SUMMARY

Dr. Melanie Rose Marie Ursell (CPSO# 71356)

1. Disposition

On December 7, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") ordered neurologist Dr. Ursell to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Ursell to:

- engage in focused educational sessions, in person, with a clinical supervisor acceptable to the College, for a six-month period, to focus on the following deficiencies:

  test result follow-up; appointment scheduling and triaging follow-up; cancellation management, absences and communication with staff

- review the College's Practice Guide and the *Test Results Management* policy and submit a 2000 word report to the College with reference to current standards of practice, how they are applicable to her situation, and how she has changed her practice

- approximately six months following the completion of the education outlined above, undergo a reassessment, with an assessor selected by the College.

2. Introduction

A patient complained to the College that Dr. Ursell delayed her diagnosis and treatment of Multiple Sclerosis (MS), and missed attending a number of scheduled follow-up appointments.

Dr. Ursell responded that she could not explain why there was a several month delay between her reviewing the patient's MRI report sometime in September or October 2014, and directing urgent follow-up, and her staff scheduling a follow-up appointment for February 2015 (which her staff then rescheduled for April 2015 when the disc of the MRI was not available for the February 2015 appointment). She noted that the staff member she had instructed to arrange the follow-up had been discharged from her employment. Dr. Ursell reported that there was another unfortunate delay after she reviewed the repeat MRI in May 2015 and seeing the patient in follow-up in July 2015 because of a six week absence from the office due to her illness.

Information from Dr. Ursell's staff member confirmed Dr. Ursell was absent for a prolonged illness and that this led to the cancellation of patient appointments, sometimes at the last minute, as staff did not know if Dr. Ursell would be attending the office or not on specific days.

Dr. Ursell reported that when she saw the patient in July 2015, she confirmed the diagnosis of MS and initiated treatment. Dr. Ursell noted that she continued to see and treat the patient, despite the complaint.

3. Committee Process

A General Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

While the Committee found that Dr. Ursell's clinical care was appropriate (in terms of her assessment of the patient, including ordering appropriate investigations, her diagnosis, and the treatment provided), they had significant concerns regarding Dr. Ursell's office management (which did in fact result in a delay in the patient's diagnosis and the start of her treatment for her serious, progressive condition).

The Committee found that it was not reasonable that the patient had to wait until April 2015 to see Dr. Ursell in follow-up regarding her September 2014 MRI results, particularly given Dr. Ursell's identification of the need for urgent follow-up. The Committee noted that Dr. Ursell was unable to provide any acceptable explanation for much of the delay (i.e. the time between when the initial MRI report was received and her staff booked the follow-up appointment for February 2015); and the Committee was concerned that after the appointment was finally scheduled for February 2015, Dr. Ursell's staff cancelled it because the disc of the MRI was not available. The Committee noted that Dr. Ursell seemed to place the blame for much of the delay on the actions of her office staff, but the Committee pointed out that Dr. Ursell is ultimately responsible for

what takes place in her office, which includes ensuring timely, appropriate follow-up of important test results.

In terms of the delay following the second MRI, the Committee stated that it was concerned with the manner in which Dr. Ursell organized her office during her absence due to illness (including how cancellations were handled). It also noted that information from Dr. Ursell's staff made it clear that Dr. Ursell's communication with her staff was problematic during this time, and led to confusion and disruption for her patients (many of whom did not learn until the day of the appointment that Dr. Ursell would not be attending).

The Committee noted that Dr. Ursell has a history of complaints with the College, and was cautioned twice in 2013 about her office management practices, including not responding to follow-up telephone calls regarding diagnostic testing for patients and staff efficiency and follow-up regarding completion of tasks.

Overall, the Committee identified concerns regarding various aspects of Dr. Ursell's office management.