SUMMARY

DR. DUNCAN CAMERON MACKINLAY
(CPSO# 55938)

1. Disposition

On August 11, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") required orthopaedic surgeon Dr. MacKinlay to appear before a panel of the Committee to be cautioned to follow up on all tests ordered and to document important findings and discussions with patients in his clinical notes.

2. Introduction

A patient's family member complained to the College that Dr. MacKinlay failed to inform the patient of the results of a chest x-ray performed prior to her knee replacement surgery.

The x-ray showed a potentially cancerous lesion in the right upper lobe of the lung; the report recommended a follow-up CT scan of the thorax.

The results of the x-ray were not disclosed to the patient or followed up on until three and a half years later, when another chest x-ray was performed and revealed a 2.3 cm lesion highly suspicious for cancer. Although the cancer is not believed to have originated in the lungs, it has since spread to the patient's pancreas, ovaries and stomach and is deemed terminal.

Dr. MacKinlay responded that he discussed his concerns about the x-ray report with the patient at the time of the surgery although he did not document this discussion in his post-operative note. He strongly recommended that the patient follow up with her family doctor as soon as possible. He reiterated his recommendation at discharge. He also ensured that a copy of the x-ray report was sent to and received by the patient's family doctor. However, he did not discuss the findings at the patient's follow -up appointment or send a note to the family doctor.

3. Committee Process

A Family Practice 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

While the Committee is unable to know with certainty what Dr. MacKinlay told the patient, we are surprised Dr. MacKinlay could remember such a conversation three years later. We note after reviewing the record that there is no mention of the abnormal chest x-ray in any of Dr. MacKinlay's notes, the discharge summary, or the records sent to the family doctor. The patient did not recall learning of these results and did not seek follow-up. In our view, the information in the medical record is presumptively reliable, and in the absence of convincing evidence to the contrary, we are confident that a contemporaneous record is an accurate reflection of what occurred. In other words, the record does not support that Dr. MacKinlay told the patient about the need for follow-up given the chest x-ray result.

Even if Dr. MacKinlay did mention the result to the patient at the time of surgery, he acknowleges he never addressed this issue at any follow-up appointment. It is not reasonable to mention a critical result and expect a patient to remember the discussion, particularly when that patient is about to undergo surgery.

The College's *Test Results Management* policy sets out that, 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.

As the ordering physician, after receiving a clinically significant result (in this case a very abnormal chest x-ray result showing a possible cancerous lung nodule) Dr. MacKinlay should have ordered the CT scan and/or spoken with the patient's family doctor to ensure the patient received the recommended and appropriate follow up, and should have documented all steps relevant to the abnormal test result. .