

## **NOTICE OF PUBLICATION BAN**

In the College of Physicians and Surgeons of Ontario and Dr. Sheridan Reavely-Diaz, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that could disclose the identity of the patients referred to orally or in the exhibits filed at the hearing, under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

Every person who contravenes an order made under ... section 45 or 47... is guilty of an offence and on conviction is liable,

(a) in the case of an individual to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence; or

(b) in the case of a corporation to a fine of not more than \$50,000 for a first offence and not more than \$200,000 for a second or subsequent offence.

**DISCIPLINE COMMITTEE  
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

**Citation:** *College of Physicians and Surgeons of Ontario v. Reavely-Diaz*, 2021 ONCPSD 2

**Date:** January 5, 2021

**BETWEEN:**

College of Physicians and Surgeons of Ontario

- and -

Dr. Sheridan Reavely-Diaz

**ORDER AND REASONS**

**Panel:** Dr. Eric Stanton (chair)  
Dr. Ida Ackerman  
Mr. Jose Cordeiro  
Dr. Ian Preyra  
Ms. Linda Robbins

**Heard:** October 14, 2020

**Appearances:**

Ms. Penelope Ng and Ms. Carolyn Silver, for the College  
Mr. Justin McCarthy and Ms. Brooke Smith, for Dr. Sheridan Reavely-Diaz  
Ms. Rachel Laurion, Independent Legal Counsel to the Discipline Committee

## **Introduction**

- [1] The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario (“the College”) heard this matter via teleconference on October 14, 2020. At the conclusion of the hearing, the Committee released its decision, stating its finding that the member committed an act of professional misconduct with written reasons to follow. A formal order was issued on October 15, 2020.

## **The Allegations**

- [2] The Notice of Hearing alleged that Dr. Reavely-Diaz committed an act of professional misconduct under:
- i. paragraph 1(1)2 of Ontario Regulation 856/93 made under the Medicine Act, 1991, in that she failed to maintain the standard of practice of the profession; and
  - ii. paragraph 1(1)33 of Ontario Regulation 856/93 made under the Medicine Act, 1991, in that she engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

## **Response to the Allegations**

- [3] Dr. Reavely-Diaz entered a plea of no contest to the allegations in the Notice of Hearing.

## **The Facts**

- [4] The following facts were set out in a ‘Statement of Uncontested Facts (Liability) and Plea of No Contest’ which was filed as an exhibit at the hearing:

### **PART I - FACTS**

#### **A. BACKGROUND**

1. Dr. Sheridan Reavely-Diaz (“Dr. Diaz”) is a 68 year-old general practitioner. She received her certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (“the College”) on August 2, 1990.
2. At the relevant times, Dr. Diaz was practising at the Pitt Street Medical Centre (the “Pitt Street Clinic”) in Cornwall, Ontario.

The ICRC’s s. 25.4 Interim Order

3. On November 11, 2019, the Inquiries, Complaints and Reports Committee of the College (the “ICRC”) ordered terms, conditions and limitations to be placed on Dr. Diaz’s certificate of registration pursuant to s. 25.4 of the Health Professions Procedural Code (the “ICRC’s s. 25.4 Interim Order”). A copy of the ICRC’s s. 25.4 Interim Order is attached at Tab 1 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest]. Pursuant to the ICRC’s s. 25.4 Interim Order, among other things, Dr. Diaz shall only practise family medicine, and only under the guidance of a high level clinical supervisor acceptable to the College.
4. Since November 11, 2019, Dr. Diaz has not started Clinical Supervision under the terms of the ICRC’s s. 25.4 Interim Order. Dr. Diaz has not practised medicine since November 13, 2019.

**B. FAILURE TO MAINTAIN THE STANDARD OF PRACTICE / DISGRACEFUL, DISHONOURABLE OR UNPROFESSIONAL CONDUCT**

(i) Registrar’s Investigation

5. On March 8, 2016, a physician contacted the College expressing concerns about Dr. Diaz’s care and treatment of a patient. The College appointed investigators on May 31, 2016.
6. The College retained an expert, Dr. Susan Goldstein (“Dr. Goldstein”), to review and provide an opinion regarding Dr. Diaz’s standard of practice. Dr. Goldstein has been actively practising in Toronto since 1985. She practises both general family medicine and medical psychotherapy and holds a GP Focused Practice Designation in GP Psychotherapy. She is also an Assistant Professor in the Department of Family Community Medicine at the University of Toronto.
7. A copy of Dr. Goldstein’s expert opinion report dated August 20, 2019 is attached at Tab 2 [to the Statement of Uncontested Facts

(Liability) and Plea of No Contest]. Based on her review of 28 patient charts, Ontario Health Insurance Plan (OHIP) billing records, interviews and direct observation with Dr. Diaz, among other things, Dr. Goldstein opined that Dr. Diaz failed to meet the standard of practice of the profession in her care of 28 out of 28 patients whose charts Dr. Goldstein reviewed. Dr. Goldstein opined that Dr. Diaz failed to meet the standard of practice with respect to her: Recordkeeping/documentation; billing practices; clinical care; and professionalism, including but not limited to the following:

*Recordkeeping/Documentation:*

- a) Dr. Diaz's file organization and documentation was substandard in all 28 charts reviewed. This includes both medical and psychotherapy/counselling encounters.
- b) Dr. Diaz's medical records are incomplete and disorganized.
- c) Throughout the various patient charts, there were many occurrences where the clinical encounter note was absent entirely, or a single sentence was started or minimally documented.
- d) Dr. Diaz did not complete a cumulative patient profile (CPP) for her patients, although this is a required element of record keeping.
- e) Dr. Diaz's medication lists were confusing, disorganized and incomplete.
- f) Dr. Diaz keeps an incomplete medical record by storing a second set of paper records at home and not in the electronic medical record (EMR).

*Billing/Documentation:*

- a) There was little concordance between the visit documentation and the OHIP billing codes and duration of service claimed. Dr. Goldstein could not predict from the content of the note the OHIP billing code used by Dr. Diaz. Similar encounters were billed using fee codes A007, A003, K007, K013 or K033 in anywhere from 1-3 units.
- b) Use of the higher paying and/or time-based OHIP billing codes (K007, K013, K033 and A033) was excessive.

- c) In order to bill time-based K code fees, the start and stop times of the time spent with the patient must be recorded in the notes. Start/stop times were documented in only 11 of the 25 patient charts for patients for whom psychotherapy (K007) was documented, and for none of the counselling visits. The time stamps appear to have been altered in 10 out of the 11 files where both start/stop times were documented and K007 was billed. The time stamps appeared to have been overwritten/modified to mirror the start time (and in a couple of instances, the stop time) as documented by Dr. Diaz. Many of the start/stop times as documented are inaccurate.
- d) Counselling services (K013 and K033) must occur in pre-booked appointments and are ineligible for walk-in patients. Dr. Diaz confirmed in an interview that neither counselling nor psychotherapy visits were planned encounters, but rather occurred ad-hoc during a medical visit, if she saw a need and/or found she had the time. Many counselling services billed by Dr. Diaz were provided to walk in patients.
- e) Counselling codes were used for visits that, based on the records, would have been considered normal follow-up for acute or chronic conditions (intermediate assessments).
- f) In all files where K013, K033 or K007 were billed (25/28 files), documentation generally did not support the use of these fee codes. Many occurred in the walk-in setting, documentation was inadequate, and most lacked start/stop time documentation. As such, the visits would have been ineligible for payment by OHIP as billed.
- g) In most cases where A003 was billed, a general assessment as defined in the OHIP Schedule of Benefits did not take place. As such, these services would have been ineligible for payment by OHIP as billed.
- h) Dr. Diaz's patients were repeatedly rostered (via multiple billings for the Q200 fee code) even though Q200 should only be used once. For example, for one patient, the Q200 fee code was submitted nine times over four years, each time on a Saturday or Sunday when a Q012 premium code was billed.

- i) Dr. Goldstein's chart audit suggests that the amount (duration) of service spent as documented (and billed) did not occur.
- j) As one example of Dr. Diaz's billing practice, Dr. Goldstein noted that on December 5, 2015, Dr. Diaz's K code billings (17 units) represented over 6 hours of service for just 9 out of 22 patients who were seen in the morning clinic. Dr. Goldstein could not see how it would have been possible for Dr. Diaz to have provided the services as billed to OHIP.

*Medical Care:*

- a) At times, Dr. Diaz's medical care was substandard due to diagnostic errors, inappropriate investigation, inappropriate treatment including use of antibiotics and medication prescribing errors, failure of follow-up, and failure to provide preventative care for patients. This was evident in both the file review and the clinical observation.
- b) With respect to two (2) different cardiac care patients, Dr. Goldstein noted that Dr. Diaz's failure to send the patients to hospital or to achieve acute intervention "could have ended up with a catastrophic outcome."
- c) There are numerous examples of Dr. Diaz's medication errors including: using an incorrect dose/duration of treatment; combining multiple antibiotics unnecessarily or in incorrect combinations; and prescribing when not indicated.
- d) Following Dr. Goldstein's direct clinical observation of four (4) patient encounters, Dr. Goldstein opined that Dr. Diaz's pace and interview style resembled that of an early family medicine resident trainee, that her histories were somewhat disorganized and superficial at times, and she made errors in assessment, diagnosis, management and prescribing.

