COLLEGE OF PHYSICIANS AND SURGEONS OF NOVA SCOTIA

SUMMARY OF DECISION OF INVESTIGATION COMMITTEE "D"

Dr. Courtney Mazeroll

OVERVIEW

Dr. Courtney Mazeroll is a family physician, licensed to practise medicine in Nova Scotia since 2012. Her licence number is 015963.

The College received a complaint concerning Dr. Mazeroll from the spouse of a patient of Dr. Mazeroll who passed away in 2015 at the age of 49.

Investigation Committee: D", formed in accordance with the *Medical Act of Nova Scotia*, 2011, was responsible for the investigation of the complaint.

Key points as reported by the Complainant

The patient began seeing Dr. Mazeroll in late 2013 or early 2014. She visited Dr. Mazeroll on many occasions for various issues and was sent for numerous tests.

The patient also continued seeing her chiropractor for back pain during this time. On October 5, 2015, the patient's chiropractor advised her that her pain was not muscle and joint related. The chiropractor advised the patient to attend Outpatients, as she was developing a yellowish colour to her eyes and skin. The patient was admitted to Yarmouth Regional Hospital that same day. Numerous tests were completed.

Two days later, the patient was informed by the hospital she had cancer and needed a biopsy of her liver. She was not permitted to go home.

On October 27, 2015, her biopsy results came back with a diagnosis of terminal cancer. She was advised it was too late for treatment.

On October 29, 2015, Dr. Mazeroll and another doctor from the community went to the hospital to visit the patient. The patient's spouse says that Dr. Mazeroll told the patient she reviewed her medical files and realized she missed findings of spots on the patient's gallbladder and liver in an ultrasound done in 2014. Dr. Mazeroll had sent the patient for an ultrasound in February 2014 thinking she may have gallbladder stones. The patient never heard from Dr. Mazeroll regarding this test result.

The next day the patient was transported to the Victoria General Hospital in Halifax for procedures which could not be completed due to her condition, and on November 3, 2015, she was discharged to return home, where she passed away on November 7, 2015.

The patient's spouse submitted the complaint due to concern about Dr. Mazeroll's failure to act on his spouse's ultrasound.

Key points as reported by the Respondent

Dr. Mazeroll offered her sincerest apologies to the patient's husband, and to the rest of the patient's family. She stated she truly wishes she could go back and change the course of events.

In 2013 Dr. Mazeroll took over an existing family practice. In September 2013, the patient became Dr. Mazeroll's patient. The patient did not suffer from any major chronic illnesses.

On January 15, 2014, the patient complained of back pain. She never had any imaging done, so Dr. Mazeroll offered an x-ray in an effort to better understand the pain.

On January 22, 2014, Dr. Mazeroll reviewed the results with the patient. The radiologist reported, "an unusual arrangement of calcifications in the right upper quadrant is identified of uncertain origin but potentially gallbladder?" Dr. Mazeroll did some research. She located information about various issues of the gallbladder, some that carried a risk of cancer. Dr. Mazeroll ordered an abdominal ultrasound for the patient.

In late January 2014, Dr. Mazeroll was approximately 36 weeks pregnant, and a week away from beginning maternity leave. Her last day of work was January 30, 2014. Her due date was February 22, 2014.

In Dr. Mazeroll's community, there is a locum physician the clinic uses for a maximum of four weeks per year. Dr. Mazeroll scheduled her locum colleague to cover her practice for as much time as possible. However, locum coverage was only for a few weeks "here and there" and the weeks were not continuous.

Because of the issue with locum coverage, Dr. Mazeroll regularly kept up with patient reports, test results, consult letters and other documentation during her leave. She had her work computer at home, and would check-in every few days. Should something urgent arise, either the on-call doctor would take care of it, or her staff would call her at home.

On February 13, 2014, the patient had her abdominal ultrasound. On Saturday February 15, 2014, Dr. Mazeroll saw the ultrasound report, and signed off on it. Her note was included as an addendum to a January 22, 2014 progress note. It reads, "abdominal ultrasound done for calcifications in gallbladder. Probably polyps according to radiologist. But solid hepatic mass, suggest MRI".

Normally when Dr. Mazeroll receives a report that suggests further workup is required, she prints the requisition, and immediately sends it off. As she was out of the office at the time, Dr. Mazeroll's plan was to go to the office on Monday February 17, 2014 and print and forward an MRI requisition.

On Monday February 17, 2014, Dr. Mazeroll began having contractions. Dr. Mazeroll did not make it into the office on February 17, 2014, and the need to follow-up on the patient's ultrasound

left Dr. Mazeroll's mind. Throughout the rest of Dr. Mazeroll's maternity leave, she did not recall the patient's ultrasound results, or the need to follow-up.

Upon return from her maternity leave, Dr. Mazeroll saw the patient multiple times for various issues, mostly neck pain. Neither Dr. Mazeroll nor the patient remembered the ultrasound of February 13, 2014. Dr. Mazeroll states during these subsequent visits the patient did not complain of the previous back pain.

