Backgrounder - Diagnostic Imaging Review at Stanton Territorial Hospital

What Happened?

- In March, 2017, the Northwest Territories Health and Social Services Authority (NTHSSA) became aware of concerns related to the practice of a specific locum radiologist who had worked at Stanton Territorial Hospital in the past.
- The practice concern that was identified related to inaccuracies in interpretation of diagnostic imaging examinations and the possibility of missed or inaccurate diagnoses.
- Initially it was determined that this physician was employed as a locum radiologist at Stanton Territorial Hospital from December 19, 2015 to January 23, 2016, and from May 8 to May 14, 2016.
- A detailed look-back of all employment records for Stanton's Radiology Department revealed an additional period of employment for the physician in question from September 1-18, 2009. This added 406 exams to the review.

What progress has been made so far?

- Of the 2,506 exams to be reviewed 2,100 have been reviewed and appropriate follow up, where required, is ongoing.

How will those affected be notified?

- For exams in the initial group from December 19, 2015 to January 23, 2016 or May 8 to May 14, 2016:
    - If follow up for further exams or treatment were required individuals in this group have already been contacted by a healthcare provider
    - If an exam had an error, but the patient received appropriate treatment at the time and do not require follow up, they will be receiving a letter. These letters were sent registered mail on June 27, 2017.
- For exams in the group from September 1-18, 2009 patients will be contacted as the review results are available.

What are the results so far? How many errors are being reported?

- Review results to-date:
    - 2,506 total exams impacted
    - 2,100 exams reviewed to date
    - Of the reviewed exams 2,008 exams were determined to have no clinical errors
    - 92 exams required further investigation to determine if clinical follow up was required

- 64 of the 92 exams showed a discrepancy in the result but the patient was treated appropriately at the time of their illness or injury. No follow up was required. These individuals will receive disclosure letters.
- 28 of the 92 exams showed discrepancies that required additional follow up with a healthcare provider. These individuals have already been personally contacted by their healthcare provider.

Why did the numbers change?

- The initial announcement was made with preliminary data because disclosure of the review was a priority.
- As the review advanced continual checks of the exam counts were ongoing to ensure accuracy and review completeness.
- The numbers in this update are the most recent and accurate to-date. Final numbers won't be known until the review is fully complete.

How was the review organized? What was the process?

- The review was coordinated in 3 phases:

Phase 1: Identifying the scope of impact and cases to review.

- It was determined there were 2,506 exams to be reviewed. This figure increased from the original quoted figure of 2,355 after further analysis and examination of past exams. (After validating the original patients impacted in 2016/17 there was 2,100 exams to review. 406 exams were added from another period in 2009)
- This expanded scope extended the timeline for the review. Of these exams 2,100 have been reviewed and appropriate follow up is ongoing.

Phase 2: Coordinating the review of diagnostic imaging results.

- From March to May a private company from Alberta sent radiologists to Stanton Territorial Hospital to review each exam. These radiologists are from the same company that routinely provides additional radiology capacity to the NTHSSA through a regular contract.
- This work is ongoing for the remaining exams.

Phase 3: Clinical management and patient disclosure.

- This phase is happening now. With the reinterpreted exams that have been completed, physicians have worked to review each individual case and determine if patients received appropriate treatment. Diagnostic imaging is just one of the tools physicians use to make decisions about care and some patients have been treated appropriately despite a discrepancy in their diagnostic imaging exam.

- Patients that require additional follow up due to the revised result are contacted directly by a healthcare provider to discuss next steps.
- Patients that do not require follow up because they have already received appropriate treatment at the time of their illness or injury will be contacted with a disclosure letter. These letters will also confirm that these patients do not need follow up and that their care was not impacted by the difference in diagnostic imaging results. This disclosure ensures transparency and follows best practice guidelines.

What are the disclosure letters for?

- If no clinical follow up was required, but an error was found, patients will receive a letter to disclose an error in the exam reading. This is important to ensure transparency and that those patients and their healthcare providers have all information for medical history.
- For the 2,100 exams to date these steps have been completed, letters have been sent via registered mail. For the 406 exams added to the review these steps are ongoing.

Did this review find results that changed diagnosis?

- This review was undertaken to ensure patient safety; we will not be commenting on any individual cases or sharing any specific diagnosis information to ensure we protect patient confidentiality.

What is the NTHSSA doing to prevent this from happening in the future?

- The NTHSSA is currently examining additional quality assurance measures for diagnostic imaging; this includes determining how peer review might be implemented in our authority.
- We often have locum radiologists. These individuals are required to meet the standards of their professional associations and licensing bodies. This is the first step in ensuring quality of work.
- A large volume of NWT radiology exams are reviewed by radiologists from a contracted service that already includes a peer-review process to ensure the quality of the reads by their radiologists.

Is this radiologist still working in the NWT?

- No, this radiologist is no longer employed in the Northwest Territories.

Who can I contact for more information?

- Anyone who has clinical concerns, related to their health or wellbeing, should contact their local clinic or regular healthcare provider.

- Concerns related to the process of the diagnostic imaging review, client complaints, or inquires about further action do the impacts of the review that are not clinical in nature can be directed to:
    - Natalie Campbell
      Director, Quality, Safety and Client Experience
      Northwest Territories Health and Social Services Authority
      Phone: 867-872-6256
      Email: natalie_campbell@gov.nt.ca
- Any requests for comment from the media can be directed to:
    - David Maguire
      Manager, Communications
      Northwest Territories Health and Social Services Authority
      Phone: 867-767-9107 ext.
      Email: david_maguire@gov.nt.ca