

SUMMARY

DR. EDWARD STERNTHAL (CPSO# 25411)

1. Disposition

On July 5, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required general surgeon Dr. Sternthal to appear before a panel of the Committee to be cautioned with respect to the timely follow up of test results.

2. Introduction

The Patient complained to the College about Dr. Sternthal's care when he attended two visits in July and October 2017 for the management of perianal lesions. Specifically, the Patient expressed concern that Dr. Sternthal failed to send a referral to a colorectal surgeon in a timely fashion after pathology results showed neoplastic lesions, and also included erroneous information in the consultation request.

Dr. Sternthal apologized for not referring the Patient earlier. He also acknowledged incorrectly stating the Patient's age and the date of his visit in the consultation request to the colorectal surgeon.

3. Committee Process

A General 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 record indicates that Dr. Sternthal received a pathology report in late July 2017 which showed high grade squamous intra-epithelial neoplasia. He then wrote to the Patient's family doctor in mid-August advising that he would be referring the Patient for management of his perianal advanced neoplastic lesions.

Dr. Sternthal advised the Patient of the pathology results at his next visit in mid-October. He stated that he would have discussed the need for a referral to a colorectal surgeon at the time of the visit.

The Committee found it concerning that Dr. Sternthal delayed three months in informing the Patient of biopsy findings that were time sensitive and in arranging appropriate follow-up. The Committee was also concerned that after informing the Patient of the results and the need for a referral during the October visit (and writing to his family physician on the same date, again advising that he would arrange such a referral), Dr. Sternthal did not do so until he received a telephone call from the Patient approximately two weeks later.

Dr. Sternthal expressed regret for not referring the Patient sooner, and he stated that he is now more diligent in addressing the follow-up needs of his patients. While the Committee acknowledged that Dr. Sternthal demonstrated insight into his errors in this case, the Committee was concerned by his failure to adequately and appropriately follow up on the Patient's significant positive biopsy results in a timely manner.

In the circumstances, the Committee determined that it was appropriate to require Dr. Sternthal to attend for a caution as set out above.

In addition, given Dr. Sternthal's acknowledged inaccuracies in the consultation request, and the Committee's finding that his handwritten records were difficult to decipher, the Committee issued advice to Dr. Sternthal to ensure his records are meticulously accurate and legible.