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. Jodie Lynne Mary Calvert Wang (CPSO# 61291)
(the Respondent)

INTRODUCTION

The late Patient attended the Franklin Medical Centre, a clinic run by the Respondent and a colleague. On two occasions in August 2013, the Respondent and her colleague both assessed the Patient for an abnormal x-ray. The Respondent ordered a CT scan for the Patient, who attended for this on October 3, 2013.

The Complainant, who was a family member of the Patient, recalled contacting the clinic frequently for results, but not receiving any. In January 2014, the Patient attended a hospital Emergency Room. A physician there obtained a copy of the October CT scan result, which showed that the Patient had lung cancer with involvement of the lymph nodes. The Patient died in February 2014.

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

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent failed to review the results of a CT scan in a timely manner, thus delaying the Patient's diagnosis and treatment.

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of July 24, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to ensuring a practice structure that provides optimum patient care and appropriate follow up for abnormal test results, with a written submission on the College's policy on *Test Results Management* and on the College of Family Physicians of Canada (CFPC)'s guidelines on running a family practice.

COMMITTEE'S ANALYSIS

As part of this investigation, the Committee retained an independent Assessor who specializes in family medicine. The Assessor opined that the Respondent's care of the Patient failed to . meet the standard of practice, that the Respondent's care displayed a lack of skill, knowledge or judgement, and that if the report had been obtained in a timely fashion, the Patient could have

been referred to consultants earlier so that both he and his family would appreciate that everything possible was being done for him. The Respondent concurred with the Assessor's view that, in this instance, her care fell below the standard of care for family doctors in Ontario

The Respondent was the ordering physician for the Patient's CT scan and had responsibility for following up on what had happened to it. The failure in this case resulted from a combination of Franklin's "shared care model" which made it difficult to determine who was the most responsible physician for a patient, and Franklin's disorganization around test result management.

The College's Policy on *Test Results Management* outlines the College's expectations for physicians regarding the management of all types of test results in all of their places of work. It discusses both system requirements and physician obligations respecting follow-up. The Committee asked the Respondent to review this policy and provide a written summary of what she has learned, so that the Committee could discuss with her at her caution how she can ensure that her current and future practices meet the College's expectations regarding management of test results.

Similarly, the CFPC has guidelines available on running a family practice (which do not recommend the "shared care" model) and the Committee also asked the Respondent to review and summarize these, to help ensure her future patients are treated in an appropriate practice model.