



## Question and Answer: Understanding the Pathology Review

### Background Information:

At DSM, we have made quality and patient safety our top priority. In fact, several of our major pathology sites have achieved gold standard accreditation status. *See News Release on Gold Accreditation Standard.* This means adding checks and balances to ensure potential errors, when they occur, are identified early. It is these processes that led DSM to discover the mistakes made by a DSM pathologist.

The pathology review was prompted by concerns identified early through DSM's internal quality assurance processes and through a routine audit required by the College of Physicians and Surgeons of Manitoba. The results, received in early June 2011, identified a potential issue with reports from a DSM pathologist (Dr. X). Dr. X is no longer employed by DSM.

The 3,006-case review, representing all of Dr. X's cases from October 2010 to June 2, 2011, was conducted by two senior internal pathologists as well as two highly-reputable international laboratories.

The review of pathology cases from Dr. X is now complete and a report was released in February 2012. See February 17, 2012 news release for more information.

*For more information on the definition of a CI and the CI process, see the Understanding Critical Incidents Q&A.*

*For more information on our Accreditation Standards, please see News Release on Gold Accreditation Standard.*

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### **Q: Why hasn't DSM confirmed or named Dr. X?**

**A:** We understand it is human nature to want to know the name of the person associated with such a deeply regrettable situation. However, we believe in protecting the privacy of all persons, whether you are a patient or a staff person. Protecting the privacy of staff serves a very important purpose in our Quality Assurance Program. It allows a staff person to come forward with any concern they may have without fear or being identified. That is one way that we are able to hear about and investigate mistakes in our system. *Please see the Understanding Critical Incidents Q&A for more information.*



**Q: Is Dr. X still employed at DSM?**

A: During the time of the review, Dr. X entered into administrative leave on June 3, 2011 and no longer performed pathology duties. Shortly after, Dr. X resigned for personal reasons.

**Q: Is Dr. X still able to work as a pathologist?**

A: DSM is not responsible for the licensing and sharing of information of a physician. This question is best directed to the College of Physicians and Surgeons of Manitoba.

**Q: Were all of Dr.X's pathology cases included in the review?**

A: Yes, all 3,006 cases pertaining to Dr. X were reviewed.

**Q: What were Dr. X's credentials and why did DSM hire this pathologist?**

A: DSM has a very rigorous hiring process and we hire skilled and well-qualified people. We know that it is our responsibility to hire the right person to perform critical diagnostic tests.

Dr. X underwent a screening process prior to being hired and was interviewed by a panel of experts and also delivered a medical presentation to his pathology peers. Dr. X came with exceptional references from his previous employers.

All of Dr. X's credentials were verified and registered by the College of Physicians and Surgeons of Manitoba.

**Q: What types of cancer did Dr. X misdiagnose?**

A: There were different types of cases in the Dr. X review and while we respect the curiosity and concern, we feel that listing the various types of cancer will lead to unnecessary anxiety. Listing the types of cancers doesn't change the fact that mistakes were made and we at DSM take full accountability for these mistakes.

We want to assure all patients that all discrepancies were reported to their treating physicians during the review timeframe. We can confirm that all patients who had their original reports amended were told by their treating physician and were provided with the appropriate follow-up care.



**Q: I still have a question or concern about my test, who can I call?**

A: Please call our Patient Inquiry Line at 1-866-633-1787. If you are unable to speak with a live person right away, leave your name, number, and personal health information number and someone will get back to you as soon as possible. We are here to answer all your questions.

**Q. Are there other pathologist reviews underway?**

A. No, no other pathologist is under review as in the case of Dr. X, but it is important to note that as part of our Quality Assurance program, the work of all our pathologists are peer-reviewed from time to time to look for discrepancies. If during this process a discrepancy or change in report is found we amend the reports and notify the physicians to follow up with the patient.

This is normal practice for DSM and normal for our health care partners in Manitoba. If a patient brings forth concerns or questions regarding their diagnosis, we have a duty of care to investigate.

**Q: Has DSM identified any more patients whose diagnosis has been upgraded to a Critical Incident or changed from not having cancer to having cancer?**

A: It is important to note that a Critical Incident definition from a medical perspective might be very different from a patient perspective. It is a serious challenge, especially when you are dealing with such a sensitive and emotional issue like cancer. We need to make medical decisions based on science in order to provide the right diagnosis to a patient's treating physician.

Within the 137 cases, there were situations where cancer may or may not have been present during the original report. There are many variables in each of the cases that could influence the impact on treatment so it is possible that cases initially reported as not being cancer would not be a critical incident.

During the course of the review, in consultation with the patient physicians and in the opinion of the critical incident review committee, these were not classified as critical incidents. Nevertheless, we took every one of these mistakes very seriously and notified the physicians and patients as quickly as possible.

We will continue to exercise caution when following up on these cases, and if necessary, will discuss any concerns with treating physicians and their patients.

See *Understanding Critical Incidents Q&A* or visit <http://www.gov.mb.ca/health/patientsafety/ci/> for more information.



**Q: What has DSM learned from this review and how can you prevent this from happening again?**

A: In our business, mistakes do happen. And that is why we will continue to work hard every day to ensure the highest quality processes are in place to detect and correct future mistakes as quickly as possible and ensure physicians have the information they need to treat their patients.

We have learned the important balance that exists when reporting on the scientific facts while at the same time recognizing and understanding the need to acknowledge and address the human emotional side of the equation. There is no doubt in our minds that the 137 patients who were affected in this review experienced great anxiety and personal anguish, in some cases, physical harm. We are deeply sorry for these mistakes.

We are committed to improving our communications with patients and the public, strengthening our hiring processes, and continuing to place the highest value in our quality processes. We will remain open and honest to the public, while respecting the privacy of our patients and staff when addressing matters such as this in the future.

**Q: How do I know that DSM meets quality standards?**

A: Patient safety is at the forefront of everything we do. Two of our largest labs achieved gold-standard accreditation from the College of American Pathologists, which also accredits institutions such as the Mayo Clinic. All our other Laboratories are accredited by the Manitoba Quality Assurance Program operated by the College of Surgeons and Physicians of Manitoba.

*For more information on our Accreditation Standards, please see News Release on Gold Accreditation Standard.*