*Professionalism:*

- a) Dr. Goldstein opined that professionalism concerns were raised by the possibilities of, among other things, altering of EMR time stamps; inaccurately documenting services, e.g., start and stop times; and billing for services that did not occur (i.e., psychotherapy session of 50 minutes duration).

### *Risk of Harm*

8. Dr. Goldstein also concluded that Dr. Diaz's clinical practice, behaviour or conduct exposes or is likely to expose patients to harm or injury. Dr. Goldstein identified a risk of harm in 21 out of 28 patient charts that she reviewed. Specifically, Dr. Goldstein opined:
  - a. Dr. Diaz's history and physical examination skills are substandard. This contributes to misdiagnoses and puts patients at risk.
  - b. There are two concerning cases where Dr. Diaz's cardiac patient management was harmful.
  - c. Dr. Diaz's medication practices put patients at risk through overuse of antibiotics, errors in prescribing/dosing and short renewal intervals.
  - d. Dr. Diaz's documentation and file disorganization creates risk for medical errors.
  - e. Dr. Diaz's failure to provide adequate screening and preventative health care puts patients at risk.
9. In an email dated September 3, 2019, Dr. Goldstein provided a clarification of information in her report related to Dr. Diaz's rostering of patients. A copy of Dr. Goldstein's September 3, 2019 email is attached at Tab 3 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].
10. Dr. Diaz failed to maintain the standard of practice of the profession in respect of her care and treatment of the 28 patients whose charts were reviewed by Dr. Goldstein.

### *EMR Time Stamps*

11. At the relevant times, Canada Health Systems was the EMR provider for the Pitt Street Clinic. Hayley Kash, the VP Operations for Canada Health Systems, provided the following information to the College:
  - a. In the Pitt Street Clinic EMR, a new time stamp is generated the moment the file is opened. If a physician opened a patient file and left an encounter note open, then subsequently opened additional patient records, the time stamp for the first patient would not continue.
  - b. Ms. Kash reviewed a time stamp from one of Dr. Diaz's patient encounters on May 2, 2015. Ms. Kash confirmed that the time



stamp had “definitely been manipulated”. Ms. Kash confirmed that she could tell the time stamp was altered because the EMR does not insert misspelled words such as “thru” and does not insert duplicate text, such as, “AM.AM.” A copy of the May 2, 2015 encounter record reviewed by Ms. Kash is attached at Tab 4. [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].

#### *OHIP Billing*

12. Although Dr. Diaz previously reported that clinic staff had been doing her OHIP billing until the summer of 2016, Dr. Diaz has actually been completing her own OHIP billing since October 18, 2013, when the Pitt Street Clinic started using the EMR system.

#### ii) Patient G

13. On August 25, 2016, the College received a complaint against Dr. Diaz by one of her former patients, Patient G. Patient G raised concerns, among others, about Dr. Diaz’s care in the management of Patient G’s high blood pressure, including that Dr. Diaz had prescribed medication but had not checked his blood pressure in ten months.
14. The College retained Dr. Goldstein to provide an opinion regarding Dr. Diaz’s care and treatment of Patient G. A copy of Dr. Goldstein’s expert opinion report dated December 2, 2019, and clarifying addendum dated December 5, 2019 are attached at Tabs 5 and 6 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest], respectively.
15. In her report, Dr. Goldstein noted that there were three unique sets of EMR records for Patient G submitted to the College through the course of the College’s investigation and there are significant differences between the four records:
  - a. The first set of records was printed and provided to the College by Pitt Street Clinic staff on March 27, 2017 (“Record 1”). At that time, the records hadn’t been accessed since August 2016.
  - b. The records were not accessed again until May 8, 2018. On that day, Dr. Diaz accessed the EMR for 16 minutes, made modifications to the records during that time and provided a

second set of modified medical records to the College ("Record 2").

- c. The records were not accessed again until September 25, 2018, when Dr. Diaz went sequentially through each encounter note starting on April 5, 2014 to August 23, 2016, making further modifications to the records ("Record 3").
- d. A fourth set of records was also provided to the College, which consisted of handwritten notes.

16. In her report, Dr. Goldstein opined that the care Dr. Diaz provided to Patient G did not meet the standard of practice of the profession with respect to Dr. Diaz's medical care, medical records, billing, and professionalism, including but not limited to the following:

*Medical care:*

- a) Patient G was treated for hypertension. Although medication was prescribed, Patient G's Record 1 indicates no blood pressure measurements were taken over the subsequent ten months.
- b) It took an excessively long time to arrange a second opinion and colonoscopy for Patient G. It took over a year to arrange the second opinion and 15 months to arrange a colonoscopy.

*Medical records:*

- a) Dr. Diaz made modifications to the medical records without the required and appropriate documentation of when and why such modifications have occurred, contrary to the policies regarding Medical Record Keeping.
- b) Two sets of medical records were maintained, contrary to the requirement to maintain a single complete medical record.
- c) There are questions as to the accuracy of the four sets of medical records provided to the College for Patient G.
  - i. Record 2 differs from Record 1 in that there are deletions, amendments and additions to the notes. There are also missing entries.
  - ii. Record 3 differs from Record 2 in that there are further deletions, amendments and additions to the notes,

such that Record 3 is much more extensive/detailed within the EMR. Record 3 contains new, inflammatory content with respect to Patient G's attitude and behaviour towards resolving his disability.

- iii. When Record 1 is compared to Records 2 and 3, they appear to communicate different narratives.
  - iv. Dr. Goldstein questioned many of the alterations to Patient G's records, including why additions were made to notes two years later and why, for example, Dr. Diaz would change a documented blood pressure by 2 mm when accessing the records 2.5 years later.
  - v. Dr. Goldstein concluded that it is possible that there are inaccuracies in all three sets of EMR records provided to the College for Patient G.
- d) Medical record keeping (need for CPP and better documentation) is substandard.

*Billing:*

- a) Dr. Diaz may have billed for medical encounters that did not occur.
- b) Dr. Diaz may have billed for encounters which based on the documentation would have been for purposes of completing third party forms and should not have been billed to OHIP.
- c) In most cases, the documentation does not support that counselling (OHIP billing code K033) or psychotherapy (OHIP billing code K007) occurred, where billed. For example, on four dates in July 2016, Dr. Diaz billed K033 and K007 codes that require a minimum of a 20-minute patient encounter, but the EMR audit shows that, for each date, Dr. Diaz only spent about 10 minutes on Patient G. Furthermore, the use of these billing codes requires the documentation of start and stop times, which were absent. As well, the billing codes did not align with the content found in the records.
- d) A general assessment did not take place where OHIP billing code A003 was billed.
- e) There is an unusually high utility of time based (counselling or psychotherapy) OHIP billing codes utilized for Patient G.

*Professionalism:*

- a) With respect to Dr. Diaz's practice management:
  - i. It appears patients are kept waiting an unreasonable amount of time to be seen. Chart audit data supported extended wait times, including for example, a five hour wait on June 20, 2016.
  - ii. Appointment cancellations by Dr. Diaz are excessive.
  - iii. The process for managing referral requests appears substandard resulting in a delay of a year to obtain a referral.
- b) Dr. Diaz ignored multiple requests to provide 3rd party information to Patient G's insurance company, creating excessive delays. Dr. Diaz failed to respond to a number of requests for information and it is unclear if the requested copies of clinical records were ever faxed to the insurer, but if they were, it was after excessive delay. This behaviour contravenes guidelines related to 3rd party reports.

17. Dr. Goldstein opined that Dr. Diaz's care displayed a lack of skill, knowledge or judgement with respect to her:

- a. Management of medical records and documentation;
- b. Failure to respond in a timely way to requests from Patient G's insurance company;
- c. Patient and practice management; and
- d. Billing practices.

18. Dr. Goldstein also opined that Dr. Diaz's clinical practice, behaviour or conduct exposes or is likely to expose her patients to harm or injury. Specifically, Dr. Goldstein opined:

- a. Dr. Diaz's failure to respond to the insurance company's requests put Patient G at financial risk;
- b. Frequent cancellations for patients, particularly after they have spent hours during a work-day in her waiting room, may lead to poorer medical care and unnecessary cost to the patient; and

- c. Large delays in obtaining consultations can put patient care at risk.

- 19. Dr. Diaz provided a response to Dr. Goldstein's report. Upon reviewing Dr. Diaz's response, Dr. Goldstein provided the College with a reply dated January 27, 2020, attached at Tab 7 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].
- 20. Dr. Diaz failed to maintain the standard of practice of the profession in respect of her care and treatment of Patient G.

