SUMMARY

DR. SHERIDAN REAVELY-DIAZ (CPSO# 62947)

1. Disposition

On August 17, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") ordered general practitioner Dr. Reavely-Diaz to appear before a panel of the Committee to be cautioned with respect to her 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.

2. Introduction

A patient complained to the College that Dr. Reavely-Diaz failed to administer her office practice in a professional manner, in that she kept the patient waiting two and a half hours for a scheduled appointment, and failed to respond to her concerns about the delay in a professional manner.

Dr. Reavely-Diaz responded that she does not own or manage the clinic where she works, and that she has no authority over the clinic's management and policies. She said that she was not aware that the patient was waiting to see her as she was not on her list of patients. She explained that she was called in to an unexpected physician meeting, after which she learned the patient was waiting to see her. Dr. Reavely-Diaz stated that she was able to get an expedited referral to a specialist for the patient. She indicated that she believed that the patient "simply does not comprehend the volume of patients that need medical care in Eastern Ontario, and who are without a doctor"; she said that she had given the patient her "best efforts under some trying circumstances".

3. Committee Process

A General Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario.

Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee was concerned that Dr. Reavely-Diaz took no ownership for the very long delay the patient experienced, and that she did not appear to show any real concern for the patient's frustration or any respect for her time. In the Committee's view, Dr. Reavely-Diaz's comment about the patient not understanding the number of patients in Ontario requiring care was simply inappropriate and she failed to show the empathy and compassion normally expected of a physician.

The Committee felt that it was unacceptable for a physician to make patients wait excessive periods of time for scheduled appointments; it noted that a prudent physician in these circumstances would have apologized for the mismanaged appointment time and taken responsibility for what had occurred.

The Committee was struck by the fact that Dr. Reavely-Diaz did not acknowledge that there was anything wrong with the excessive wait time that occurred in this case nor did she suggest that she has any intention of taking steps to try to improve her office management to ensure a similar situation does not arise in the future.

The Committee was also concerned by the fact that Dr. Reavely-Diaz did not provide any notes of what occurred during two of the patient's recorded visits, even though the College asked her to provide a copy of the patient's complete record. The Committee was further concerned that the record Dr. Reavely-Diaz provided did not contain any documentation of the call she said she made to the specialist to expedite the patient's referral. The Committee noted that the lack of documentation was particularly problematic, as there was some confusion in the record about appointment dates and when Dr. Reavely-Diaz made the referral.

Overall, the Committee had concerns regarding Dr. Reavely-Diaz' office management, and the fact that she has failed to demonstrate the type of self-critical appraisal that the Committee would expect to see in these sorts of circumstances. The Committee was also concerned about the lack of clear and complete documentation in this case.