SUMMARY

DR. WENDY ROSENTHALL (CPSO# 32177)

1. Disposition

On February 12, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required internist and endocrinologist Dr. Rosenthall to appear before a panel of the Committee to be cautioned with respect to compliance with the College policy, *Test Results Management*, and to review and submit a written report of the policy.

2. Introduction

The College received information from a family physician raising concerns about Dr. Rosenthall's test results management in her endocrinology practice, including that she missed a clinically significant test result for Patient A, which resulted in a delayed diagnosis of cancer recurrence. Subsequently, the Committee approved the Registrar's appointment of investigators. As part of this investigation, the Registrar appointed a Medical Inspector to review the relevant patient chart and submit a written report to the Committee.

Dr. Rosenthall responded that her test management system is not, and never has been, to only review test results when patients return for a follow-up visit. She only became aware of the missing CT scan result for Patient A when the family physician contacted her. She does not dispute the Medical Inspector's opinion that she erred in failing to communicate the clinically significant CT scan result to Patient A, and failing to arrange follow-up in a timely manner. She deeply regrets that this error occurred. Regarding the elevated antibody test results, Dr. Rosenthall told the College that she was waiting to communicate that result after she received the CT scan result to avoid causing Patient A undue anxiety.

3. Committee Process

An Internal Medicine Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the investigation. 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 Medical Inspector concluded that Dr. Rosenthall did not meet the standard in the care she provided to Patient A. Specifically, the Medical Inspector found Dr. Rosenthall failed to communicate and follow up on clinically significant and abnormal test results (that is, a CT scan and anti-thyroglobulin antibody results) in a timely manner.

The Committee agreed with the Medical Inspector and was troubled that Dr. Rosenthall overlooked these clinically significant results for Patient A, and did not have a system in place such that these results were flagged correctly. This was a serious miss, as the CT scan showed a recurrence of cancer, and Dr. Rosenthall provided no reasonable explanation as to why the result was missed (other than it was mistakenly filed before she saw it), which resulted in Patient A not attending for appropriate follow-up. Had the primary care physician not seen the clinically significant CT scan result some nine months later, Patient A would have been unaware of these results, and that the cancer had recurred.

In this instance of a clinically significant result showing the recurrence of cancer, we would have expected Dr. Rosenthall and/or her staff to alert Patient A that a clinically significant test result had been received, even if the details of the result were only provided in person. Furthermore, if Patient A did not attend the scheduled visit, the Committee would have expected Dr. Rosenthall and/or her staff to contact the patient about the need to reschedule, as otherwise

Patient A might have assumed any results received were normal or of no concern. By the time Patient A missed their appointment, three months had passed since the result (showing a recurrence of cancer) had been received.

Similarly, Dr. Rosenthall did not inform Patient A of another abnormal result, that is, of elevated antibodies, either in advance of the appointment or after the appointment was missed. Again, she had no alert in her test management system to ensure this result was communicated to Patient A in a timely manner.

Dr. Rosenthall also told the College that she did not physically mark test results to show she had seen them. We would have expected her to record that she has reviewed test results (such as by initialling, stamping or dating them) after she looks them. As a result of her failure to mark her review of results, it is impossible for the Committee to know if Dr. Rosenthall actually reviews results before they are filed, or if she simply waits until a patient attends, and then reviews any results received at that time.

While this was a major miss and was concerning to the Committee, Dr. Rosenthall has recognized the error and deficiency in her practice, and taken appropriate steps to improve her management of test results to prevent the error from recurring.