

**SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee
(the Committee)**
(Information is available about the complaints process [here](#) and about the Committee [here](#))

**Dr. Anatoly Dimitri Ross (CPSO # 89462)
(the Respondent)**

INTRODUCTION

The Complainant was a patient in the Respondent's family practice, and underwent chest x-rays in February and November 2016, followed by a CT scan in July 2017, which led to a diagnosis of lung cancer. The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent:

- failed to follow-up on significant clinical findings on two chest x-rays in 2016, where further investigations were suggested by the radiologist (a subsequent CT scan in 2017 confirmed lung cancer that would have been diagnosed in 2016); and
- said that he would not have done anything differently.

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of June 12, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to his test results management and medical record-keeping. In addition, the Committee directed the Respondent to complete a specified continuing education or remediation program that included:

- completing the *Medical Record-Keeping Course*, and the Canadian Medical Protective Association eLearning modules - Documentation: Charting Medical Records and Documentation II: Principles of Medical Record Keeping, at the first available date;
- reviewing and providing a summary of College policies, *Medical Records* and *Test Results Management*;
- a reassessment approximately six months following the Respondent's completion of the remediation.

The Committee took no action regarding the concern that the Respondent said he would not have done anything differently.

COMMITTEE'S ANALYSIS

Test results management

- While the Respondent recalled reviewing the Complainant's x-ray results from February 2016 with her at a visit in August 2016, his notes do not mention the results or any discussion with the Complainant about them and the Complainant's recollection was that she was not told anything about the results of this x-ray (or of the subsequent x-ray in November 2016) until July 2017, when the Respondent ordered the CT scan (approximately 16 months after it had originally been suggested by a radiologist).
- It is clear that the Complainant's second chest x-ray did not occur until November 2016, and the Respondent did not review the findings with the Complainant until a visit in June 2017, some seven months later. The Respondent acknowledged the lengthy delay, offered his apologies, admitted that the delay was unacceptable, and advised that it was not his standard practice. He also advised that the delay could be attributed, in part, to the delay in his office receiving a copy of the report for the second chest x-ray. The Respondent outlined steps he was taking to improve his test management system.
- The College's policy on *Test Results Management* states that managing test results effectively is vital to quality patient care, and that a failure to follow up on test results can lead to patient harm. The policy sets out the expectations for physicians, which includes the expectation that a physician will develop and maintain an effective system for managing test results in order to ensure that appropriate follow-up on test results occurs. When in receipt of a clinically significant result, physicians are expected to communicate that result to their patient in a timely fashion, urgently if necessary, and to take appropriate action with appropriate urgency.
- The Respondent clearly failed to follow up on the Complainant's abnormal investigations in a timely and appropriate manner (both after the February 2016 x-ray and the November 2016 x-ray), thereby demonstrating very poor test results management. While the Respondent pointed to the fact that the Complainant did not have "red flag" symptoms when he saw her in August 2016, the Committee noted that in a patient of the Complainant's age, whether a smoker or not, a finding of an obvious mass on x-ray images is an indication for further, prompt investigations. The Committee

was concerned that the Respondent demonstrated a lack of insight in failing to identify the inappropriate delay in following up on the initial chest x-ray. Overall, the Committee was struck by the fact that the time between the tests the Respondent ordered and his response to the results obtained far exceeded the standard.

Medical record-keeping

- The Committee also had significant concerns about the Respondent's record-keeping in this case, including a lack of complete documentation of patient visits, including the discussions he had with the Complainant about the imaging results and their significance, the differential diagnoses (if any) he reviewed with her, and a clear outline of his management plans.