DECISION NO. 2010-HPA-0156(b)

In the matter of an application under section 50.6 of the Health Professions Act, R.S.B.C. 1996, c. 183, as amended, (the “Act”) for review of a complaint disposition made by an inquiry committee

BETWEEN: The Complainant

AND: The College of Physicians and Surgeons of BC

AND: A Physician

A Physician

BEFORE: David A. Hobbs, Panel Chair

COMPLAINANT

COLLEGE

REGISTRANT 1

REGISTRANT 2

REVIEW BOARD

DATE: Conducted by way of written submissions concluding February 27, 2013

APPEARING: For the Complainant: Self-represented

For the College: Sarah Hellmann, Counsel

For Registrant 1: Lindsay Johnston, Counsel

For Registrant 2: Self-represented

I INTRODUCTION

[1] The Complainant seeks review by the Review Board of the Inquiry Committee’s disposition to take no further action on his complaint against the Registrants concerning emergency hospital care received after a motor vehicle accident.

II BACKGROUND

[2] The Complainant, by his representative, filed on October 30, 2009 with the College a complaint against the Registrants (the “Complaint”).

[3] The Complainant was dissatisfied with the information recorded and diagnoses made by the Registrants in connection with the Complainant’s emergency treatment at a hospital on June 2, 2008, following a motor vehicle collision.
The Patient Care Report records the Complainant:

(a) was a restrained front seat passenger and the vehicle contained hazardous material of a radioactive nature;
(b) was quarantined, decontaminated and deemed safe by the hazardous material crew at the accident scene;
(c) was difficult to assess because he was handcuffed and under arrest; and
(d) spoke Russian and there existed a language barrier.

A letter from the police dated October 15, 2008 acknowledges the materials being carried in the vehicle in which the Complainant was a passenger “were harmless” and any questioning regarding possible terrorist links and any involvement in such activity “was determined to be completely unfounded”. The materials detected were Thallium and Palladium Chloride - which lead to a concern of possible radioactive materials.

The College wrote the Complainant by letter dated December 23, 2009 and advised it was having difficulty understanding the Complaint. The College argued the Registrants merely took into account and recorded what they were being told at the time, namely, a possibility of radioactive material. The College suggested the hospital be contacted and an addition be made to the hospital records confirming the lack of any hazardous materials as subsequently confirmed. The College suggested that if it misunderstood the Complaint the Complainant should provide a further explanation.

By letter dated January 3, 2010 the Complainant wrote the College submitting:

(a) there was nothing written about head-body moderate to severe injury and bruises;
(b) the information was “guesses and fictitious information”;
(c) neither Registrant ordered a special clinical examination, assessment, diagnostic test or “medical and lab tests” and discharged the Complainant without a complete diagnosis of what the Complainant says was “MVA head-body moderate to severe injury”;
(d) the diagnosis was “#3 Radioactive Exposure” but, the Complainant was discharged with no ongoing care or treatment to provide for the Complainant in his “special condition”; and
(e) the Registrants need to up-date their training.

I note the Patient Care Report actually records “possible Radioactive Exposure” under the notes section and the Provider’s Impression says “MVA with complication hazmat exposure”.

Registrant 2 stated his sole involvement with the Complainant on June 2, 2008 was to interpret the electrocardiogram taken as there was some concern about the Complainant’s reported chest pain.

Registrant 1 was the emergency physician who assessed the Complainant. Registrant 1 says the Complainant was examined and found to have no serious head or neck injuries. Cervical spine x-rays were obtained and reviewed with no abnormalities noted. A work up including electrocardiogram, blood work, and a chest x-ray were performed and considered. Registrant 1 says the diagnosis was made as to possible radioactive exposure because it was reported that he had radioactive material in his vehicle, although likely not significant as he had been cleaned by the Hazmat team.

On April 1, 2010 Registrant 1 forwarded the College a history and progress note confirming the Complainant had not suffered any radiation exposure.

The College obtained the relevant medical records and invited any further information from the Complainant by letter dated May 31, 2010.

By letter dated August 24, 2010 the Inquiry Committee informed the Complainant in its disposition that the records were a brief but adequate documenting of the emergency assessment on June 2, 2008, and therefore, met the standard of care to be expected. No further action was to be taken on the Complaint (the “Disposition”).

The Disposition does not specifically say under what section of the Act the Complaint was disposed of but I infer as the conduct of Registrant 1 met the standard of care in the Inquiry Committee’s opinion and the Complaint did not relate to Registrant 2’s minimal involvement, the Complaint was disposed of under s. 33(6) (a) of the Act to take no further action.

The Complainant wrote the Review Board on September 17, 2010 expressing concerns about the Disposition.

The Complainant wrote the Deputy Registrar of the College by an unsigned letter dated September 22, 2010 date stamped received September 21, 2010. The Complainant argued Registrant 1 was negligent causing him trauma, and further, challenged the fact that Registrant 1 had dictated an amendment to the hospital records regarding the possible radioactive exposure. I note the amendment in question, which updated the hospital records to confirm there was no radiation exposure, indicated it was dictated by Registrant 1 and typed on February 9, 2010.

