

SUMMARY

DR. CLARA CHINYERE IROBI (CPSO# 81990)

1. Disposition

On December 14, 2016, the Inquiries, Complaints and Reports Committee (“the Committee”) required endocrinologist Dr. Irobi to appear before a panel of the Committee to be cautioned with respect to (a) test results management, including office organization and following up on test results, and (b) timely management and investigation of neck masses.

The Committee also issued advice to Dr. Irobi to ensure that she knows what is billed in her name and that all claims meet OHIP requirements.

2. Introduction

Patient A was referred to Dr. Irobi by her family doctor regarding a mass on the neck.

Patient A complained to the College that Dr. Irobi behaved unprofessionally in seeing Patient A twice without having copies of Patient A’s relevant medical reports, in failing to perform a physical assessment, and in not treating Patient A in a professional manner as she did not make eye contact with Patient A.

Dr. Irobi responded that she had a copy of Patient A’s initial ultrasound results, which was ordered by Patient’s A’s family physician, at the first appointment with Patient A, but determined it was important to wait for the results of the repeat ultrasound. She booked Patient A for a follow-up appointment approximately six weeks later, at which time she still had not received a copy of the repeat ultrasound results. At that appointment, Patient A told her a biopsy was scheduled for a few days later. She decided a follow-up appointment would be appropriate after the biopsy results were completed. She took a history from Patient A during the visits and performed a focused physical examination. Given the time she spent with Patient A, which can be confirmed by her consultation notes, it would have been impossible for her not to have made eye contact with Patient A.

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 Committee was concerned about the length of time between Patient A's referral to see Dr. Irobi for a mass on the neck and the cancer diagnosis, which was found following a fine-needle biopsy approximately two months after Patient A was referred to Dr. Irobi and was ordered by Patient A's family physician

Dr. Irobi overlooked numerous red flags, including the results of the initial ultrasound report, which suggested Patient A may have had thyroid cancer and which recommended further testing. Given Patient A had a thyroid mass, Dr. Irobi should have ordered thyroid testing in a timely manner.

Similarly, Dr. Irobi did not order other tests or imaging to monitor or work towards a differential diagnosis, and the record does not include a differential diagnosis and was quite sparse. Instead, Dr. Irobi went along with the testing as ordered by Patient A's family doctor; this, in itself, is not inappropriate. However, when she did not receive the results of the repeat ultrasound, and later the biopsy report, in a timely fashion, she should have followed up.

As Dr. Irobi did not have ideal ultrasound results for a neck mass in this case, she should have assumed the worst-case scenario and acted accordingly, including by ordering thyroid testing. As such, Dr. Irobi failed to diagnose metastatic cancer in a timely manner. The Committee was of the view that Dr. Irobi mismanaged this case and was concerned that other patients could be at risk in the future. The Committee believes a caution in person will provide a helpful opportunity to discuss this case with Dr. Irobi to prevent a similar situation arising in future.

Dr. Irobi told the College that the repeat ultrasound results from October 2015 were sent directly to the family physician and not to her, and the family doctor was to send her a copy of the

results. Under the circumstances of a referral regarding a neck mass, if Dr. Irobi did not have all the test results she required, she should have called Patient A's family doctor and had them faxed over promptly.

The College's Policy Statement #1-11, *Test Results Management*, sets out that managing test results effectively is essential to quality patient care, and that failure to follow up on test results can lead to patient harm. The Committee is of the view that Dr. Irobi needs to better organize tests, ensure she obtains test results in a timely manner, and follow up on patient concerns in a timely manner.

The Committee also noted that Dr. Irobi billed for a flu shot bonus related to Patient A's care. This bonus is intended for health care providers who administer the flu shot. Dr. Irobi confirmed that she did not give Patient A a flu shot and that she does not do this as part of her normal practice. She also told the College that she was unaware of the billings, though the clinic offers the flu shot to all patients during flu season. While the Committee recognizes that someone else likely prepared Dr. Irobi's OHIP billings on her behalf, Dr. Irobi is responsible for all billings submitted in her name.