SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Roya Rahimpour (CPSO #59223)
(the Respondent)

INTRODUCTION

The Complainant went to the Respondent in February 2020 for pain in his bladder and stomach area. He underwent a pelvic ultrasound that showed a mass for which urgent follow-up was required.

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concern about the Respondent's care.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent failed to provide appropriate care. Specifically, the Respondent:

- **Did not follow up on a February 2020 ultrasound that identified a mass and indicated the Complainant required urgent follow-up and further investigation**
- **Told the Complainant in February 2020 after his ultrasound report that he was fine and had a "clean bill of health"**
- **Failed to appropriately prescribe Taro-Rosuvastatin 20 mg for the Complainant's blood clots**
- **Failed to follow up on concerns of possible skin cancer when the Complainant asked about a large growth on the left side of his face and failed to refer to a dermatologist**
- **Failed to follow up on the Complainant's reports of seizures and failed to appropriately assess him or refer him to a neurologist**
- **Was unprofessional in her communication in that she was rude and dismissive.**

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of February 16, 2022. The Committee required the Respondent to appear before a panel of the Committee to be cautioned with respect to abiding by the College's *Managing Tests* policy and ensuring that she follows up appropriately on every test, especially when the results are of great significance to the patient.

The Committee also noted its expectation that physicians communicate in a professional manner with patients at all times.

COMMITTEE'S ANALYSIS

Did not follow up on a February 2020 ultrasound that identified a mass for which the Complainant required urgent follow-up and further investigation

The Respondent did not document her rationale for ordering the February 2020 ultrasound, but the report suggested that it was for abdominal and pelvic pain. The report clearly indicated that a bladder neoplasm was identified and urgent referral was required; however, nowhere was it evident in the medical record that the Respondent saw these very concerning results.

The Respondent indicated that she approached her staff on February 26 to contact the Complainant to arrange follow-up regarding the ultrasound result. This would mean that she waited three weeks before responding to the urgent findings. The Respondent did not make note in the record that she asked her staff to call the Complainant.

The Respondent indicated that her staff called the Complainant many times to ask him to come into the office. They did not document these calls in the medical record. The Complainant attended at the office on March 5, one month after the ultrasound.

The Committee considered the Respondent's care in regard to this clinical issue to be unacceptable. The Respondent failed to follow the College's *Managing Tests* policy, and her inadequate care and management delayed the diagnosis and treatment of a large bladder cancer by several weeks.

Told the Complainant in February 2020 after his ultrasound report that he was fine and had a "clean bill of health"

The Respondent denied that she ever told the Complainant that he had a clean bill of health. She maintained that she discussed the abnormal result of the ultrasound with him at the appointment on March 5, but there is no documentation to support this. Nor is there any reason to believe from the medical record that the Respondent made any effort to refer the Complainant to a urologist at the March 5 appointment.

The Committee concluded on the basis of the documentation in the medical record that there was no support for the Respondent's claim that she discussed the February 2020 ultrasound results with the Complainant. It appeared that the Respondent overlooked the ultrasound report altogether and made no plan at the March 5 visit to deal with a potentially life-changing disease.

On the basis of the above, the Committee decided to require the Respondent to appear before a panel of the Committee, as indicated.

Was unprofessional in her communication in that she was rude and dismissive

There was no information before the Committee to indicate that the Respondent's communication with the Complainant was unprofessional. The Committee took no action on this area of concern aside from stating its expectation that physicians communicate in a professional manner with patients.

The Committee took no action on the other areas of concern.