SUMMARY

DR. SHVETA SURYAVANSHI
(CPSO# 87912)

1. Disposition

On August 11, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") required family physician Dr. Suryavanshi to appear before a panel of the Committee to be cautioned to recall patients urgently when there are significant test results and to have a system in place to ensure that such test results are not overlooked.

2. Introduction

A patient's family member complained to the College that Dr. Suryavanshi failed to inform the patient of the results of a chest x-ray or follow up on those results, consider the need for a biopsy and offer a referral to an oncologist.

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 after the date of the x-ray, 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. Suryavanshi responded that she received the x-ray report, reviewed it and commented on it that she should discuss the findings with the patient at the next visit. She made these comments the day after receiving the report. She did not arrange follow-up as she believed the surgeon would have done so. Unfortunately, the patient did not follow up with her until 16 months later. At that appointment, she did not discuss the x-ray result as she believes her staff deleted the alert message from the Electronic Medical Record (EMR) by mistake. She has since made changes to her office practice with respect to the monitoring of test results and medical records.

She offered the patient an ultrasound-guided biopsy, and recommended a referral to a specialist but initially the patient declined the referral indicating that she did not want any chemotherapy or treatment. At the next appointment, Dr. Survayanshireferred the patient to an oncologist.

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

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

> When in receipt of a clinically significant result, physicians should also use their clinical judgement to determine if it is necessary to contact other health professionals who are involved in their patient's circle of care.
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> Sometimes physicians receive or become aware of a clinically significant result for a test they have not ordered. The result may pertain to their patient, a patient previously in their care, or the patient of another physician. In these situations, the physician may have a duty to inform the patient or the patient's physician of the result. The more serious the result and possible consequences of the result, the more urgent it is for the physician in possession of the result to take steps to inform the patient or the patient's physician of the result.

Dr. Suryavanshi acknowledges receiving the chest x-ray results and annotating that she should discuss them with the patient at the next visit. Given the highly abnormal result, in the Committee's view, Dr. Suryavanshi should have called the patient immediately to determine if the recommended CT scan had in fact been ordered and she should not have waited until the patient booked a return visit (which ultimately was over a year later).

Dr. Suryavanshi's test results management system then failed a second time, as at the next appointment 16 months later, she failed to discuss the abnormal chest x-ray with the patient or to ensure appropriate follow-up. Two months later, Dr. Suryavanshi again failed to review the patient records at the patient's annual physical examination.

While Dr. Suryavanshi indicates she has since made changes to her office practices to ensure in the future she appropriately follows up clinically significant test results, given the errors in this case and the unfortunate outcome, the Committee would like to meet with Dr. Suryavanshi in person to discuss what occurred.