On September 28, 2015, Dr. Mazeroll saw the patient in her office for the last time. The patient complained of stomach pain and nausea. Dr. Mazeroll did a complete work up.

As the patient's results came in, Dr. Mazeroll knew something was wrong and ordered further imaging. However, the patient became very sick, very fast. She was admitted to Yarmouth Regional Hospital before the imaging was done.

While the patient was in the hospital, her liver mass was seen by one of the attending physicians. It was noted the mass was present on the ultrasound imaging done on February 13, 2014. One of the patient's attending physicians called Dr. Mazeroll to inform her of the situation. When Dr. Mazeroll reviewed the patient's chart, her heart sank when she realized what happened.

On October 29, 2015, Dr. Mazeroll met with the patient and her husband at the hospital, accompanied by her medical director. Dr. Mazeroll informed the patient there had been a liver mass present on the ultrasound of February 2014. Dr. Mazeroll explained the timeline of events that led up to her not making it into the office to order further testing. She apologized the report never crossed her mind again.

Dr. Mazeroll advises she waited a period of time to see the patient as she had been advised by the Canadian Medical Protective Association (CMPA) to wait until there was a definitive diagnosis, which came with the biopsy results. In the meantime Dr. Mazeroll had made several calls to the patient's attending physicians to ask how she was doing.

Dr. Mazeroll states this case has deeply affected her. She feels she failed the patient. Dr. Mazeroll cannot say whether things would have turned out differently if she had gone into the office on Monday February 17, 2014 as planned, but she will always wonder.

After the patient passed away, Dr. Mazeroll called the patient's husband to offer her sympathy.

In hindsight, Dr. Mazeroll would not have entered the February 15, 2014 post-ultrasound note in the EMR as an addendum to the January 22, 2014 note (in which the imaging was requested). She wishes she could change what she did, as if she had entered the February 15, 2014 note in an electronic pop-up window, the reminder would have opened automatically every time she opened the patient's chart.

Going forward, Dr. Mazeroll now uses pop-up windows for many things, no matter how small. If some information is identified that should not be forgotten, it will be present in a pop-up.

The clinic now also has meetings to address issues such as call backs and making sure patients do not cancel appointments staff know are important.

Dr. Mazeroll states she has learned from this experience.

Preliminary Investigation

Pursuant to Section 88 (1) of the Medical Practitioners Regulations, an Investigator was appointed to conduct a preliminary investigation of complaint.

It was determined an audit would take place of Dr. Mazeroll's practice with her consent before the complaint was referred to Committee.

DISCUSSION

The Committee offered its condolences to the patient's husband on the loss of his spouse. The Committee expressed its appreciation to the family for bringing this matter forward for investigation.

Dr. Mazeroll conveyed to the Committee she is sorry for the events that led to this complaint.

The patient appears to have been an otherwise healthy young woman up until the point she was diagnosed with cancer. Due to Dr. Mazeroll's admitted failure to order an MRI, a solid hepatic mass noted on a February 2014 ultrasound was not addressed until October 2015. By this time the patient had become quite ill and had been admitted to Yarmouth Regional Hospital. The outcome for the patient and her family was catastrophic. Metastatic intrahepatic cholangiocarcinoma was identified as a "most responsible diagnosis" of the patient's illness. The patient and her family had very little time to prepare for the patient's end of life.

Upon return from her planned absence, Dr. Mazeroll saw the patient on seven occasions between September 2014 and September 2015. At no point did Dr. Mazeroll order the radiologist-recommended MRI. In her interview before the Committee, Dr. Mazeroll stated, "…you think you're doing everything right. You check, you double-check…"

Dr. Mazeroll also indicated she often goes back to review the notes from the previous patient encounter, but assumed she did not during the September 2014 encounter with the patient, because if she had, Dr. Mazeroll might have been prompted to look for the ultrasound results.

The Committee found Dr. Mazeroll failed to "double-check" when she did not at any point review the patient's January 22, 2014 clinic note upon return from her planned absence. Dr. Mazeroll had multiple opportunities between September 2014 and September 2015 to correct her mistake, and failed to do so. This is aggravated by the fact Dr. Mazeroll displayed a lack of ability to use the EMR to its full potential when she entered the need for follow-up as an "addendum" to the January 22, 2014 note vs. an "alert". The Committee came to the conclusion if Dr. Mazeroll had made use

of the full capabilities of the EMR, she may have been reminded to review the ultrasound results with the patient and order the MRI for the solid hepatic mass.

The Committee considered several mitigating factors with respect to Dr. Mazeroll's failure to ensure adequate follow-up for the patient.

Dr. Mazeroll's practice audit was generally positive. Her care of patients was consistently noted to be in keeping with good practice.

The auditor's conclusions included:

1. Dr. Mazeroll's charting system "appears robust with a good electronic trail of ensuring that abnormal results do not fall through the cracks";
2. Dr. Mazeroll's physician record-keeping is above average;
3. Dr. Mazeroll "appears to be taking good care of her patients and is managing diseases at an appropriate level";
4. The auditor reviewed 29 separate patient encounters - he had no significant criticisms of any of the charts.

