



Suite 5005 -- 7071 Bayers Road
Halifax, Nova Scotia
Canada B3L 2C2
Phone: (902) 422-5823
Toll-free: 1-877-282-7767
Fax: (902) 422-5035
www.cpsns.ns.ca

**Summary of Decision of Investigation Committee re: Dr. Martin Dzierzanowski
Truro, Nova Scotia**

By decision dated June 9, 2014, Investigation Committee "B" (the "Committee") of the College of Physicians and Surgeons of Nova Scotia ("College") has concluded its investigation of Dr. Martin Dzierzanowski.

A complaint was initiated by family members of a patient respecting a gall bladder surgery performed by Dr. Dzierzanowski in 2012. In the course of that surgery, Dr. Dzierzanowski attempted to biopsy the patient's gall bladder. Pathology later confirmed that the biopsy was of the patient's pancreas. Dr. Dzierzanowski concluded the surgery, having been unable to remove the patient's gall bladder as intended. Post-operatively, the patient's condition deteriorated. Dr. Dzierzanowski arranged for transfer of the patient to Halifax. The patient underwent further surgery and later passed away.

On October 10, 2012, the Committee issued an interim restriction of Dr. Dzierzanowski's licence to practise medicine, pursuant to section 54 of the *Medical Act*. Dr. Dzierzanowski was restricted from performing any surgery requiring conscious sedation or general anaesthesia. He was permitted to continue to see patients in his office and to do minor office-based procedures with the investigation ongoing.

The Committee later permitted Dr. Dzierzanowski to perform endoscopies, after being satisfied that no concerns with endoscopies had been identified, and that adequate support and back-up was available for such procedures if needed.

The College conducted an audit of Dr. Dzierzanowski's charts to review his general surgical competence. The audit identified positive aspects of Dr. Dzierzanowski's practice, and did not identify specific instances of surgical error. The audit did note that Dr. Dzierzanowski showed a willingness to embark on difficult surgeries on complicated patients that arguably would be more appropriately done in a tertiary center, although the audit recognized this was a judgment call that differs among surgeons.

On December 2013, Dr. Dzierzanowski returned to limited practice, participating in a period of direct supervision by another surgeon for purposes of ongoing assessment.

The supervisor provided reports to the College, indicating he found no deficiencies in Dr. Dzierzanowski's approach to patients, his preparation for surgery, or his technical skill.

Following consideration of all material gathered during the investigation, the Committee concluded that Dr. Dzierzanowski:

- (1) Failed to demonstrate appropriate knowledge, skill and judgment during the February, 2012 surgery;
- (2) Failed to communicate appropriately with the family of the patient when the pathology report was received;
- (3) Failed to maintain adequate chart documentation respecting the patient; and
- (4) Failed to maintain legible and complete chart documentation on a variety of other patients.

As a result of these conclusions, the Committee issued the following disposition:

- (1) Dr. Dzierzanowski is reprimanded for the deficiencies in his practice identified by the Investigation Committee;
- (2) Dr. Dzierzanowski must complete the next available offering of the Medical Record Keeping Course, offered in Ontario;
- (3) The prior restrictions on Dr. Dzierzanowski's licence are lifted and replaced with additional restrictions and conditions respecting particular surgeries, details of which are available through the College;
- (4) Dr. Dzierzanowski will have his surgical cases audited for the next six month period, and any concerns will be immediately reported to the College.
- (5) Dr. Dzierzanowski will pay a contribution toward the College's costs in this matter.

Upon completion of the six month audit period, the restrictions and conditions on Dr. Dzierzanowski's licence will be lifted. The final results of the audit will be reviewed by the Physician Performance Department of the College to determine whether any further action is needed.

The Investigation Committee of the College concluded that this disposition, when combined with the earlier restrictions and conditions placed on Dr. Dzierzanowski's license since 2012, reflects the serious concerns of the Committee concerning the failure to apply appropriate knowledge, skill and judgment during the surgery on February, 2012. At the same time, the Committee recognizes that the audits and assessments throughout the College's investigative process did not identify any pattern of surgical errors or current deficiencies in practice that warranted more significant disciplinary intervention.