(iii) Patient H

- 21. On October 17, 2017, the College received a complaint against Dr. Diaz by one of her patients, Patient H. Patient H raised concerns, among others, about Dr. Diaz's care and treatment of her, including that Dr. Diaz constantly found reasons, such as borderline diabetes, to issue new prescriptions.
- 22. The College retained Dr. Goldstein to provide an opinion regarding Dr. Diaz's care and treatment of Patient H. A copy of Dr. Goldstein's expert opinion report dated December 30, 2019 is attached at Tab 8 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].
- 23. In her report, Dr. Goldstein noted that there were three different versions of medical records for Patient H that were submitted to the College during its investigation. Dr. Goldstein further noted that there were significant discrepancies between the three sets of records, which raised questions as to the integrity of the records provided:
  - a) The original clinical encounter notes (the "Original Records") were created on the actual days of the patient encounters in 2015-2017, as seen by Dr. Goldstein in the audit trail report from the EMR.
  - b) On May 8, 2018, Dr. Diaz created a new set of records by printing out each day's encounter, one at a time ("Patient H's Record 2"). In Patient H's Record 2, some of the notes had been altered. The changes ranged from minor additions to the narrative, additions or changes to physical examination data recorded, or in some cases, a rewrite of the note in its entirety. The notes were not provided in sequential order and some were missing.

- c) The third set of records was printed on September 26, 2018 ("Patient H's Record 3"). The audit trail report for September 26, 2018 showed that Dr. Diaz accessed each of the clinical encounter notes sequentially and added additional narrative and information to essentially every clinical note. Dr. Goldstein noted that these modifications were made approximately one to three years after the patient encounters. Dr. Goldstein also noted that some of the additional notes to the records were quite expansive.

24. In her report, Dr. Goldstein opined that the care Dr. Diaz provided to Patient H did not meet the standard of practice of the profession with respect to Dr. Diaz's medical care, medical records, billing, and professionalism, including but not limited to the following:

*Medical care:*

- a) Dr. Diaz prematurely diagnosed Patient H with hypertension after a single moderately elevated blood pressure reading and treatment was initiated. The applicable guidelines for diagnosis of hypertension in effect at that time were not followed. No workup was considered as documented nor follow-up renal assessment after initiating treatment. The medication prescribed by Dr. Diaz was not indicated at the time it was prescribed.
- b) Dr. Diaz's diagnosis of Patient H with adult onset diabetes mellitus (DM) was an over call. The blood work did not support that diagnosis. Diabetic flow sheets or an organized approach to diabetic monitoring was absent. The medication prescribed by Dr. Diaz was not indicated at the time it was prescribed. Although the diagnosis of DM was premature, given Dr. Diaz's assumption of a DM diagnosis, diabetic monitoring was substandard as documented.
- c) Dr. Diaz failed to adequately monitor Patient H's aortic stenosis.

*Medical records:*

- a) Dr. Diaz made modifications to the medical records without the required and appropriate documentation of

when and why such modifications occurred, contrary to the policies regarding Medical Record Keeping.

- b) There are questions as to the accuracy of the newer versions of the medical records.
- c) Medical record keeping is substandard. The required CPP was absent. At times, clinical notes were sparse and/or insufficient; necessary physical examination documents were absent in the original records, and although added to the more recent records, the conflicting data in the records leads to questions as to the accuracy of the documentation.

*Billing:*

- a) In most cases, Dr. Diaz's documentation does not support that counselling or psychotherapy or general assessments occurred, where billed.
- b) There is an unusually high utility of time-based (counselling or psychotherapy) codes utilized for Patient H.
- c) Patient H is neither schizophrenic nor bipolar, however, Dr. Diaz repeatedly billed supplementary mental health codes (Q020, Q021) for these diagnoses, which would trigger a mental health care bonus payment.
- d) In the total of 16 visits, intermediate assessments were only billed for three of the visits. In 13/16 visits, the higher paying "K" codes or A003 general assessment codes were billed but not supported by the documentation.

*Professionalism:*

- a) With respect to practice management, Dr. Diaz's appointment cancellations appear problematic and her waiting times appear excessive at times, including Patient H waiting up to three hours or more to be seen for scheduled appointments.

25. Dr. Goldstein opined that Dr. Diaz's care displayed:

- a. A lack of knowledge with respect to medical care;
- b. A lack of skill with respect to medical care; management of medical records and documentation; practice management

and professional behavior with the patient; and in making prescribing errors such as renewing/restarting Metformin in a diabetic patient already taking Januvia with adequate blood sugar control; and

- c. A lack of judgment with respect to her short medical renewal intervals; refusal to renew necessary psychiatric medications; and billing practices.

26. Dr. Goldstein also opined that Dr. Diaz's clinical practice, behaviour or conduct exposes or is likely to expose her patients to harm or injury by:

- a. Maintaining inadequate and inaccurate medical records;
- b. Errors in the care of common medical conditions such as pre-DM or hypertension;
- c. Failure to provide adequate follow-up (i.e. for aortic stenosis);
- d. Prescribing errors; and
- e. Refusing to provide even a short-term renewal for necessary medications, and in particular psychotropic medications, for a patient Dr. Diaz has identified as high risk.

27. Dr. Diaz provided a response to Dr. Goldstein's report. Upon reviewing Dr. Diaz's response, Dr. Goldstein provided the College with a reply dated March 6, 2020, attached at Tab 9 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].

28. Dr. Diaz failed to maintain the standard of practice of the profession in respect of her care and treatment of Patient H.

### C. DISGRACEFUL, DISHONOURABLE OR UNPROFESSIONAL CONDUCT

#### (i) Patient A

29. On January 24, 2017, the College received a complaint against Dr. Diaz by two developmental support workers (the "support workers") for Patient A. At the relevant times, Patient A was a developmentally disabled and non-verbal patient and was incapable of consenting to treatment.

30. Dr. Diaz engaged in disgraceful, dishonourable or unprofessional conduct in her conduct and communications with Patient A and the support workers who assisted Patient A, including in the following ways:



- a. Dr. Diaz refused to extend Patient A's prescriptions for more than one month to two months at a time, despite the support workers' request for renewals every six months;
- b. Dr. Diaz consistently failed to respond to faxes from Patient A's pharmacy regarding Patient A's prescriptions. One of the support workers estimated that Dr. Diaz failed to respond to at least 40, and possibly over 100, faxes from the pharmacy. Dr. Diaz indicated to the support workers that if they dealt with the pharmacy next door to Dr. Diaz's clinic, this would not be an issue;
- c. Despite being advised that Zolpidem was not effective for Patient A, Dr. Diaz continued to prescribe Zolpidem for Patient A's sleep;
- d. Dr. Diaz refused to provide Open Hands with the blood test results for Patient A;
- e. Dr. Diaz refused to return Open Hands' medical treatment form;
- f. Dr. Diaz would consistently not show up for scheduled home appointments with Patient A; and
- g. Dr. Diaz refused to refer Patient A to a new psychiatrist who had agreed to assess Patient A and was awaiting the referral.

31. A pharmacist at Patient A's pharmacy advised that:

- a. There had been concerns with Dr. Diaz not responding to requests for prescription authorization refills;
- b. Dr. Diaz would prescribe medication to Patient A on a weekly basis, with no refills, but sometimes she would authorize up to 3 refills;
- c. There is a "mountain of paperwork to try to keep up with faxing Dr. Diaz";
- d. He has over 400 documents, many of them prescription authorization requests, to which Dr. Diaz did not respond;
- e. The problem began in 2012 when Dr. Diaz started prescribing to Patient A;
- f. Patient A started seeing another physician for her prescriptions in July 2017 and the problem has since stopped.

*Failure to Cooperate in Investigation / Failure to Respond to the College in a Timely Way /Inappropriate Altering of Medical Records*

32. The College's initial request to Dr. Diaz for Patient A's medical records was made on July 25, 2017. In the letter to Dr. Diaz, dated July 25, 2017, the College investigator, Ms. Martin, wrote, "The records may not be altered in any way. If changes are required, they must be made on a separate document." Ms. Martin also invited Dr. Diaz's response to the complaint and asked that it be sent by August 25, 2017. A copy of Ms. Martin's July 25, 2017 letter is attached at Tab 10 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].
33. On January 16, 2018, Ms. Martin sent a follow up request for Patient A's records, reminding Dr. Diaz of her duty to cooperate. In her letter, Ms. Martin wrote, "Since the records cannot be amended in any way, there should be no delay in providing the records to the College. Please send the records to my attention no later than 4pm on Tuesday, January 23, 2018." A copy of Ms. Martin's January 16, 2018 letter is attached at Tab 11 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].
34. By May 8, 2018, Dr. Diaz still had not produced Patient A's records to the College. Therefore, on May 8, 2018, Ms. Martin attended in-person at the Pitt Street Clinic to retrieve the records ("Patient A's May 8, 2018 Record"). At that time, Dr. Diaz advised that some portions of the records were at her home in Morrisburg. Ms. Martin re-attended at the Pitt Street Clinic on May 9, 2018 to retrieve additional paper records for Patient A.
35. On May 8, 2018, prior to releasing Patient A's May 8, 2018 Record to the College, Dr. Diaz altered the record, including by adding a new note to the previously blank December 3, 2016 entry. The new note specifically mentions Patient A's support workers and addresses the complaint against Dr. Diaz in relation to Patient A. Dr. Diaz did not document the date on which she altered the record and she did not document reasons for the alterations. Dr. Diaz's alterations to Patient A's records provided inaccurate information and/or were inappropriate and unprofessional. Extracts from Patient A's records and the Pitt Street Clinic's EMR audit trail are attached at Tab 12 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].

