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. Ronald Bjorndahl Sorensen (CPSO #30034)
(the Respondent)

INTRODUCTION

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care related to a prostate biopsy which diagnosed adenocarcinoma of the prostate. The results of the biopsy were not communicated to the Complainant or the referring physician. A few months later, the Complainant was diagnosed with metastatic cancer.

COMPLAINANT'S CONCERNS

The Complainant is concerned the Respondent:

- **failed to follow up on his prostate biopsy results and missed a diagnosis of prostate cancer**
- **failed to provide him with adequate pain management during the prostate biopsy**
- **failed to respond to his family physician in a timely manner about the prostate biopsy results and failed to send his family physician the results of the biopsy.**

COMMITTEE'S DECISION

A Surgical Panel of the Committee considered this matter at its meeting of October 7, 2022. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to following the College's *Managing Tests* policy and timely response to patients, physicians, and the College.

COMMITTEE'S ANALYSIS

As part of this investigation, the Committee retained an independent Assessor who specializes in urology. The Assessor opined that the Respondent's clinical care met the standard of practice of the profession, but noted that the Respondent displayed a potential lack of judgement in ensuring communication of results of medical investigations and management to patients and referring physicians. The Assessor did not state that the Respondent posed a risk of harm to patients.

Failed to follow up on the Complainant's prostate biopsy results in December 2020 and missed a diagnosis of prostate cancer
AND
Failed to respond to the Complainant's family physician in a timely manner about the prostate biopsy results and failed to send Complainant's family physician the results of the biopsy

The Committee noted that, although the Respondent's clinical care and management was acceptable as identified by the Assessor, his failure to adequately communicate the biopsy results either to the Complainant or the Complainant's family doctor was a serious shortcoming, and the Respondent failed to follow the guidelines set out in the College's policy, *Managing Tests.*

The Committee acknowledged that the Respondent was under significant stress related to the COVID-19 pandemic and a family emergency situation, but also noted that the Respondent had a significant and concerning history with the College, including related to communications.

In addition, the Committee had concerns about the timeliness of the Respondent's response to the College, which was delayed by many months.

Taking all these concerns together, the Committee determined that it was appropriate to caution the Respondent.

Failed to provide the Complainant with adequate pain management during a prostate biopsy in December 2020

The Committee took no action with respect to this area of concern.