SUMMARY

DR. VIKAS AGARWAL (CPSO# 81205)

1. Disposition

On June 20, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required Dr. Agarwal (Diagnostic Radiology and Family Medicine) to appear before a panel of the Committee to be cautioned with respect to a preventable/avoidable error (in the interpretation of an ultrasound) with significant risk of harm consequences.

The Committee also requested Dr. Agarwal to provide a written report about the preventive measures he has put in place to prevent this type of error from occurring again.

2. Introduction

A patient attended a hospital Emergency Room (ER) with shortness of breath. In the ER, a physician ordered an ultrasound to rule out a blood clot in the patient's leg. Dr. Agarwal was the diagnostic radiologist who reviewed the ultrasound images and initially reported there was no evidence of a blood clot. The patient died early the next morning; the cause of death was a blood clot that travelled from the right leg to the lung.

A family member of the deceased patient complained to the College about Dr. Agarwal's interpretation of the ultrasound.

Dr. Agarwal apologized for his error in interpreting the ultrasound. He noted that deep vein thrombosis was subtle and present in only a few views. He said he commits to changes in his practice, he has shared this case with colleagues to benefit from learning points, and he is working within the hospital to make improvements.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion (IO) provider who specializes in diagnostic radiology. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

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

The IO provider opined that Dr. Agarwal's initial report was incorrect and therefore did not meet the standard of practice and Dr. Agarwal displayed a lack of knowledge, skill and judgement. The IO provider was of the view this appears to have been an isolated incident, and therefore Dr. Agarwal's clinical practice, behaviour or conduct does not expose or is not likely to expose his patients to harm or injury.

The Committee agreed with the IO provider that this appeared to have been an isolated error. While noting Dr. Agarwal showed insight in reflecting on this case, given this was a significant error, the Committee decided to require Dr. Agarwal to appear before a panel of the Committee to be cautioned and it requested him to provide a written report, as set out above.