. The policy clearly states that when a patient has sustained harm while under a physician's care, then the physician must ensure that the nature of the harm is communicated to the patient. The physician has to disclose all of the material facts of the incident which caused the harm, the consequences for the patient and any/all actions that have been taken to address them. Physicians have an obligation to disclose the harm directly to the patient, unless the patient is incapable, in which case it should be disclosed to the patient's substitute decision-maker. The Committee was thus troubled that Dr. Schnider did not tell the patient about her mistake. According to the College policy, talking to the patient's mother about the error was insufficient. Even if Dr. Schnider had important family matters that she needed to attend to immediately, she could have telephoned, and spoken with, the patient as soon as the patient had awoken.

The Committee therefore concluded that the appropriate disposition in this particular case was to require Dr. Schnider to complete the SCERP, as described above.