

SUMMARY

Dr. Joseph Antonio Zadra (CPSO# 52584)

1. Disposition

On September 26, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required urologist Dr. Zadra to appear before a panel of the Committee to be cautioned with respect to review and appropriate follow-up of test results. Further, the Committee requested that before attending for the caution, the Respondent provide the Committee with a written report with respect to College Policy #1-11, *Test Results Management*, including the importance of reviewing imaging reports thoroughly, effectively communicating the results to patients and arranging appropriate follow-up.

2. Introduction

The patient complained to the College that Dr. Zadra failed to provide appropriate follow-up and investigations regarding a computed tomography (CT) scan that he ordered, where the CT report indicated that the patient had a mass that required further investigation.

Dr. Zadra responded that he focused on the main reason he was asked to assess the patient (renal cysts), and read only the part of the radiology relating to her kidneys. As a result, he did not identify the described non-urologic abnormality on the CT.

3. Committee Process

A 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 College's Policy #1-11, *Test Results Management* states, "When a physician receives a clinically significant result for a test that he or she has ordered, the physician is expected to take appropriate action and follow-up with the patient with appropriate urgency."

The Policy makes no exception for results related to any particular system of the body. In the present case, as the ordering physician of the CT scan, Dr. Zadra should have informed the Complainant of the abnormal findings which would have expedited the needed further work-up and treatment of the patient's lymphoma. The Committee was troubled to note that the Respondent appeared to lack insight into this significant deficiency.

The Committee noted Dr. Zadra's history with the College which included previous advice from the Committee in a case involving poor follow-up of a renal lesion on a CT scan.