A pre-hearing conference was held in this matter on May 31, 2011 and the Complainant was directed to complete a Statement of Relief form and file it with his Statement of Points. The style of hearing was to be determined, either oral or written, after the parties had exchanged and filed their Statements of Points with the Review Board.

The Complainant filed his Statement of Points with the Review Board on June 29, 2011. I would summarize the Complainant’s Statement of Points as an assertion that Registrant 1 behaved in a grossly negligent manner with regard to her emergency assessment record keeping, diagnosis and treatment given the Complainant’s
submission that he had been in a serious motor vehicle accident and sustained serious injuries. I note the Complainant’s advice he has a claim regarding the accident involving an insurance company. I also note Registrant 2 is not mentioned in the Complainant’s Statement of Points.

[20] In the Complainant’s Statement of Points he writes: “I will be satisfied without further written or oral hearing to resolve this issue if (Registrant 1) will send me directly the excuse and apology letter”. Contrary to this statement the Complainant also filed with the Review Board a Statement of Relief Sought ticking boxes for relief in the form of the Review Board directing the Inquiry Committee to:

(a) take appropriate action;
(b) issue a citation via the Registrar;
(c) request undertakings of Registrant 1 to not repeat, take special education or other special action; or
(d) give the matter reconsideration.

To this the Complainant attached a document entitled “Patient’s Bill of Rights”.

[21] On July 19, 2011 the Review Board received the College’s Statement of Points and application for Summary Dismissal, submitting that:

(a) the application has no reasonable prospect for success being a ground for summary dismissal under s. 31(1)(f) of the Administrative Tribunals Act, S.B.C. 2004, c. 45 (the “ATA”)
(b) the investigation was adequate; and
(c) the disposition was reasonable.

[22] Registrant 1 filed with the Review Board her Statement of Points and Summary Dismissal application on July 25, 2011. The points made by Registrant 1 are very similar to the College’s points, and therefore, don’t require repetition here. Registrant 1 also cites s.31(1)(c) of the ATA arguing the application for review should be summarily dismissed as being frivolous, vexatious and trivial, because it has no substance or merit.

[23] The Review Board received the Complainant’s Final Reply Statement of Points on August 15, 2011. The Final Reply repeats that the Complainant would be satisfied with an “excuse and apology letter” as a remedy without more.

[24] By Decision No. 2010-HPA-156(a) dated May 1, 2012 the Review Board dismissed the applications of the College and Registrant 1 for summary dismissal. The matter was to proceed by oral hearing with the Complainant having liberty, at his own expense, to be assisted by an independent interpreter.

[25] By letter dated November 9, 2012, the Complainant advised he could not afford an interpreter, and therefore, he wished to have a change in the method of the hearing of the Complaint from oral to written submissions.
On November 15, 2012, the Review Board directed the hearing be dealt with in writing as sought by the College and Registrant.

The Review Board received further written submissions from the Complainant, College and Registrant 1 during the period December 2012 to February 2013 basically repeating the things previously stated.

III ANALYSIS

The role of the Review Board on this application is to consider the adequacy of the investigation and the reasonableness of the Disposition.

The Inquiry Committee obtained and considered the hospital records of the emergency admission on June 2, 2008 Registrant 1’s further explanation of what occurred and the Complainant’s concerns.

The Complaint is not really about the Inquiry Committee’s investigation. The Complaint vigorously questions the advice, assessment and medical care the Complainant received, and further, the recording of the same.

The question of whether the standard of practice was met by Registrant 1, in all the circumstances, is a question the Inquiry Committee considered and answered positively. The Complainant may disagree but it is not the role of the Review Board to substitute its opinion on to this question for that of the Inquiry Committee. The Review Board treats the opinion of the Inquiry Committee on an issue such as the standard of practice expected of an emergency hospital physician such as Registrant 1, in all the circumstances, with some deference.

There is no complaint regarding Registrant 2 to consider as he merely interpreted an electrocardiogram.

I note that the circumstances of the language barrier reported, decontaminated but possible radioactive exposure, handcuffs, arrest and presence of police officers at the emergency department of the hospital on June 2, 2008 were unusual and would have made a normal assessment and diagnosis routine more challenging for the Complainant and Registrant 1.

I find that the Inquiry Committee conducted an adequate investigation and well understood the assessment, advice, diagnosis and treatment plan Registrant 1 gave the Complainant on June 2, 2008. The Inquiry Committee and Complainant disagree whether what occurred meets the expected standard of practice, in all the circumstances. The Review Board treats with deference the Inquiry Committee’s positive conclusion in this regard.

As the Registrant 1 met the standard of practice in the Inquiry Committee’s opinion, the Disposition to take no further action on the Complaint was within the range of reasonable outcomes defensible on the facts and law.
IV CONCLUSION

[36] I confirm the Inquiry Committee’s Disposition to take no further action on the complaint against Registrants 1 and 2.

[37] I have reviewed the complete record and submissions of the parties though not referred to in their entirety herein.

“David A. Hobbs"

David A. Hobbs, Panel Chair
Health Professions Review Board

June 3, 2013