SUMMARY

Dr. Patrick Joseph Whelan (CPSO# 52250)

1. Disposition

On June 10, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") ordered Dr. Whelan, a general practitioner to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Whelan to:

- Attend and successfully complete the next available course or program on surgical approaches to neck masses through a course provider acceptable to the College
- Review and provide written summaries of the following documents:
    - Cancer Care Manitoba Practice Guideline on Disease Management;
    - Cancer Care Ontario Practice Guideline on The Management of Head and Neck Cancer in Ontario; and
    - The College's policy statement on *Test Results Management* #1-11
- Within six months, undergo a reassessment with an assessor selected by the College

2. Introduction

A family member of a patient complained to the College that Dr. Whelan indicated that the patient had no risk factor for the development of head and neck malignancy when the patient had been a smoker for the past 20 years, and that Dr. Whelan failed to order a repeat biopsy when a cytology report indicated that the sample was not diagnostic and that a repeat biopsy was recommended.

Dr. Whelan responded that the patient's family physician referred the patient to him for an assessment of lipoma around the neck region, so he saw the patient and ordered a CT scan. The CT scan results showed several nodes and a complex cystic mass and the recommendation was that the patient undergo an ultrasound guided Fine Needle Aspiration ("FNA") biopsy. The results of the biopsy were "non-diagnostic" and a repeated FNA biopsy was recommended. Dr. Whelan discussed the results with the patient and proceeded to do a second FNA biopsy in his office. The node disappeared upon being punctured and produced only clear innocuous fluid,

and based on this test, Dr. Whelan concluded that the node was a benign process as opposed to a neoplastic one. The patient's family physician referred the patient to Dr. Whelan again a year later for recurrence of enlarged lymph glands and on examination he concluded that an open biopsy was indicated. The pathology report on the lesion confirmed a diagnosis of metastatic squamous carcinoma and he subsequently discussed the results with the patient and referred him to an oncologist.

3. Committee Process

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 Committee noted that the initial CT scan report indicates that the patient's lesions were concerning for malignancy and that a benign diagnosis was therefore less likely to be the case. Despite the report, and Dr. Whelan's own consultation in which he must have considered cancer as part of the differential diagnosis, he did not order a repeat CT scan or FNA by interventional radiology.

In the Committee's view, Dr. Whelan should have, at a minimum, arranged for a repeat CT scan in three months or less and then either a repeat FNA by interventional radiology or open biopsy. The chance of missing a tumour without an ultrasound-guided biopsy is a serious risk and in the interim the patient was left for over a year without a diagnosis. When a patient presents with a large mass in his or her neck, one should not take a benign diagnosis as an answer by default; one should pursue every single avenue of investigation to reach a firm diagnosis.

The Committee was unclear as to why Dr. Whelan did not order a repeat CT scan or FNA by interventional radiology and from its perspective, either his judgment was flawed in not

following up on the first report, or there is a broader deficiency in his practice in that he does not have appropriate mechanisms in place to ensure follow-up on clinically significant results.

The Committee stressed the importance of having a failsafe system in one's office where there is a protocol that the result of each and every investigation gets logged, and the log gets checked every week or two, so that when specimens or reports come in they are not missed and are followed up on in a timely manner and with the appropriate level of urgency if necessary. The College's policy on *Test Results Management* clearly indicates that when a physician receives a clinically significant result for a test that he or she has ordered, the physician must take appropriate action and follow up with the patient with appropriate level of urgency. A clinically significant result includes serious symptoms and/or life-threatening illness.