SUMMARY

Dr. Thomas Joseph Barnard (CPSO# 31831)

1. Disposition

On September 15, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") required Dr. Barnard, a family physician, to appear before a panel of the Committee to be cautioned with respect to the delay in diagnosis of a lymphoma and his deficient records, even after attempts at remediation.

2. Introduction

A Patient wrote to the College and expressed concern that Dr. Barnard failed to follow up on a CT (computed tomography) scan that he ordered in the summer of 2014 when the Patient first discovered a lump in his groin, and which demonstrated early stage lymphoma (cancer affecting one's immune system), failed to expedite a biopsy in the summer of 2015 after the Patient had a CT scan showing multiple lumps, rushed through appointments, and failed to provide the full set of medical records to the Patient's new family physician, including the 2014 CT scan results.

Dr. Barnard responded that he appropriately ordered an ultrasound (not a CT scan) in June 2014 when the Patient reported groin pain. When he received the ultrasound report that demonstrated enlarged and abnormal lymph nodes, he was under the impression that the Patient was already scheduled to return to review the result. Accordingly, he did not instruct his staff to contact the Patient and book an appointment. He accepted that he should have been more proactive in relaying the results to the Patient, and that he should not have trusted that the Patient had made a follow-up appointment. In the future, he will direct staff to contact patients when he receives positive test results.

Dr. Barnard stated that when the Patient returned in May 2015and reported that he had "noticed lumps" in the axillae (below the shoulder), he immediately arranged a CT scan of the Patient's abdomen and pelvis. When he received the test results, he contacted the Patient and saw him in June 2015 at which time he relayed the results and told the Patient that a biopsy was indicated. He referred the Patient to a diagnostic radiologist, who performed an ultrasound-guided biopsy on the Patient later in June 2015.

Dr. Barnard reported that he unfortunately does not have a record of the length of his visits with the Patient; however, he indicated that he believes the Patient's recollection of a "30 second" visit is mistaken. He stated that he did not rush through appointments and he always gave the Patient his full attention.

In terms of the transfer of the Patient's records, Dr. Barnard stated that he provided the Patient's new family physician with all of the Patient's records. While the Patient suggested that a September 2014 CT scan "vanished" from his chart, Dr. Barnard noted that there was only a 2015 CT scan and the report of that scan is in the Patient's records.

3. Committee Process

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

In addition, the Committee reviewed information from the Patient's new family physician, who indicated that to the best of his knowledge the medical records he received were complete. Further, the Committee obtained information from a family physician who has been supervising Dr. Barnard's practice since May 2016, who indicated that Dr. Barnard is engaged in the supervision process, is following his recommendations and has made improvements to how he manages patients' test results.

A Family Practice Panel of the Committee, consisting of both public and physician members, met in order to review all the relevant medical records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies 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. Barnard's medical care failed to meet the standard of practice, that he demonstrated a lack of judgement and that his care could potentially harm his patients. Specifically, the IO provider expressed concern that Dr. Barnard did not set aside the 2014

ultrasound result for review (although Dr. Barnard stated that was his practice), and that he did not communicate the results of the May 2015 CT scan to the Patient urgently. The IO provider also noted that Dr. Barnard's charting is minimal and it is not clear what follow-up instructions he gives patients, which test results Dr. Barnard reviewed, or how much time he spends with patients at appointments. The IO provider observed that Dr. Barnard's referral forms contain very minimal clinical information about patients. The IO provider noted, however, that she was impressed by the steps that Dr. Barnard has taken to remediate the follow-up of abnormal tests results and that he has made appropriate changes.

The Committee noted that the record confirms that the Patient actually underwent an ultrasound in the summer of 2014, not a CT scan, which investigation showed abnormally enlarged nodes in the Patient's groin, and not a hernia. Dr. Barnard apparently saw this report and noted the abnormal results, yet nothing in the record indicates that he made any attempt to contact the Patient with the results. Dr. Barnard conceded that he was wrong to assume the Patient would arrange follow up. Almost a year later, the Patient noted multiple lumps in his axillae and Dr. Barnard ordered a CT scan and an ultrasound which demonstrated lymphadenopathy. The biopsy that Dr. Barnard subsequently arranged confirmed the diagnosis, and indicated that the lymphadenopathy was very widespread.

The Committee notes and appreciates Dr. Barnard's acknowledgment of his error in not following up on the Patient's abnormal ultrasound results when he received them in 2014 and the Committee is impressed that he has since put in place new procedures to prevent similar mistakes. This case remains troubling, despite Dr. Barnard's efforts at remediation, as Dr. Barnard does not appear to acknowledge the serious outcome of his lapse in judgment. The Committee is not convinced Dr. Barnard fully appreciates the repercussions of his error. The Committee would emphasize that the College's policy on *Test Results Management* states that when a physician receives a clinically significant (i.e. an abnormal) result for a test that he or she orders, he or she is expected to act and follow up with the patient with appropriate urgency, which Dr. Barnard failed to do in this case.

The Committee is satisfied that Dr. Barnard did promptly and appropriately arrange a biopsy when the Patient returned in the summer of 2015, after reviewing CT and ultrasound results

showing multiple lumps. In the Committee's view, a one-month wait for a guided biopsy is not considered out of the ordinary; hence there is nothing to impugn Dr. Barnard's care with respect to this particular issue.

With respect to the Patient's concern that Dr. Barnard rushed through appointments with him and typically saw him for only "30 seconds," the Committee cannot know with certainty exactly how long the appointments were. However, Dr. Barnard's inadequate documentation in the Committee's view lends some support to the Patient's allegation that the appointments were perhaps overly brief. It would have been helpful had Dr. Barnard documented in patients' charts the length of time he spent with them during any given encounter.

In general, this particular case brings to light that Dr. Barnard's medical record-keeping is still not adequate, despite the fact that he has engaged in remediation to improve it. Dr. Barnard barely documents any history, and for his examinations, he cuts and pastes information (which at times does not even address the patients' areas of concern) from a template. Plus, he received abnormal results, and incorrectly documented that there were no abnormal findings. As indicated in the College's policy statement on *Medical Record*s, accurate medical records are a crucial component of good medical care and an important measure of the quality of care that a patient receives from a physician..

In terms of Dr. Barnard's transfer of the Patient's records, the Committee reiterates that the Patient had an ultrasound and not a CT scan in 2014, and we note that his new family physician states that the Patient's records Dr. Barnard transferred seemed complete.