SUMMARY

DR. STEWART (CPSO# 67001)

1. Disposition

On August 13, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required neurologist Dr. Stewart to appear before a panel of the Committee to be cautioned with respect to his inappropriate test results management and failure to inform a patient of a significant diagnosis.

2. Introduction

The Patient first saw Dr. Stewart in 2011, at which time Dr. Stewart provided the Patient with a laboratory test requisition, which included testing for a significant, progressive hereditary condition. The Patient is concerned that Dr. Stewart did not inform her that he was testing for the condition, and failed to inform her of the positive test results, causing a five-year delay in the diagnosis and treatment of the condition.

Dr. Stewart responded that the requisition he gave to the Patient clearly states that she would be tested for the condition in issue. He suggested that perhaps the Patient's recollection was being affected by her failing memory, and maintains that the Patient left the office knowing that he suspected the condition and that the purpose of the testing was to confirm this.

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 Committee was not able to determine with any certainty what Dr. Stewart may or may not have discussed with the Patient during the appointment, but considered that there may have been a lack of adequate communication regarding the purpose of the testing, such that it was not properly understood by the Patient.

Regardless of whether Dr. Stewart discussed the reason for the blood work, the fact remains that he failed to ensure that the Patient received her genetic testing results. The Committee noted that this significant failure has resulted in serious consequences for the Patient. The Committee also pointed out that genetic testing carries implications which can affect life choices, and as such, it is important to inform patients of genetic testing results in a timely manner.

While Dr. Stewart stated that he tried to call the Patient multiple times about the test results but could not reach her, there was no documentation of any such attempts in the record, and the Patient stated that she never received any calls from Dr. Stewart or his office regarding her results. There was also no documentation of any planned follow-up by Dr. Stewart with respect to the abnormal findings.

Given the significant nature of the test results, in the Committee’s view a prudent physician would have tried other means of getting the information to the Patient, including reaching out to her family physician in order to schedule another appointment to discuss the results in person. The Committee pointed out that if the Patient’s mental health history and memory issues were indeed so significant (that they impaired her ability to remember correctly), then a prudent physician would have taken all the more care to ensure that the Patient or her family physician were informed of her results. As it stands, the Patient was left to believe that there

was nothing to be concerned about, which delayed her ultimate diagnosis by approximately five years. The Committee noted that this is not acceptable, and that in this regard, Dr. Stewart failed to comply with the College's policy on *Test Results Management.*

The Committee was also concerned that Dr. Stewart has not shown insight into his shortcomings in this case and has not taken responsibility for his error, nor has he provided any assurance to the Committee that he has reviewed or made changes to his process for managing test results. As such, the Committee was not convinced that a similar oversight would not happen again. Given all of the above, the Committee felt the appropriate disposition in this matter was to caution Dr. Stewart in person, as outlined above.