

## **SUMMARY**

### **DR. PETER BARANICK (CPSO# 31037)**

#### **1. Disposition**

On March 8, 2017, the Inquiries, Complaints and Reports Committee (“the Committee”) required family physician Dr. Baranick to appear before a panel of the Committee to be cautioned with respect to test results management and professional communications.

#### **2. Introduction**

A patient complained to the College that Dr. Baranick failed to provide adequate care and behaved in an unprofessional manner. Specifically, Dr. Baranick informed the patient that she had an enlarged cyst on her ovary, but provided no further information with respect to management or follow-up; told her she needed a CT scan, but would not provide the requisition; and stated that he would not discuss the CT scan further or talk about other concerns that she had.

Dr. Baranick responded that he explained to the patient that she had an enlarged ovary and the radiologist recommended a CT scan; he reassured her that urgent intervention was needed and she could contact the ordering physician to arrange this in a few days. He only follows up with further investigations and refers patients to specialists where he requested the initial investigations. He does not do so for other physicians’ patients.

#### **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](http://www.cpso.on.ca), under the heading “Policies & Publications.”

#### 4. Committee's Analysis

As outlined in the College's policy on *Test Results Management*:

In certain health care environments, the physician who orders a test may not be the same physician who receives the test result (for example in the emergency room or a walk-in clinic). In these environments, practitioners should take extra care to ensure the system in place will ensure that the physician who receives the result can follow up on the result appropriately.

Handovers of care can present added challenges and risks for the safe management of test results. In particular, when handovers occur in environments like hospitals, emergency rooms, and walk-in clinics it is particularly important for physicians to consider the system that is in place to manage results and ensure they are confident the system will prevent pending results from slipping through the cracks during handovers of care from one physician to another.

The Committee is concerned that after clinic staff contacted the patient to attend to receive a test result, Dr. Baranick provided this abnormal, clinically significant result without fully explaining its meaning to her, informing her of the next steps, and taking action to ensure those steps occurred.

In the Committee's view, Dr. Baranick should have either ordered a CT scan and/or referred the patient to an obstetrician/gynecologist, even though he was not the physician who ordered the initial test. By only partially communicating this abnormal result to the patient and refusing to provide her with the required follow-up, Dr. Baranick likely increased the patient's anxiety and made her return to see a physician who would provide the required follow-up. Further, the Committee was concerned that in other circumstances, this system could lead to a patient not receiving appropriate follow-up care, should the patient not return.

Finally, the Committee noted that if Dr. Baranick does not want to review and provide test results ordered by other physicians and ensure appropriate follow-up of them, then he should not be seeing or billing OHIP for those patients.

The Committee's concern was heightened in this case by Dr. Baranick's history with the College, including several cases in which similar issues of inadequate communications with patients and follow-up arose.