

## SUMMARY

### DR. DANIEL ROBERT REILLY (CPSO# 74888)

#### 1. Disposition

On January 24, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required obstetrician and gynecologist Dr. Reilly to appear before a panel of the Committee to be cautioned with respect to a failure to maintain appropriate boundaries, inappropriate narcotics prescribing, and practising outside his scope of practice.

The Committee also ordered Dr. Reilly to complete a specified continuing education and remediation program (SCERP). The SCERP requires Dr. Reilly to:

- Practice under the guidance of a Clinical Supervisor acceptable to the College for nine (9) months commencing at a moderate level of supervision and progressing to a lower level of supervision
- Successfully complete the following courses:
  - Understanding Boundaries and Managing Risks Inherent in the Doctor-Patient Relationship through Western University
  - Safe Opioid Prescribing Series through the University of Toronto
  - ProBE Canada Program (in professionalism and ethics)
- Engage in self-directed learning to include review of the following documents and publications, and written summaries of each:
  - CPSO Policy Statement #2-17, Ending the Physician-Patient Relationship
  - 2017 Canadian Guideline for Opioid Therapy and Chronic Non-Cancer Pain
- Undergo a reassessment of his practice by an assessor selected by the College approximately three (3) months following completion of the education program.

## **2. Introduction**

A patient complained to the College that Dr. Reilly failed to provide appropriate care in that he removed her labia minora during an anterior vaginal wall repair surgery in December 2012 and also behaved in an unprofessional and inappropriate manner towards her during office visits.

Dr. Reilly responded that he did not remove the patient's labia minora and this is confirmed by two post-operative examinations that revealed normal external genitalia. Dr. Reilly in general denied the patient's allegations of unprofessional behaviour but acknowledged that some of his interactions with the patient could have been improved. He noted that the patient was very challenging and unique.

## **3. Committee Process**

As part of this investigation, the Committee retained an Independent Opinion provider (IO provider) who specializes in obstetrics and gynecology. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

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](http://www.cpso.on.ca), under the heading "Policies & Publications."

## **4. Committee's Analysis**

The Committee noted that the IO provider's report indicated:

- Dr. Reilly did not meet the standard of practice of the profession in his care of the patient. There were significant shortcomings in Dr. Reilly's prescribing, in that he

inappropriately prescribed high doses of a highly addictive narcotic to the patient and did not maintain appropriate boundaries in the physician-patient relationship.

- Dr. Reilly's care displayed a lack of knowledge and skill in that: he did not have adequate skill or training in the management of a patient with chronic pain; he did not have adequate training and experience in prescribing narcotics for chronic pain; once he realized the patient was addicted to narcotics, his response was inadequate and placed the patient at risk of overdose.
- Dr. Reilly displayed a lack of judgement in that he did not address issues regarding maintenance of the physician-patient relationship until the patient reported him to a professional body, even though there was evidence of concern for the preceding 10 months.
- By inappropriately prescribing Percocet and Ativan to the patient, Dr. Reilly put her at risk for addiction and overdose.

Dr. Reilly responded to the IO provider's report, noting that he had reflected on the College's investigative process which although difficult was a good learning exercise. He indicated he has taken the IO provider's comments seriously.

The Committee acknowledged that Dr. Reilly's response showed some insight into the situation that arose with the patient. The Committee was reassured that Dr. Reilly was taking steps on his own initiative towards self-remediation to address the identified shortcomings in his practice. The Committee agreed with Dr. Reilly that there was no medical evidence to support the patient's claim that Dr. Reilly had surgically removed her labia minora.

The Committee remained concerned, however, by the deficiencies in Dr. Reilly's practice that the IO provider identified. Dr. Reilly's clinical management of the patient was disturbing in that he appeared to be practising outside the scope of his expertise while trying unsuccessfully to practise in the area of chronic pain. In addition, Dr. Reilly's

interactions with the patient appear to indicate that he had no clear understanding or ability to identify significant boundary issues in the context of the physician-patient relationship.

Given the above concerns, the Committee determined that it was appropriate to caution Dr. Reilly and require him to complete the SCERP as outlined.