36. On September 25, 2018, Ms. Martin sent a further letter to Dr. Diaz's counsel, requesting copies of any medical records stored outside of the EMR, along with Dr. Diaz's submissions. Finally, on October 16, 2018, Dr. Diaz provided the College with her response to the complaint along with additional patient records. In Dr. Diaz's response to the College, she provided her explanation to the complainant's allegations, including regarding her decisions not to extend the patient's prescriptions, to continue to prescribe Zolpidem, and not to refer the patient to another psychiatrist.

(ii) Ms. B

37. On June 6, 2017, the College received a complaint from Ms. B, who raised concerns that Dr. Diaz subjected her to a long (four hour) wait and failed to show compassion to her children. Ms. B indicated that in May 2017, she called the Pitt Street Clinic and was advised by the receptionist that her two sons, who were experiencing abdominal discomfort and had red eyes, could be seen by a physician at the Clinic that day and would be seen before 1:00 p.m. Ms. B, her husband, and her three children attended at the Pitt Street Clinic and checked into the Clinic at approximately 10:27 a.m. Ms. B's two sons were added to the top of Dr. Diaz's day sheet.

38. After waiting in the Clinic for almost four hours to see Dr. Diaz, Ms. B saw Dr. Diaz sitting and looking at her iPod. Ms. B asked Dr. Diaz how much longer she was going to take. Dr. Diaz accused Ms. B of looking for special treatment, refused to see or treat Ms. B's children, and told Ms. B and her family to leave the Clinic.

39. Dr. Diaz engaged in disgraceful, dishonourable or unprofessional conduct in her conduct and communications towards Patient B, Patient B's husband and their children, including in the following ways:

- a. In subjecting Ms. B and her family to an approximately four-hour wait and then refusing to provide care or treatment to Ms. B's two children who were experiencing abdominal discomfort.
- b. In her tone and communications towards Ms. B, including accusing Ms. B of seeking special treatment and approaching Ms. B and lifting her chest close to Ms. B during a confrontation.

*Failure to Cooperate in Investigation / Failure to Respond to the College in a Timely Way*

40. The College's initial request to Dr. Diaz for Patient B's medical records, as well as an invitation to make written submissions to the ICRC, was made on August 28, 2017. A copy of the letter dated August 28, 2017 is attached at Tab 13 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest]. On January 16, 2018, a reminder letter was sent to Dr. Diaz requesting that the information be provided by January 23, 2018. In the letter, Dr. Diaz was reminded of her duty to cooperate with the investigator and she was advised that her cooperation with the investigation would also be reported back to the ICRC. A copy of the January 16, 2018 letter is attached at Tab 14 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest]. On February 8, 2018, a further letter was sent to Dr. Diaz reminding her that the College had not yet received her response. On September 25, 2018, a letter was sent to Dr. Diaz's counsel, requesting that copies of any medical records for Ms. B's children, as well as Dr. Diaz's submissions, be forwarded to the College by October 12, 2018. Finally, on October 16, 2018, Dr. Diaz provided the College with her response to the complaint.

(iii) Patient C

41. In October 2017, the College received a complaint against Dr. Diaz from the daughter of one of Dr. Diaz's patients, Patient C. Patient C was approximately 85 years old at the time of the complaint and Patient C's daughter held power of attorney for Patient C's care.

42. Dr. Diaz engaged in disgraceful, dishonourable or unprofessional conduct in her conduct and communications towards Patient C and Patient C's daughter, including in the following ways:

- a. After Patient C's chart was left for Dr. Diaz at the Pitt Street Clinic reception, Dr. Diaz refused to take responsibility when the chart went missing.
- b. Dr. Diaz would not allow Patient C to book appointment times with Dr. Diaz. Wait times for Patient C to see Dr. Diaz were up to four hours.
- c. Dr. Diaz booked weekly or bi-weekly appointments with Patient C and refused to give Patient C repeats on her medications. When Patient C's daughter asked Dr. Diaz if Patient C's bi-weekly appointments could be eliminated and if

Dr. Diaz could provide Patient C with medication repeats for six months, Dr. Diaz refused.

- d. When Patient C's daughter asked, Dr. Diaz refused to give her information about the reason for her appointments with Patient C.
- e. Dr. Diaz failed to show up for a scheduled house call appointment with Patient C.
- f. Dr. Diaz cancelled an appointment with Patient C's daughter as Patient C was driving to the appointment.
- g. After Patient C's daughter complained to the College about Dr. Diaz, Dr. Diaz called Patient C's daughter and threatened to sue her in civil court for libel if she did not retract the complaint. Patient C's daughter expressed that Dr. Diaz's call to her was "pure intimidation".

*Failure to Cooperate in Investigation / Failure to Respond to the College in a Timely Way /Inappropriate Altering of Medical Records*

- 43. The College's initial request to Dr. Diaz for Patient C's medical records was made on January 17, 2018. In the letter to Dr. Diaz, dated January 17, 2018, the College investigator, Ms. Martin, wrote, "The records may not be altered in any way. If changes are required, they must be made on a separate document." Ms. Martin also invited Dr. Diaz's response to the complaint and asked that it be sent by February 22, 2018. A copy of Ms. Martin's January 17, 2018 letter is attached at Tab 15 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest]
- 44. By May 8, 2018, Dr. Diaz still had not produced Patient C's records. Therefore, on May 8, 2018, Ms. Martin attended in-person at the Pitt Street Clinic to retrieve the records ("Patient C's May 8, 2018 Record"). At that time, Dr. Diaz advised that some portions of the charts were at her home in Morrisburg. Ms. Martin re-attended at the Pitt Street Clinic on May 9, 2018 to retrieve the additional paper records for Patient C.
- 45. On June 25, 2018, Ms. Martin sent Dr. Diaz's counsel a letter confirming that Dr. Diaz's response to the complaint had not yet been received. On September 25, 2018, Ms. Martin sent a further letter to Dr. Diaz's counsel, requesting copies of any medical records stored outside of the EMR, along with Dr. Diaz's submissions.

Finally, on October 16, 2018, Dr. Diaz provided the College with her response to the complaint along with additional patient records ("Patient C's October 16, 2018 Record"). In Dr. Diaz's response to the College, she explained her rationale for the timing of patient appointments and the patient's other allegations.

46. On May 8, 2018, prior to releasing Patient C's May 8, 2018 Record to the College, Dr. Diaz altered the record, including by adding additional notes to the record. In addition, on September 26, 2018, prior to sending Patient C's October 16, 2018 Record to the College, Dr. Diaz further altered the record, including by adding additional notes to the record. The new notes added by Dr. Diaz specifically address the complaint against Dr. Diaz in relation to Patient C. Dr. Diaz did not document the dates on which she altered the record and Dr. Diaz did not document reasons for the alterations. Dr. Diaz's alterations to Patient C's records provided inaccurate information and/or were inappropriate and unprofessional. Extracts from Patient C's records and the Pitt Street Clinic's EMR audit trail are attached at Tab 16 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].

(iv) Patients D and E

47. On September 4, 2018, the College received a complaint from Patient D, who expressed concerns regarding Dr. Diaz's care and conduct towards Patient D and her husband, Patient E. Dr. Diaz engaged in disgraceful, dishonourable or unprofessional conduct in her conduct and communications towards Patients D and E, who are former patients of Dr. Diaz, including in the following ways:
- a. Even when Patient D had scheduled appointments with Dr. Diaz, Dr. Diaz's wait times were between four to six hours.
  - b. Despite that Dr. Diaz charged Patient D \$60 to complete her Health Canada form and a form for Patient D's CPP disability application, Dr. Diaz failed to complete the forms. As a result, Patient D's CPP disability benefits and medical pension were initially denied.
  - c. After Patient E called Dr. Diaz's office to ask when Dr. Diaz would finish completing his wife's forms, Dr. Diaz advised Patient D that she would no longer see Patient E as a patient.
  - d. Dr. Diaz failed to follow up with Patient E regarding his outstanding test results from an ultrasound and x-ray.

- e. After Patient D posted on a public Facebook group that she was looking for a lawyer in order to “pursue a doctor”, Dr. Diaz’s secretary contacted Patient D to request that she attend for an appointment. When Patient D attended for the appointment, Dr. Diaz brought her to a patient room and Dr. Diaz “grilled” Patient D, intimidated her, demanded that she delete her Facebook post, and demanded a public letter of apology.

*Failure to Cooperate in Investigation / Failure to Respond to the College in a Timely Way*

48. The College’s initial request to Dr. Diaz for Patient D’s and E’s medical records, as well as an invitation to make written submissions to the ICRC, was made on October 23, 2018. A copy of the letter dated October 23, 2018 is attached at Tab 17 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest]. On January 9, 2019, a reminder letter was sent to Dr. Diaz requesting that the information be provided by January 17, 2019. In the letter, Dr. Diaz was reminded of her duty to cooperate with the investigator and she was advised that her cooperation with the investigation would also be reported back to the ICRC. A copy of the January 9, 2019 is attached at Tab 18 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest]. On March 11, 2019, a further reminder letter was sent to Dr. Diaz requesting that the outstanding information be provided by April 5, 2019. Finally, on March 27, 2019, Dr. Diaz provided copies of Patient D’s and E’s medical records, as well as her written response to the complaint. In Dr. Diaz’s response to the College, she described her view of her efforts to complete Patient D’s requested CPP and disability forms. She also described her view of the circumstances of the end of her doctor/patient relationship with these patients. She responded to Patient D’s allegations regarding his outstanding test results. Finally, she provided her own characterization of the discussion regarding Patient D’s Facebook post.