The auditor did note some improvements could be made to her record keeping. Dr. Mazeroll has reflected on the advice of the auditor and made changes to her practice, especially with respect to how she uses the EMR. She no longer puts important information in the medical record as an "addendum". Anything that needs to be discussed with a patient is recorded in an "alert box". The alert will appear as a pop-up every time a chart is opened. Dr. Mazeroll also does her own scheduling for follow-ups. She books the appointment in the "scheduler" and gives her patient an appointment card.

Dr. Mazeroll is young and has the potential of a long career ahead of her. She has shown insight into the issues that led to this matter and has already made changes to her practice. The Committee also noted the patient's catastrophic outcome appeared to be an unfortunate isolated incident in Dr. Mazeroll's clinical practice, as opposed to the result of any pattern of poor practice.

The Committee noted Dr. Mazeroll was transparent with the College about her error, and provided her full cooperation throughout the investigation process. She agreed to undergo a practice audit before the matter came to Committee.

Dr. Mazeroll took responsibility for her failure to order a MRI for the patient, and she spoke directly to the patient and her spouse about her oversight. The failure to order the MRI was not willful or deliberate.

The Committee also considered the way in which the health centre managed both planned and expected physician absences. This system was not developed by Dr. Mazeroll. It was already in place when Dr. Mazeroll joined the health centre. Locum services are employed for the limited periods they are available, and otherwise physicians are responsible for following their patients when they are on leave.

Subsequent to this complaint, the health centre staff had a meeting to discuss ways it could minimize the chances of something "falling through the cracks". Dr. Mazeroll also met with the clinic's medical director prior to another planned absence. Dr. Mazeroll was told if there was anything that needed urgent attention while she was away, it could be forwarded to her director. The Committee is reassured appropriate follow-up will occur when physicians are absent from the office. The Committee acknowledges the lack of available locum coverage for the health centre, and encourages staff to continue to communicate with one another about effectively managing patient health and safety.

The Committee acknowledges Dr. Mazeroll indicated her labour and delivery impacted her ability to go into the clinic on February 17, 2014, and that her immediate departure for planned parental leave played a role in her failure to follow-up.

DECISION

In the specific circumstances of this case the Committee spent considerable time determining whether the actions of Dr. Mazeroll warranted a licensing sanction. The Committee reviewed the sanctioning principles generally applicable in professional regulatory matters. There is no one case identical to that of Dr. Mazeroll, and the Committee recognizes it must weigh mitigating and aggravating factors in coming to its decision.

In assessing the mitigating and aggravating factors, the Committee was cognizant of the objectives of the sanctioning process in terms of:

- public protection;
- the need to promote specific and general deterrence;
- the need to maintain the public's confidence in the integrity of the medical profession;
- the degree to which the offensive conduct was regarded as being the type of conduct that would fall outside the range of permitted conduct; and
- the range of dispositions in other cases.

The patient's outcome was catastrophic for her and for her entire family. Dr. Mazeroll's breach of the expected standard of practice was serious, going directly to the quality of patient care. Her failure to adequately follow-up on a concerning test result goes to the core of patient care, and the need to maintain the public's confidence in the medical profession is of utmost importance. Dr. Mazeroll had multiple opportunities between September 2014 and September 2015 to correct her mistake, and failed to do so. She also failed to employ the full capabilities of the EMR.

However, given the changes Dr. Mazeroll has made to her practice, and given she was at all times transparent, cooperative, remorseful, and at the beginning of her career, the Committee finds the risk to public safety going forward is low. Dr. Mazeroll is aware of her shortcomings with respect to the use of the EMR, and has implemented changes. This complaint also led to a discussion at the health centre on how to avoid a repeat of what happened with the patient's test results and necessary follow-up.

The Committee concluded in accordance with subclause 99(5)(f)(i)(A) of the Medical Practitioners Regulations, there is sufficient evidence that, if proven, would constitute a finding of professional misconduct in the context of a breach of the expected standards of practice. The Committee determined that pursuant to subclause 99(5)(f)(ii) the conduct in this case warrants a licensing sanction.

With the consent of Dr. Mazeroll, the Committee orders the following pursuant to subclauses 99(7)(a)(i) and (ii) of the Regulations:

a) Dr. Courtney Mazeroll is Reprimanded for failing to review the patient's ultrasound report in follow-up with her, and for failing to order a MRI for the solid hepatic mass as per the radiologist's suggestion.
b) Dr. Mazeroll must supply evidence she has completed educational training as to the best use of the Nightingale EMR, and must also provide evidence relevant training has been completed prior to transitioning to a new EMR.

Dr. Mazeroll is reminded to ensure medical records are in compliance with the College's Professional Standard Regarding Medical Records.

Dr. Mazeroll is required to pay to the College a portion of the costs of this investigation in a manner prescribed by the Committee.

After meeting with Dr. Mazeroll, the Committee is satisfied she has learned from this experience. It is the Committee's hope this case will serve as a critical reminder to other physicians of the importance of having appropriate systems in place to follow up on lab results.