SUMMARY

DR. MIAH HAHN (CPSO #59311)

1. Disposition

On March 17, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") required orthopedic surgeon Dr. Hahn to appear before a panel of the Committee to be cautioned with respect to her failure to take responsibility for the deficiencies in her care, and for overlooking the clinical findings in discussions with the parents of a patient and not reporting her practice restrictions to the College.

2. Introduction

The parents of a patient complained to the College that Dr. Hahn failed to provide appropriate care to their daughter from September 2006 to April 2007. Dr. Hahn performed an open left hip reduction on their one-year-old daughter for late hip dislocation. It was found after surgery that the patient's left hip was dislocated and she required further surgeries.

The parents complained that Dr. Hahn failed to perform their daughter's surgery correctly, failed to assess their daughter during her hospitalization, and failed to inform them and their family physician that the surgery had not been successful.

Dr. Hahn responded that she performed a left hip reconstruction, open reduction femoral osteotomy with internal fixation, soft tissue reconstruction of the hip, and application of a hip spica cast on the patient in October 2006. She indicated that she followed the patient closely in the post-operative period between October 2006 and January 2007, with x-rays every four to six weeks. Dr. Hahn noted that there were no changes to the hip during this time period except

lack of growth and healing of the femoral osteotomy. She indicated that she was direct and forthright in all of her communication with the patient's health care providers.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider ("IO provider") who specializes in orthopedic surgery. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

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 IO provider indicated the following in the IO report:

- It was not Dr. Hahn's surgical care that fell below the standard in this case but her post-operative clinical management.
- The discrepancy between Dr. Hahn's perceived communication and the family's feeling that Dr. Hahn's communication was inadequate suggests that Dr. Hahn lacks insight into how effective a communicator she is.
- Subluxation of the hip was evident as early as December 15, 2006, and more pronounced by January 19, 2007. Dr. Hahn failed to recognize the change in position and was planning to follow along without intervention.

- Dr. Hahn demonstrated a lack of knowledge in that she was unable to identify the most concerning and common complication related to her surgical intervention and post-operative care.
- Even when Dr. Hahn documented that she was concerned about subluxation and felt a pelvic osteotomy might be required, her plan was not to refer the patient but to follow up in three months.
- There is no documentation to suggest that Dr. Hahn recognized that a dislocation occurred or that she planned to intervene in regard to the patient's dislocated hip.

The Committee agreed with the IO provider's conclusion that there were deficiencies in Dr. Hahn's post-operative care in this case and that she failed to communicate adequately with the patient's parents. There was radiological evidence as early as December 2006 that the patient's hip was dislocated rather than simply subluxed, but Dr. Hahn's documented plan involved follow-up rather than intervention. It is not possible for the Committee to determine at what stage Dr. Hahn recognized the situation with the patient's hip, but it seems unlikely that she communicated to the parents about any problems, as it appeared they were completely unaware until their family physician referred them to another orthopedic surgeon.

Dr. Hahn indicated in her response to the complaint that she informed the family that a second surgery would be needed in March. Her notes, however, state that the plan was further observation. It appeared to the Committee that Dr. Hahn overlooked the clinical findings in her discussions with the patient's parents. They reported that they expressed concern to Dr. Hahn that the x-ray reports mentioned dislocation, but Dr. Hahn dismissed their concerns and told them the surgery had been successful.

The Committee found support for this version of events in the fact that the patient's parents continued to bring her to Dr. Hahn for follow-up for some months before deciding that they wanted a second opinion. It seemed unlikely to the Committee that if Dr. Hahn had accurately

conveyed the radiological findings, the parents would have wanted intervention for their daughter's dislocated hip to be delayed.

Dr. Hahn claimed that she referred the patient to another orthopedic surgeon for a second opinion. The investigative record indicates that the patient's mother herself arranged this referral through the family physician. In addition, Dr. Hahn reported that she communicated adequately with the family physician, whereas the family physician described minimal communication from Dr. Hahn. The family physician noted that the x-ray reports that accompanied Dr. Hahn's notes showed femoral head dislocation, but Dr. Hahn stated in her note to the family physician dated March 9, 2007, that her plan was to have another x-ray in three months.

The Committee found it concerning that Dr. Hahn showed minimal insight into the deficiencies in her care in this case. In her responses to the complaint and the IO report, Dr. Hahn maintained that she provided appropriate and thorough care, despite obvious deficiencies identified in the IO report. Dr. Hahn acknowledged only that her communication with the family could have been better.

The Committee is aware that Dr. Hahn has signed an undertaking with the College in a parallel matter. The undertaking requires, among other things, that Dr. Hahn practice under supervision for a period of time and undergo a reassessment of her practice.

In light of the above, the Committee was of the view that it would be appropriate to issue a caution to Dr. Hahn in this case.

The Committee noted that Dr. Hahn came to an agreement with her hospital to cease performing surgery for developmental dysplasia of the hip in infants. She did not notify the College about this change in her privileges, nor did the hospital. The College was dismayed about Dr. Hahn's lack of candour in regard to the restriction on her privileges and decided to

add this issue to the caution it will deliver to Dr. Hahn. We noted that this restriction was also added to the undertaking Dr. Hahn signed with the College in the parallel matter.