(v) Patient F

49. On January 15, 2019, the College received a complaint from Patient F, who expressed concerns regarding Dr. Diaz’s clinical care and conduct. Dr. Diaz engaged in disgraceful, dishonourable or unprofessional conduct in her conduct and communications with Patient F, including in the following ways:

- a. Dr. Diaz allowed another patient to access Patient F's personal health information without Patient F's consent. In particular, Dr. Diaz left Patient F's patient chart out in the Pitt Street Clinic and another patient accessed it, learned of Patient F's cancer diagnosis, and told others about the diagnosis.
- b. When Patient F spoke with Dr. Diaz about the privacy breach, Dr. Diaz indicated that her file was "read on the clinic side," that Dr. Diaz always flips her files over, that she had called the patient that had seen Patient F's file, and there was not much else that could be done about it.
- c. When Patient F spoke to Dr. Diaz about her lawyer billing Dr. Diaz directly for a copy of her patient file, Dr. Diaz began raising her voice, and yelling and cursing at Patient F so that staff and patients in the waiting room could hear. When Patient F told Dr. Diaz that it was not appropriate to yell that way and it wasn't the right place, Dr. Diaz said, "let them all hear".
- d. Dr. Diaz also behaved unprofessionally towards the law clerk at Patient F's lawyer's office, including by refusing to allow the law firm to make the \$50 payment for Patient F's medical records; by continuously making comments that lawyers stiff her on the bill and that Patient F's lawyers were just like the rest of them and were not going to pay; by making comments that if Patient F could afford a lawyer, she could afford to pay Dr. Diaz for her records; and by continuously talking over, and interrupting, the law clerk.
- e. Dr. Diaz failed to complete Patient F's long term disability forms in a timely manner. The forms had been with Dr. Diaz since January but were not completed until March 2019.
- f. Dr. Diaz failed to facilitate a timely referral for Patient F to a cancer clinic.
- g. Dr. Diaz refused to provide Patient F with a prescription refill when Patient F attended at Dr. Diaz's clinic in person in March of 2019. Dr. Diaz told Patient F to attend at the pharmacy and have the pharmacy fax her.
- h. Dr. Diaz cancelled Patient F's appointment on the morning of the appointment.



50. On September 13, 2019, Dr. Diaz provided to the College a response to Patient F's complaint. In her response, Dr. Diaz responded to the complaint about the timing for her to complete Patient F's long-term disability forms and her referral for Patient F to a cancer clinic. Dr. Diaz described steps that she indicated had been taken in response to the privacy breach and she described her view of the interactions with Patient F and the law clerk.

(vi) Patient G

51. Dr. Diaz engaged in disgraceful, dishonourable or unprofessional conduct in her conduct and communications with Patient G, including in the following ways:

- a. Dr. Diaz failed to respond in a timely manner to requests for information from Patient G's insurer relating to Patient G's long-term disability claim. Between December 15, 2015 and June 10, 2016, Patient G's insurer sent no less than ten letters/emails to Dr. Diaz requesting a copy of Patient G's medical records, including a letter expressing that because the records remained outstanding, Patient G's long term disability benefits are under suspension. Copies of the correspondence from Patient G's insurer are attached at Tab 19 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].
- b. On one occasion, Dr. Diaz left the office when she was already behind in seeing her appointments. On that day, Patient G had an appointment with Dr. Diaz for noon and he did not get to see her until approximately 3:00 to 3:30 p.m.
- c. Dr. Diaz booked appointments for 9:00 a.m. but she sometimes would not show up until 10:00 a.m.
- d. Dr. Diaz cancelled appointments with Patient G, without any explanation. Despite cancelling the appointments, on some occasions, Dr. Diaz nevertheless billed OHIP for counselling and also charted in Patient G's record for that day. For example:
  - i. On June 20, 2016, Dr. Diaz cancelled Patient G's appointment on the morning of the appointment. Despite that this appointment was cancelled by Dr. Diaz, Dr. Diaz billed OHIP for one unit of counselling

(K033A) for Patient G on this day. The appointment was rescheduled for July 8, 2016.

- ii. On July 8, 2016, Dr. Diaz cancelled Patient G's appointment after he had already been sitting in the waiting room for two hours.
- iii. On July 11, 2016, Dr. Diaz cancelled Patient G's appointment while Patient G was sitting in the waiting room. Despite that this appointment was cancelled by Dr. Diaz, Dr. Diaz billed OHIP for one unit of counselling (K033A) for Patient G for this day. The appointment was rescheduled for July 18, 2016.
- iv. On July 18, 2016, Dr. Diaz cancelled Patient G's appointment after he had already been sitting in the waiting room for three hours. Despite that this appointment was cancelled by Dr. Diaz, Dr. Diaz billed OHIP for three units of counselling (K033A) for Patient G for this day. The appointment was rescheduled for July 25, 2016.
- v. On July 25, 2016, Dr. Diaz cancelled Patient G's appointment while he was sitting in the waiting room. Despite that this appointment was cancelled by Dr. Diaz, Dr. Diaz billed OHIP for one unit of counselling (K033A) for Patient G for this day. The appointment was rescheduled for July 30, 2016.
- vi. When Patient G attended at the Clinic on July 30, 2016, he was told that he did not have an appointment. Despite that Patient G was told that he did not have an appointment with Dr. Diaz, Dr. Diaz billed OHIP for one unit of counselling (K033A) for Patient G for this day. An appointment was booked for August 11, 2016.
- vii. On August 11, 2016, Dr. Diaz cancelled Patient G's appointment during the morning of the appointment and rescheduled for August 22, 2016.
- viii. On August 22, 2016, Dr. Diaz cancelled Patient G's appointment while he was in the waiting room. An appointment was rescheduled for August 23, 2016.

- e. On one occasion, when Patient G had a scheduled appointment, Dr. Diaz made him wait three to five hours after his scheduled appointment time. When Patient G asked Dr. Diaz why it took so long, Dr. Diaz responded that Patient G was paid by his insurance company to wait just like he does at home. Dr. Diaz also ripped up Patient G's hospital records in front of him and threw them in the garbage.

*Failure to Cooperate in Investigation / Failure to Respond to the College in a Timely Way Inappropriate Altering of Medical Records*

- 52. The College's initial request to Dr. Diaz for Patient G's medical records was made on October 17, 2016. In the letter to Dr. Diaz, dated October 17, 2016, the College investigator, Ms. Martin, wrote, "The records may not be altered in any way. If changes are required, they must be made on a separate document." A copy of Ms. Martin's letter dated October 17, 2016 is attached at Tab 20 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].
- 53. Despite a telephone message to Dr. Diaz's counsel on December 15, 2016 and a written reminder sent the same day, Dr. Diaz failed to provide the College with a copy of Patient G's records. In Ms. Martin's December 15, 2016 letter to Dr. Diaz's counsel, Ms. Martin wrote, "Since the records cannot be amended in any way, there should be no delay in providing the records to the College. Please send the records...to my attention no later than 4pm on January 13, 2016." A copy of Ms. Martin's letter dated December 15, 2016 is attached at Tab 21 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].
- 54. As Dr. Diaz failed to provide Patient G's records, an appointment of investigators was obtained under section 75(1)(c) of the Health Professions Procedural Code so that Patient G's records could be summonsed from the Pitt Street Clinic. The College obtained a copy of Patient G's records on March 29, 2017 by way of the summons.
- 55. On May 8, 2018, a College investigator attended in-person at the Pitt Street Clinic and Dr. Diaz provided a second version of Patient G's records.
- 56. On June 25, 2018, Ms. Martin sent Dr. Diaz's counsel a letter confirming that Dr. Diaz's response to the complaint had not yet been received. On September 25, 2018, Ms. Martin sent a further letter to Dr. Diaz's counsel, requesting copies of any medical records

stored outside of the EMR, along with Dr. Diaz's submissions. Finally, on October 16, 2018, Dr. Diaz provided the College with her response to the complaint along with additional patient records. In her response, Dr. Diaz provided her version of events and responded to Patient G's allegations against her. On July 5, 2019, Dr. Diaz's counsel sent a letter to the College enclosing a set of handwritten notes, which were described as "handwritten notes Dr. Diaz had for [Patient G]".

57. As set forth in Dr. Goldstein's report dated December 2, 2019, Dr. Diaz made alterations to Patient G's medical records on May 8, 2018 and September 25, 2018, prior to sending the records to the College. Dr. Diaz's alterations to Patient G's records provided inaccurate information and were inappropriate and unprofessional. Extracts from Patient G's records and the Pitt Street Clinic's EMR audit trail are attached at Tab 22 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].

