

## **SUMMARY**

### **DR. ELIZABETH GALANTER (CPSO# 61908)**

#### **1. Disposition**

On October 3, 2017, the Inquiries, Complaints and Reports Committee (the Committee) required paediatrician Dr. Galanter to appear before a panel of the Committee to be cautioned with respect to: assessment of paediatric headache; ordering tests without adequate indication; retention of records; altering records inappropriately; and ordering tests on family members who are not her patients and with no clinical indication. The Committee also noted that Dr. Galanter had resigned her certificate of registration and accepted an undertaking from Dr. Galanter, which terms include never to apply or reapply to practice medicine in Ontario or any other jurisdiction, and the Committee directed its concerns about Dr. Galanter's billing to the General Manager of the Ontario Health Insurance Plan (OHIP).

#### **2. Introduction**

A family member of a patient complained to the College that Dr. Galanter failed to diagnose an underlying brain tumour despite symptoms of persistent headache and vomiting, failed to consider other diagnoses or make a referral to another health care provider when ordered test results came back negative and dismissed parental concerns.

In her response, Dr. Galanter described her two appointments with the patient and her family, and that her physical and neurological examinations both times were non-concerning, save and except for small, soft, anterior cervical nodes, less than 0.5 cm in diameter, noted at the first appointment. She said that she thought the patient's headaches were possibly migraines and suggested a CT scan. The parties disagree on who decided to put off doing the CT scan. Dr. Galanter ordered blood work, including vitamin D levels, and suggested the patient take vitamin

D daily. Dr. Galanter also arranged for the patient to see a paediatrician who was joining her practice who had training in gastroenterology.

### **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.cpsso.on.ca](http://www.cpsso.on.ca), under the heading "Policies & Publications." In this case, the Committee referenced the College policy, *Medical Records* (#4-12).

### **4. Committee's Analysis**

The Committee was perturbed that Dr. Galanter changed her records for the patient after learning of the patient's diagnosis (made later by another physician); the Committee noted Dr. Galanter did so without marking her changes as a late entry, and this was not in accordance with the College's policy on *Medical Records*. The Committee was also concerned that the original note was nowhere to be found in Dr. Galanter's records. The Committee was of the view that this made it difficult to assess Dr. Galanter's care. It also found it difficult to accept that Dr. Galanter had done a detailed neurological examination, which had not been present in her earlier note (a copy of which the College received from another physician involved in the patient's care).

The Committee was of the view that Dr. Galanter ordered testing that appeared to be largely irrelevant to the patient's documented history, as well testing that was not necessary (including for vitamin D, B12, and zinc levels). In addition, records show Dr. Galanter ordered testing for other family members she had not assessed and who were not her patients.

The Committee observed that the fact the patient's tumour was not diagnosed until later would not necessarily have been problematic if Dr. Galanter had done a reasonable assessment and if the other issues arising from the investigation were not so concerning. Dr. Galanter's involvement was early on and there may not have been specific physical findings at that time, but in the Committee's view it was difficult to be certain, due to the changes Dr. Galanter made to the chart.

The Committee was satisfied that Dr. Galanter did arrange for the patient to see a paediatrician with gastroenterology training, and while it seemed she was not listening as carefully as she should have to the patient's parents, she did talk about this referral with them.

However, overall, the Committee was very concerned by Dr. Galanter's behaviour and practice in this case, including her clinical management of the case, ordering tests without adequate indication, retention of records, altering records inappropriately and ordering tests on family members who were not her patients and with no clinical indication. For all these reasons, it concluded that Dr. Galanter should attend at the College to be cautioned.

Noting its concerns from this case, along with those raised in a wider, parallel investigation, and Dr. Galanter's resignation of her certificate of registration, the Committee also accepted an undertaking from Dr. Galanter, which terms include that she never apply or re-apply for registration as a physician in Ontario or any other jurisdiction, she deactivate her OHIP billing number, and she acknowledge that she was the subject of College investigations into her general medicine practice. The Committee stated that given Dr. Galanter's undertaking, its remaining concerns about public protection were satisfied.

Finally, given the Committee had concerns about Dr. Galanter's OHIP billings, it directed such information to the General Manager of OHIP.