SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee
(the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Annette Richard (CPSO # 69310)
(the Respondent)

INTRODUCTION

The Complainant was under the care of the Respondent (Family Medicine) from November 2017 to February 2019. The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent:

- **Behaved in an unprofessional manner by ending scheduled appointments early, and by abruptly exiting an appointment, dismissing her health concerns and ending the patient-physician relationship;**
- **Failed to inform her, treat and follow up on test results;**
- **Failed to follow up on or make referrals; and**
- **Failed to provide a complete medical record as requested, and only provided her with parts of her medical record.**

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of January 23, 2020. The Committee required the Respondent to complete a specified continuing remediation and education program (SCERP) consisting of a review of College policies, the College's Practice Guide, and the Canadian Medical Protective Association (CMPA) Good Practices Guide – Managing Risk, a six-month period of clinical supervision, and a reassessment.

COMMITTEE'S ANALYSIS

As part of this investigation, the Committee retained an independent Assessor who specializes in Family Medicine.

Unprofessional behaviour

- The Assessor concluded that there appeared to have been a breakdown of the relationship between the parties during the final appointment in February 2019. The Assessor and the Committee shared the opinion that it was reasonable for the

Respondent to end the visit early given that the Complainant was evidently upset and dissatisfied with her care, and that it was also reasonable for her to conclude that it was in the Complainant's best interest to find another physician. However, having properly decided that it was appropriate to terminate the relationship, the Respondent failed to adequately follow the College's policy, *Ending the Physician-Patient Relationship*.

Follow-up of test results

- The Assessor found that the Respondent demonstrated a lack of judgement by not promptly arranging follow-up on an abnormal result, and the Committee agreed. The Assessor noted that it would be standard of care to disclose the results to the patient promptly, to document this communication in the clinical record, and to promptly refer the patient for appropriate investigations/consultations. However, the Respondent failed to record such communication with the Complainant or details of a follow-up plan, and she did not promptly refer the Complainant for further investigation or consultation. The Assessor also noted that in the case of another abnormal test result, the Respondent failed to document subjective and objective data, an assessment, and a plan regarding the symptoms that led to the investigation.

Management of referrals

- In the case of one referral, the Assessor and the Committee noted that there was no documentation to explain the reasons why the referral was made, nor a documented management plan, and it was unclear why the Complainant failed to attend the scheduled appointment with the consultant.

- Concerning another referral for an investigation, the Respondent made two referrals to the same consultant (requested by the Complainant). The Assessor noted that it was unclear if the Complainant was made aware that the second referral was declined, and if she understood the consequences of not allowing referral to another consultant. The Committee agreed with the Assessor's comment that there was no documented evidence to support that the Respondent's communication with the Complainant was sufficient for her to make an informed decision about the choice of referral.

- The Assessor noted that another referral was not made for over six months, which represented a significant and inappropriate delay.

Medical records

- The Respondent acknowledged that two documents were missing from the medical record, including a note for the final visit with the Complainant, which should have been documented appropriately. The Assessor stated that, overall, the Respondent demonstrated a lack of medical record-keeping skills. The Assessor found that the Respondent's clinical notes were consistently insufficient, as did the Committee. The Respondent noted that she had enrolled to take the Medical Record Keeping course offered by the University of Toronto and had completed other online modules in documentation.

Conclusions

- As a result of the investigation, the Committee had concerns regarding the Respondent's test results management, medical record-keeping, and her termination of the physician-patient relationship. The Committee had no assurances from the Respondent that she has a proper system in place to ensure proper follow-up occurs. While the Committee acknowledged the steps the Respondent had taken to improve her record-keeping, given the consistent inadequacy of the records in this case, they required more reassurance that this aspect of her care will be brought up to standard. Finally, the Committee noted that the Respondent had not provided any reassurance that she will terminate relationships in an appropriate manner in the future. In the circumstances, the Committee decided that it was appropriate to require the SCERP referenced above.