(vii) Patient H

58. Dr. Diaz engaged in disgraceful, dishonourable or unprofessional conduct in her conduct and communications with Patient H, including in the following ways:

- a. Dr. Diaz required Patient H to attend the Clinic to review all test results, even if the results were normal.
- b. Dr. Diaz required Patient H to attend the Clinic every two months for medication renewals.
- c. On three different occasions, Dr. Diaz failed to show up for scheduled appointments by cancelling the appointments the same day while her patients were waiting in the waiting room.
- d. Following the appointments that Dr. Diaz cancelled, Dr. Diaz failed to respond to medication renewal requests from the pharmacist for Patient H's antidepressant medication to cover the period until the next appointment.
- e. Dr. Diaz fraternized with certain patients while other patients were left to wait in the waiting room.
- f. Dr. Diaz constantly interrupted Patient H when she was discussing her concerns. Patient H described Dr. Diaz as, "rude, condescending, ignorant, inconsiderate, a liar".

*Failure to Cooperate in Investigation / Failure to Respond to the College in a Timely Way Inappropriate Altering of Medical Records*

59. On May 8, 2018, Ms. Martin attended in-person at the Pitt Street Clinic to retrieve Patient H's records. On June 25, 2018, a letter was sent to Dr. Diaz's counsel with a reminder that Dr. Diaz had not yet responded to the complaint. On September 25, 2018, a letter was sent to Dr. Diaz's counsel requesting Dr. Diaz's submissions and a complete copy of Dr. Diaz's medical records for Patient H, along with a reminder about Dr. Diaz's duty to cooperate with the investigator. On October 16, 2018, Dr. Diaz provided a second set of records for Patient H, along with a response, which provided Dr. Diaz's version of events and responded to Patient H's allegations against her.
60. As set forth in Dr. Goldstein's report dated December 30, 2019, Dr. Diaz made alterations to Patient H's medical records before releasing the records to the College. Dr. Diaz's alterations to Patient H's records provided inaccurate information and were inappropriate and unprofessional. Extracts from Patient H's records and the Pitt Street Clinic's EMR audit trail are attached at Tab 23 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].

(viii) Failure to Cooperate with Respect to Registrar's Investigations

*Registrar's Investigation – Additional Patient Charts*

61. On July 27, 2016, a College investigator attended at the Pitt Street Clinic to retrieve 25 of Dr. Diaz's patient records in the context of the Registrar's Investigation into Dr. Diaz's practice. Dr. Diaz objected to the investigator's presence, was argumentative, and spoke in a very loud voice. Dr. Diaz calmed down after a lengthy period of time and the investigator was able to retrieve 25 patient files from the Clinic. Dr. Diaz was given a copy of the files that were retrieved and was told she would have the chance to review the files before signing the College's standard acknowledgement and receipt form attesting to the completeness of the records.
62. Following the College's retrieval of the 25 patient records from the Pitt Street Clinic, the College followed up no less than nine times, including seven written and two verbal follow-up requests, with Dr. Diaz's counsel for Dr. Diaz to sign an Acknowledgement & Receipt Form attesting to the completeness of the records retrieved. Specifically, follow-ups and/or requests were made by the College on the following dates: August 19, 2016 (Tab 24); August 31, 2016

(Tab 25); September 12, 2016 (Tab 26); September 14, 2016 (Tab 27); October 7, 2016 (Tab 28); November 22, 2016 (Tab 29); January 2, 2017 (Tab 30); January 2, 2017 (Tab 31); and January 9, 2017 (Tab 32) [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].

63. On October 29, 2018, the College's independent expert, Dr. Goldstein, met with Dr. Diaz for an interview. At that time, Dr. Diaz advised, for the first time, that the charts retrieved by the College were not complete and that there were between 20-25 patients charts at Dr. Diaz's home, including records for patients whose care by Dr. Diaz was being reviewed by Dr. Goldstein. When Dr. Diaz was asked why the College was not aware until October 29, 2018 that there were records outstanding, Dr. Diaz responded, "...it was never mentioned to me uh, that you needed to have more than what you've gotten from the EMR. I hadn't hear [sic] anything more about it...I never signed that the files were complete." When Dr. Diaz was asked why she had not signed that the files were complete, Dr. Diaz responded, "I didn't sign it 'cause the files weren't complete because there were paper files." Dr. Diaz stated that it had never occurred to her to tell the College that there were paper records outstanding and that it was never asked.

*Registrar's Investigation – Scheduling an Interview with Dr. Diaz*

64. On November 22, 2016, a College investigator, Ms. Martin, wrote to Dr. Diaz's counsel indicating that the independent expert, Dr. Goldstein, would need to interview Dr. Diaz and proposed three dates (Jan. 4, 9 or 11, 2017) for the interview. By January 2, 2017, Ms. Martin had not received a response to her correspondence and sent follow up requests to Dr. Diaz's counsel through voicemail, email and fax. On January 5, 2017, Dr. Diaz's counsel wrote to Ms. Martin indicating that he was still not able to confirm Dr. Diaz's attendance for an interview with Dr. Goldstein on January 11, 2017. Therefore, the January 11, 2017 interview date was cancelled. Copies of this correspondence are attached at Tab 33 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest]. An interview between Dr. Goldstein and Dr. Diaz was scheduled for July 16, 2018.

*Registrar's Investigation – Dr. Diaz Cancels the July 16, 2018 Interview*

65. On July 12, 2018, four days before the scheduled interview, Dr. Diaz's counsel wrote to Ms. Martin advising that Dr. Diaz had a fall

the previous day that caused a significant injury and that Dr. Diaz would not be able to attend the interview as scheduled. Ms. Martin asked that medical documentation be provided when it is available. Copies of this correspondence are attached at Tab 34 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest].

66. Despite Dr. Diaz's counsel indicating that Dr. Diaz could not attend for the interview on July 16, 2018 due to a fall that caused significant injury, OHIP records show that Dr. Diaz billed OHIP for medical services she provided to patients the day immediately after Dr. Diaz's counsel called to cancel the interview, as well as the immediately following days. In particular, the OHIP records show:

- a. With respect to a service date of July 13, 2018 (which is the day after Dr. Diaz cancelled the meeting with Dr. Goldstein), Dr. Diaz billed OHIP in respect of 12 separate patients.
- b. With respect to a service date of July 14, 2018, Dr. Diaz billed OHIP in respect of 40 separate patients.
- c. With respect to a service date of July 15, 2018, Dr. Diaz billed OHIP in respect of 26 separate patients.
- d. With respect to a service date of July 16, 2018, Dr. Diaz billed OHIP in respect of four separate patients.

67. The fee codes billed by Dr. Diaz over these days include, but are not limited to, fee codes for general and intermediate assessments, injections, multiple units of counselling, multiple units of psychotherapy, travel premiums, and after hours premiums.

68. On August 23, 2018, Ms. Martin wrote to Dr. Diaz's counsel indicating that she had not received any medical documentation as confirmation of Dr. Diaz's fall and need for recovery time. Ms. Martin also indicated that she would like to reschedule the next interview. On September 4, 2018, Ms. Martin wrote to Dr. Diaz's counsel indicating that she still had not received medical documentation of Dr. Diaz's concussion. Ms. Martin also asked for confirmation if the documentation confirms that Dr. Diaz needs to be out of practice for a specific length of time, as Ms. Martin wanted to reschedule the independent expert's interview as soon as possible. On September 19, 2018, Ms. Martin called the Pitt Street Clinic and received confirmation that Dr. Diaz had been practising at the clinic that week. An interview was scheduled for October 29, 2018.

*Registrar's Investigation – Dr. Diaz Cancels the March 14, 2019 Interview*

69. On February 21, 2019, Ms. Martin emailed Dr. Diaz's counsel confirming that Dr. Goldstein would need to interview Dr. Diaz again following receipt of the additional information that was received at the previous interview. An interview was scheduled for March 14, 2019.
70. On March 6, 2019, Dr. Diaz's counsel wrote to Ms. Martin advising that Dr. Diaz has pneumonia and requesting that the March 14, 2019 interview be rescheduled. Dr. Diaz's counsel also enclosed a doctor's note advising that Dr. Diaz "requires bedrest and absence from work duties in order to recuperate, at least until March 22nd, 2019." A copy of the email from Dr. Diaz's counsel is attached at Tab 35 [to the Statement of Uncontested Facts (Liability) and Plea of No Contest]. The March 14, 2019 interview date was cancelled in accordance with Dr. Diaz's request.
71. Despite Dr. Diaz's counsel indicating, on March 6, 2019, that Dr. Diaz could not attend for the March 14, 2019 interview due to Dr. Diaz having pneumonia and requiring bedrest until at least March 22, 2019, OHIP records show that Dr. Diaz billed OHIP for services that she provided to patients on March 6, 2019 and the immediately following days. In particular, the OHIP records show:
- a. With respect to a service date of March 6, 2019 (which is the day that Dr. Diaz cancelled the meeting with Dr. Goldstein), Dr. Diaz billed OHIP in respect of six (6) separate patients.
  - b. With respect to a service date of March 7, 2019, Dr. Diaz billed OHIP in respect of 16 separate patients.
  - c. With respect to a service date of March 8, 2019, Dr. Diaz billed OHIP in respect of 13 separate patients.
  - d. With respect to a service date of March 9, 2019, Dr. Diaz billed OHIP in respect of 27 separate patients.
  - e. With respect to a service date of March 10, 2019, Dr. Diaz billed OHIP in respect of 20 separate patients.
72. The fee codes billed by Dr. Diaz over these days include, but are not limited to, fee codes for general and intermediate assessments, injections, multiple units of counselling, multiple units of psychotherapy, travel premiums, and after hours premiums.



