SUMMARY

DR. MARK ALEXANDER SWANSON (CPSO# 33403)

1. Disposition

On September 12, 2018, the Inquiries, Complaints and Reports Committee (the Committee) ordered radiologist Dr. Swanson to complete a specified continuing education and remediation program (SCERP). The SCERP requires Dr. Swanson to:

- Practice under the guidance of a Clinical Supervisor acceptable to the College for three months
- Engage in self-directed learning and review and discuss with the Clinical Supervisor the following: relevant Clinical Practice Guideline(s), Canadian Association of Radiologists Standard for Communication of Diagnostic Imaging Finds, and the Choosing Wisely Canada recommendations for diagnostic imaging
- Approximately three months after completion of the program, undergo a reassessment of his practice by an assessor selected by the College.

2. Introduction

The College received information regarding Dr. Swanson's resignation of his hospital privileges during the course of an investigation into allegations relating to the clarity and timeliness of his reporting of diagnostic imaging. The Committee approved the Registrar's appointment of investigators to conduct a broad review of Dr. Swanson's practice.

3. Committee Process

As part of this investigation, the Registrar appointed a Medical Inspector to review a number of Dr. Swanson's patient charts and submit a written report.

A General Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the investigation. 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 had concerns around Dr. Swanson's ability to communicate the interpretation of reports based on an internal review at the hospital where he worked. The hospital's review identified, among other things, issues in Dr. Swanson's reporting which could lead to unnecessary overutilization of resources, in some cases, lead to increased radiation exposure to patients.

The Medical Inspector retained by the College provided a report concluding that Dr. Swanson did not pose a potential risk of harm to patients. The Medical inspector did not identify any major concerns, except one case in which Dr. Swanson did not meet the standard of care. In the Committee's view, this case was concerning.

The Medical Inspector noted cases in which Dr. Swanson made no statements or conclusions as to whether the findings were abnormal or normal. The Committee believes this is an area for improvement.

Dr. Swanson no longer practices at the hospital. The Committee remains concerned that several of Dr. Swanson's reports took longer than the average time to complete. A lack of timely communication of reports can have an impact on patient care.

The Committee believes that for this reason, and given the concerns related to Dr. Swanson's medical record keeping noted above, Dr. Swanson would benefit from a period of continued monitoring and education to ensure that his reports are timely and appropriate within the clinic setting and are mindful of resource utilization implications.