SUMMARY

DR. PAUL RUSSELL HANSON (CPSO# 65864)

1. Disposition

On January 17, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required general practitioner Dr. Hanson to appear before a panel of the Committee to be cautioned with respect to following the College's policy *Test Results Management* regarding critical results, and the policy *Medical Records* regarding adequate record-keeping; and with respect to proper follow-up of a patient on anticoagulation.

2. Introduction

A family member of the patient complained to the College that Dr. Hanson failed to provide appropriate care to the patient in that he failed to notify them that a blood sample provided for an INR (international normalized ratio) test (a measurement to determine the effect of anticoagulants on the body's blood clotting) was rejected by the laboratory and that another blood sample was needed. The following week, the patient suffered two falls and was taken by ambulance to the hospital where she was diagnosed with subdural hematomas on both sides of her brain. She subsequently underwent emergency surgery.

Dr. Hanson responded that his office never received any verbal or written notification from the laboratory of the problem with the patient's blood sample and the need for the patient to provide a new sample. He advised that while it is not routine practice in his experience for a laboratory to contact his office to have him contact a patient to repeat a mishandled specimen, if they had been contacted by the laboratory in this case, he or his office staff would have called the patient and told her to provide a further sample as soon as possible.

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

There is no dispute that the patient followed Dr. Hanson's instructions to provide a blood sample for INR testing, and that as a result of a technician's error, the sample was placed in the incorrect vial and the INR test could not be performed. What is unclear is what communications, if any, occurred between the laboratory and Dr. Hanson's office regarding the error and the need for a further sample. While the laboratory maintains that it attempted to contact Dr. Hanson's office by telephone and faxed a note to his office the day after receiving the blood sample in order to notify him of the problem, Dr. Hanson and his staff deny receiving any communication from the laboratory, and there is no record of the sent fax to assist in determining what occurred.

Regardless of whether Dr. Hanson's office received the fax from the laboratory, it is concerning that Dr. Hanson did not follow up on the results of the patient's INR test when he did not receive them within the usual period of time. This was particularly important given his statement that the patient had been somewhat poorly compliant and was at high risk of adverse events.

The College's policy *Test Results Management* acknowledges that managing a patient's test results effectively is vital to quality patient care, and that a failure to follow up on results can lead to patient harm. The policy states that when ordering a test for a patient who has a high risk of receiving a clinically significant result, physicians must communicate to the patient the

added significance of taking the test, and ensure results are received when expected, and tracked if not received. In this case, it was incumbent on Dr. Hanson to follow up on the patient's INR results in a timely fashion, which he failed to do. There is no indication in the information Dr. Hanson provided that he had a mechanism in place in his office to ensure that he received the patient's INR results, which was more critical in these circumstances given the fact that she had missed other INR tests and office visits and was reportedly non-compliant with instructions/dosage changes.

In terms of Dr. Hanson's overall monitoring of the patient's INR levels, Dr. Hanson's record does not indicate what was done in response to the various results (i.e. adjustment's to the patient's warfarin dosage, instructions regarding further INR tests). While Dr. Hanson stated that the patient's non-compliance had been a problem, there is very little documentation in the record regarding the management of her INR levels, which made it difficult to obtain a clear picture of this aspect of Dr. Hanson's care.

Also of concern was Dr. Hanson's failure to address the fact that the laboratory claimed it had couriered a report to his office a few days after sending the fax about the rejected blood sample. The Committee questioned why there is no documentation of receipt of this report, and how it is that two documents that the laboratory reported sending to Dr. Hanson's office went astray.

In considering the above issues, the Committee was cognizant of Dr. Hanson's history of complaints with the College, including several matters raising significant issues with his record-keeping. It noted that in some of these prior matters, Dr. Hanson had been directed to undergo remediation, which was ongoing.

In the circumstances, the Committee determined that it was appropriate to caution Dr. Hanson, as set out above.