73. On March 11, 2019, staff at the Pitt Street Clinic confirmed that Dr. Diaz had been at the Clinic all day on March 11, 2019 and that she saw patients in the afternoon. Staff at the Clinic also confirmed that Dr. Diaz was planning to see patients the next day, March 12, 2019. On March 14, 2019, staff at the Pitt Street Clinic confirmed that Dr. Diaz had been seeing patients in the Clinic on March 13, 2019 and that Dr. Diaz was also in the office on March 14, 2019.

*Disgraceful, Dishonourable or Unprofessional Conduct*

74. Dr. Diaz engaged in disgraceful, dishonourable or unprofessional conduct:

- a. By failing to cooperate with the College's investigations and failing to respond to the College in a timely way;
- b. In her record keeping, including but not limited to, creating false and/or inaccurate medical records and/or inappropriately altering medical records;
- c. In her billing practice, including but not limited to, inappropriately billing and/or submitting inappropriate claims to OHIP; and
- d. In her conduct and communications with Patients A, C, D, E, F, G, H and Ms. B, and or the family members/caregivers of such patients and Ms. B.

**PART II – PLEA OF NO CONTEST**

75. Dr. Diaz does not contest the facts specified above, and does not contest that, based on these facts, she engaged in professional misconduct, in that:

- a. She engaged in an act or omission relevant to the practise of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, under paragraph 1(1)33 of O. Reg. 856/93, made under the Medicine Act, 1991("O/Reg. 856/93"); and
- b. She has failed to maintain the standard of practice of the profession under paragraph 1(1)2 of O. Reg. 856/93.

**Rule 3.02 – Plea of no contest**

- [5] Rule 3.02 of the Rules of Procedure of the Discipline Committee regarding a plea of no contest states:

3.02(1) Where a member enters a plea of no contest to an allegation, the member consents to the following:

- (a) that the Discipline Committee can accept as correct the facts alleged against the member on that allegation for the purposes of College proceedings only;
- (b) that the Discipline Committee can accept that those facts constitute professional misconduct or incompetence or both for the purposes of College proceedings only; and that the Discipline Committee can dispose of the issue of what finding ought to be made without hearing evidence.

## Findings

- [6] The Committee accepts as correct all the facts set out in the Statement of Uncontested Facts (Liability) and Plea of No Contest. Having regard to these facts, the Committee finds that Dr. Diaz committed an act of professional misconduct under subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 (the “Code”), in that she engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and has failed to maintain the standard of practice of the profession.

## Facts on Penalty

- [7] The following facts were set out in an Agreed Statement of Facts Regarding Penalty which was filed as an exhibit at the hearing:

### A. Undertaking

- i. Dr. Diaz entered into an undertaking with the College on October 8, 2020, wherein she agreed to resign from the College, and not to apply or re-apply for registration as a physician to practice medicine in Ontario or any other jurisdiction, effective immediately. A

copy of Dr. Diaz's Undertaking is attached at Tab 1 [to the Agreed Statement of Facts Regarding Penalty].

B. Dr. Reavely-Diaz's History with the College

ii. On October 17, 2019, the Inquiries, Complaints and Reports Committee of the College (the "ICRC") considered a complaint that Dr. Diaz failed to appropriately manage the care of a patient, including that Dr. Diaz failed to conduct any testing or follow-up when the patient presented with yellowing eyes, weight loss and extra abdominal weight. The ICRC directed Dr. Diaz to attend at the College to be cautioned in person regarding her professionalism, delayed response to the College, and altered medical records. The ICRC also advised Dr. Diaz to conduct and document a more comprehensive history and physical examination on patients presenting with non-specific complaints, and to consider possible underlying serious illness, including malignancy, in such situations. A copy of the ICRC's Decision and Reasons dated October 17, 2019 is attached at Tab 2 [to the Agreed Statement of Facts Regarding Penalty].

iii. Also on October 17, 2019, the ICRC considered a complaint about Dr. Diaz's ordering of a blood test and colon screening, and delay in sending a referral. The ICRC directed Dr. Diaz to attend at the College to be cautioned in person regarding her professionalism, delayed response to the College, and altered medical records. The ICRC also advised Dr. Diaz regarding professional office management, including ensuring that correct referrals are sent in a timely manner and that she and clinic staff communicate in a professional manner. A copy of the ICRC's Decision and Reasons dated October 17, 2019 is attached at Tab 3 [to the Agreed Statement of Facts Regarding Penalty].

iv. Also on October 17, 2019, the ICRC considered a complaint that Dr. Diaz failed to provide appropriate management of a patient's care, including that Dr. Diaz discontinued the patient's medications abruptly. The ICRC advised Dr. Diaz to make reasonable efforts to assist patients who are moving out of the practice in terms of continuity of care, for a short period, and to follow opioid prescribing guidelines and medical record-keeping guidelines. A copy of the ICRC's Decision and Reasons dated October 17, 2019 is attached at Tab 4 [to the Agreed Statement of Facts Regarding Penalty].

v. Also on October 17, 2019, following its consideration of a Registrar's Investigation regarding Dr. Diaz's medical practice, the ICRC directed Dr. Diaz to attend to be cautioned in person regarding altered medical records. A copy of the ICRC's Decision and Reasons dated October 17, 2019 is attached at Tab 5 [to the Agreed Statement of Facts Regarding Penalty].

vi. On July 19, 2018, the ICRC considered a complaint that Dr. Diaz failed to complete a patient's Ontario Disability Support Program application and that the patient attended four appointments to discuss the application but did not see Dr. Diaz. The ICRC required Dr. Diaz to participate in a Specified Continuing Education and Remediation Program consisting of a course in medical record-keeping. The ICRC also directed Dr. Diaz to attend at the College to be cautioned in person regarding her medical records, her office management, her completion of third party reports, and her response to the requests from the College for information in regard to the complaint. A copy of the ICRC's Decision and Reasons dated July 19, 2018 is attached at Tab 6 [to the Agreed Statement of Facts Regarding Penalty].

vii. On August 17, 2016, the ICRC considered a complaint about the administrative conduct of Dr. Diaz. The ICRC directed Dr. Diaz to attend at the College to be cautioned in person regarding office management, including properly administering scheduled appointments and taking responsibility for such management, and maintaining complete records and providing the same to the College when requested. In its Decision and Reasons, the ICRC noted its view that it is unacceptable for a physician to make patients wait excessive periods of time for scheduled appointments and that it was striking to the ICRC that Dr. Diaz had not acknowledged that there was anything wrong with the excessive wait time that occurred in the case. A copy of the ICRC's Decision and Reasons dated August 17, 2016 is attached at Tab 7 [to the Agreed Statement of Facts Regarding Penalty]

### **Submissions on Penalty**

- [8] Counsel for the College and counsel for Dr. Diaz made a joint submission as to an appropriate penalty and costs order, consisting of: a reprimand and costs payable to the College in the amount of \$6,000.00.

## Reasons for Penalty

- [9] The Committee was cognisant of its discretion to accept or reject a joint submission on penalty. Specifically, the law provides that the Committee should not depart from a joint submission on penalty, unless the proposed penalty would bring the administration of justice into disrepute, or is otherwise not in the public interest (*R. v. Anthony-Cook*, 2016 SCC 43).
- [10] Further, in considering the jointly proposed penalty, the Committee took into account the well accepted principles of penalty. First and foremost, the penalty must provide for public protection. Further, it must maintain the integrity of the profession and the public's confidence in the College's ability to regulate the profession in the public interest. The penalty should also serve as a specific deterrent to the member, and general deterrent to the broader profession. While an appropriate penalty must be proportional to the misconduct found, it must also denounce the misconduct, signaling to the profession that this type of misconduct will not be tolerated. Where applicable, the penalty should also provide for the rehabilitation of the member.
- [11] In reaching a decision on penalty, the Committee weighed the penalty principles, considered the specific facts and circumstances in the case and the prior decisions of the Committee that were submitted by the parties.

### Aggravating factors

#### *(i) Egregiousness of the misconduct*

- [12] The Committee considered the egregiousness of Dr. Diaz's misconduct, particularly the nature and scope, to be an aggravating factor. Over several years, Dr. Diaz repeatedly demonstrated a lack of professionalism in her practice management. Further, in her care of patients, Dr. Diaz exhibited deficiencies in her knowledge, skill, and judgment. She also lacked professionalism and judgment in her dealings with the College.

[13] The Committee is concerned that Dr. Diaz's behaviours persisted, despite prior cautions issued by the College and opportunities for remediation. In the Committee's view, Dr. Diaz demonstrated a troubling lack of insight into the serious professional deficiencies that permeated her practice.

