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. Miah Hahn (CPSO# 59311)
(the Respondent)

INTRODUCTION

The Respondent, who is an orthopaedic surgeon, performed the Complainant's spinal surgery to correct scoliosis including inserting two titanium rods. Following the surgery, the Complainant was found to be paraplegic.

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

COMPLAINANT'S CONCERNS

The Complainant is concerned the Respondent:

- **incompetently performed spinal surgery to correct scoliosis, including damaging the spinal cord in two places and left instrumentational holes in the spine, rendering the Complainant an incomplete paraplegic;**
- **failed to obtain consent to use the right T10 rib as a bone graft; and**
- **failed to properly and adequately disclose what occurred during the surgery and the outcome.**

COMMITTEE'S DECISION

A Surgical Panel of the Committee considered this matter at its meeting of May 8, 2020, and again on February 18, 2022. The Committee required the Respondent to attend at the College to be cautioned in person to thoroughly document significant discussions with patients, such as when disclosing harm after a surgery, and to ensure the breadth of the consent discussion is thoroughly documented, including all specific components of a complex operation are noted in the record (e.g. in this case, the requirement for a rib to be resected and used in the surgery).

The Committee also accept an undertaking from the Respondent which included that the Respondent complete education to improve her communications with patients with respect to obtaining consent and disclosing harm.

COMMITTEE'S ANALYSIS

As part of this investigation, the Committee retained an independent Assessor who specializes in orthopaedic surgery. The Assessor opined the Respondent met the

standard in the care provided to the Complainant and did not show a lack of skill, knowledge or judgement.

The Committee agreed with the Assessor's conclusion that the Respondent met the standard in terms of the performance of the procedure, that the wake-up test used to evaluate neurologic function was standard, and neuromonitoring should be used if available. The Assessor did not comment on the Respondent's consent discussion or her post-operative discussions during which she disclosed harm. The Committee had concerns with these aspects of the Respondent's care as well as her documentation of these discussions. As set out further below, for these two issues, the Committee determined that a caution in person along with education was appropriate.

Re: incompetently performed the spinal surgery to correct scoliosis, including damaging the spinal cord in two places and left instrumentational holes in the spine, rendering the Complainant an incomplete paraplegic

The Committee agreed with the Assessor's conclusion that the Respondent met the standard in terms of the performance of the procedure. While this was a tragic and catastrophic complication, it is a recognized risk of the surgery performed, and the fact that it occurred in this case does not in and of itself indicate that there was any deficiency in the manner in which the Respondent proceeded with the surgery.

The Committee took no further action on this area of concern.

Re: failed to obtain consent to use the right T10 rib as a bone graft

The Complainant appeared to have been completely surprised by the fact that part of the rib was resected and used to fill screw holes. The Respondent told the College that she did discuss the use of the T10 rib as a bone graft with the Complainant on several occasions.

The Committee was unable to know with certainty exactly what was discussed, and the Respondent may have mentioned the rib resection to the Complainant. In general, her consent discussions were not documented in the chart in sufficient detail. Her note did indicate possible thoracoplasty, but there is no evidence that she discussed rib resection with the Complainant to the extent that the Complainant understood; in this regard, consent was not adequately informed. On this basis, the Committee determined a caution in person and education through an undertaking was appropriate.

Re: failed to properly and adequately disclose to the Complainant what occurred during the surgery and outcome

The Respondent told the College that she first spoke with the Complainant's parents, and then once the Complainant was stabilized and alert, she spoke to the Complainant about the spinal cord injury and told the Complainant that he had paralysis or paraplegia, not that his legs were "asleep."

The nursing record supports several discussions occurring between the Respondent, the Complainant and his family post-operatively. Again, the Committee could not know with certainty what the Respondent said to the Complainant. The Respondent made two notations regarding her post-operative discussion with the family initially, and again when the Complainant was transferred. Significantly, the Respondent never documented having a discussion with the Complainant and this should have been done.

These were significant discussions in which the Respondent was disclosing harm after surgery with a catastrophic result. These discussions should have been carefully documented with both the Complainant and his family.

The Committee also noted that the Respondent has had prior College complaints and investigations. In addition to dispositions imposing practice restrictions, education, monitoring and re-evaluation, concerns have been expressed with her communications, including the disclosure of harm.

The Committee decided this area of concern would also form part of the caution in person for the Respondent as well as the education she agreed to pursue.

This summary was amended following a review by the Health Professions Appeal and Review Board ("HPARB"), a decision by HPARB dated July 23, 2021, and the Committee's consideration of the matter on February 18, 2022.