[14] Dr. Diaz's misconduct is broad, varied, and serious. The misconduct relates not only to serious clinical deficiencies, but also comprises repeated instances of disgraceful, dishonourable, and/or unprofessional conduct, including but not limited to: unprofessional behaviour; inappropriate OHIP billing; unprofessional conduct and communications towards patients and other parties; excessive patient wait times; abrupt cancellations without explanation; and failing to cooperate with the College.

*(ii) Actions Hindered Investigative Process*

[15] Another aggravating factor on penalty is that Dr. Diaz's actions hindered the investigative process, thereby compromising the College's regulatory function. During the investigation, Dr. Diaz altered medical records. Further, Dr. Diaz provided false or misleading statements to College investigators. Particularly, Dr. Diaz said on two occasions that she was injured or ill and was, therefore, unable to attend the College for an interview. On the days that Dr. Diaz was allegedly unable to attend the College, she nevertheless continued to see patients at the Pitt Street Clinic.

[16] Additionally, Dr. Diaz repeatedly failed to produce documents to the College investigator, despite the College investigator's numerous requests. Ultimately, the College investigator was forced to attend the Clinic to access these documents. By providing false information, failing to produce documents, and altering documents, Dr. Diaz impeded the investigative process. Dr. Diaz demonstrated a blatant disregard for the College's investigative process. Physicians are expected to cooperate with the College as their governing body.

*(iii) Practice Deficiencies Put Patients at Risk of Harm*

[17] A third aggravating factor that the Committee finds is that Dr. Diaz's practice exhibited significant and widespread deficiencies, which put patients at risk of harm. Dr. Diaz failed to meet the standard of care with respect to her clinical practice. Indeed, the following deficiencies were evident within Dr. Diaz's patient charts: diagnostic errors; inappropriate investigations and treatments; medication errors, including prescribing medications when not indicated; and failure to provide appropriate follow up.

[18] The Committee was particularly alarmed by Dr. Diaz's failure to refer two cardiac patients to a hospital's emergency department, as is current practice, causing the potential for catastrophic harm. Dr. Diaz also put her patients at risk of harm by repeatedly refusing to provide long-term prescription renewals for essential medications. Further, Dr. Diaz contributed to patient hardship by repeatedly failing to complete disability and insurance forms and/or failing to do so in a timely manner.

*(iv) Lack of Insight Regarding Office Management*

[19] A fourth aggravating factor that the Committee finds is Dr. Diaz's lack of insight or understanding as to the inappropriateness of excessive patient wait times. In particular, Dr. Diaz attended at the College on August 17, 2016 to be cautioned in person regarding office management, including properly administering scheduled patient appointments. In its decision directing Dr. Diaz to attend at the College to be cautioned, the ICRC noted that Dr. Diaz did not acknowledge that there is anything wrong with excessive wait times.

*(v) College History*

[20] Over the past four years, the College has issued repeated warnings and cautions to Dr. Diaz with respect to her conduct and medical care. Despite this, Dr. Diaz continued to engage in egregious behaviour. Dr. Diaz's failure to maintain the standards of the profession and her unprofessional behaviour, not only put patients at risk of harm, but also demonstrated an alarming lack of judgment. The

Committee finds Dr. Diaz's failure to correct her clinical deficiencies and her chronic acts of unprofessionalism to be the fifth and final aggravating factor in this case.

[21] The foregoing aggravating factors evidence Dr. Diaz's unsuitability for practice in the medical profession.

#### Mitigating Factors

[22] Dr. Diaz's plea of no contest spared the College the time, resources and expense of a potentially lengthy hearing, and spared witnesses from having to attend and testify.

[23] Dr. Diaz's undertaking to resign her certificate of registration from the College and never to re-apply for registration to practice medicine in Ontario or any other jurisdiction is also a factor mitigating on penalty.

#### Prior Cases

[24] Although prior Committee decisions are not binding as precedent, the Committee has accepted as a principle of fairness that generally, like cases should be treated alike. The Committee considered three prior cases submitted by the parties. In each of these cases, the physician undertook to resign his or her certificate of registration and the Committee ordered a reprimand and costs. A brief summary of these cases follows.

- i. *Ontario (College of Physicians and Surgeons of Ontario) v. Hoffer*, 2020 ONCPSD 3: Dr. Hoffer, a psychiatrist, pleaded no contest to allegations that he failed to maintain the standard of practice with respect to his care of 28 patients. Independent experts opined that Dr. Hoffer was deficient in his record keeping, prescribing practices, and in providing reports to family physicians or referral sources regarding his findings. Dr. Hoffer's deficiencies in patient care spanned many years with no improvement, despite numerous interventions by the College.



Dr. Hoffer undertook to resign his certificate of registration and never to reapply in Ontario or any other jurisdiction. The Committee ordered a reprimand and costs in the amount of \$6,000.

- ii. *Ontario (College of Physicians and Surgeons of Ontario) v. Hyde*, 2019 ONCPSD 48: Dr. Hyde, a general practitioner, admitted to failing to maintain the standard of practice of the profession and disgraceful, dishonourable or unprofessional conduct. Expert reports revealed clinical deficiencies in Dr. Hyde's practice, including absent patient treatment plans; undocumented OHIP billings; unprofessional behaviour towards patients, staff and the general public; and failure to maintain appropriate boundaries by treating a staff member. Unlike the facts in this case, Dr. Hyde had no prior involvement with the College. Dr. Hyde undertook to resign his certificate of registration and never to reapply in Ontario or any other jurisdiction. The Committee ordered a reprimand and costs in the amount of \$6,000.
- iii. *Ontario (College of Physicians and Surgeons of Ontario) v. Cameron*, 2018 ONCPSD 25: Dr. Cameron, a general practitioner, was found to have failed to maintain the standard of practice of the profession with respect to his prescribing of narcotics. Dr. Cameron had a significant history with the College, which the Committee considered aggravating on penalty. During the period between 2001 and 2017, the College received and investigated four public complaints regarding Dr. Cameron's clinical care and two public complaints regarding his office practices. In 2011 and 2013, Dr. Cameron was the subject of two findings of disgraceful, dishonourable or unprofessional conduct by the Discipline Committee. Dr. Cameron undertook to resign his registration and never to reapply. A reprimand and costs were ordered.

## **Conclusion**

[25] The Committee accepts the jointly proposed penalty and orders a reprimand and the payment of costs of \$6,000. The proposed penalty falls within the range of penalties from prior cases. Further, it guarantees public protection as Dr. Diaz undertook to resign her certificate of registration and to never reapply. The reprimand serves as a general deterrent to the profession as it underscores the importance of maintaining integrity and professionalism and practising in accordance with the standards of practice. The reprimand also serves to maintain public confidence in the College's ability to regulate the profession in the public interest.

## **Order**

[26] The Committee stated its findings in paragraph 1 of its written order of October 15, 2020. In that order, the Committee ordered and directed on the matter of penalty and costs that:

- Dr. Diaz attend before the panel to be reprimanded.
- Dr. Diaz pay costs to the College in the amount of \$6000.00 within 30 days of the date of [the October 15, 2020] Order.

[27] At the conclusion of the hearing, Dr. Diaz waived her right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand via videoconference.

**DISCIPLINE COMMITTEE  
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

**In the matter of:**

College of Physicians and Surgeons of Ontario

- and -

Dr. Sheridan Reavely-Diaz

**Reprimand delivered by the Discipline Committee**  
by videoconference on Wednesday, October 14, 2020.

**\*\*\*NOT AN OFFICIAL TRANSCRIPT\*\*\***

Dr. Reavely-Diaz:

This Committee is deeply disturbed by the breadth, depth and multifaceted nature of your misconduct. This is one of the most egregious examples of a lack of professionalism that has appeared before this Committee.

By breaching your responsibility to fill out insurance forms and failing to respond to repeated requests for medical records of your patients in a timely manner, you demonstrated a significant lack of respect and a callous disregard for the well-being of your patients.

One of the basic tenets of the profession is, first, do no harm. The public trusts that the physician will maintain the standard of practice of the profession. By breaching that trust, you put your patients in harm's way. This cannot and will not be tolerated.

In regard to your interactions with the College, you displayed a blatant contempt for your governing body. This also cannot and will not be tolerated.

Healthcare resources are a valuable commodity, and the public puts trust in the profession that physicians will manage healthcare resources appropriately. By billing OHIP for care not provided, you also breached that trust. This again cannot and indeed will not be tolerated either by the public or the profession.

Trustworthiness, integrity and honesty are fundamental qualities that are expected of physicians. The public trusts that a physician will practise with integrity, demonstrate sound judgment and insight. You again betrayed that trust.

The medical record is a key component of ongoing patient care. By modifying your medical records after the fact, you have potentially compromised patient care. Again, neither the profession nor the public will tolerate this behaviour. By your actions, you have brought not only disgrace to yourself, but the profession as a whole.

Finally, it is reassuring to the Committee, by signing the undertaking that you resign from the College and you will not apply or reapply for registration to practise medicine in Ontario or any jurisdiction, the public will be protected.

While this will conclude the reprimand, the Committee would like to just offer one more comment. The Committee would like to express its regret that after a long career of medicine, you will now be leaving the profession in disgrace.