DECISION NO. 2010-HPA-0170(a)

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 Physicians  

**BEFORE:**  
Donald A. Silversides, Q.C., Panel Chair  

**COMPLAINANT**  

**COLLEGE**  

**REGISTRANT**  

**REVIEW BOARD**  

**DATE:**  
Conducted by way of written submissions concluding on February 18, 2013  

**APPEARING:**  
For the Complainant: Self-represented  

For the College:  
Sarah Hellmann, Counsel  

For the Registrant: W. Sean Taylor, Counsel  

I DECISION

[1] Upon considering the Application by the Complainant pursuant to section 50.6 of the Act, I order that the matter be sent back to the inquiry committee of the College (the “Inquiry Committee”) for reconsideration with directions.

II INTRODUCTION

[2] At the time relevant to her complaint, the Complainant carried on the practice of dentistry in British Columbia. The Registrant is a physician who specializes in diagnostic radiology. As of October, 2010, the Registrant had practiced that specialty for 32 years.

[3] After she suffered severe headaches, a CT scan of the Complainant’s head was performed on May 8, 2005 at a hospital in the lower mainland of British Columbia at which the Registrant practiced (the “First Hospital”). There was a tumor visible in the CT scan but when the Registrant read the image of the scan on May 10, 2005, he did not notice the tumor.
On October 25, 2006, after suffering severe symptoms, the Complainant attended at the emergency department of another hospital in the lower mainland of British Columbia (the “Second Hospital”) and another CT scan of her head was conducted. This scan revealed the tumor visible in the 2005 CT scan had grown significantly. The medical treatment the Complainant subsequently received to deal with this tumor has resulted in significant adverse long term medical consequences which have prevented her from carrying on her practice as a dentist.

The Complainant complained about the failure of the Registrant to diagnose her tumor when he read the image of the 2005 scan. The registrar of the College dismissed the complaint pursuant to section 32(3) of the Act. By virtue of section 32(5) of the Act that disposition is considered to be a disposition by the Inquiry Committee and pursuant to section 50.53(1)(c) of the Act is subject to review by the Review Board.

After the Complainant was informed of the disposition of her complaint she applied to the Review Board for a review of the disposition. In her application for review dated October 26, 2010 she stated that after the Registrant had completed his report of his review of the image of the 2005 scan, she directly questioned him about his diagnosis and that he told her he would review the image again while she was placed on hold. She stated that after reviewing the image again the Registrant informed her that there were no significant findings and she should not be concerned. The substance of these statements by the Complainant were not included in the complaint to the College. The record of the investigation and the Inquiry Committee’s disposition of the complaint (the “Record”) shows that after the College received the complaint it did not interview the Complainant or engage in any discussions or correspondence with the Complainant or otherwise follow up with her about the complaint before dismissing it. The statements in her application for review about her conversation with the Registrant were therefore new information which the registrar did not consider before dismissing the complaint.

The College treated the statements about the Complainant’s conversations with the Registrant in her application for review as new information. The College wrote to the Registrant asking him whether he recalled receiving the telephone call mentioned by the Complainant and reviewing the results of the CT scan as stated in the application for review. The Registrant subsequently wrote to the College and provided his comments about the statements made by the Complainant in her application for review.

The Complainant requested that the review of her application be delayed because she had difficulty dealing with it due to her ill health. With the consent of the other parties, this matter was therefore placed in abeyance by the Review Board between November 30, 2011 and November 1, 2012.

III ISSUES

Based on the Record and my analysis which follows, the issues to be determined are:

(a) Whether the statement by the Complainant in her application for a review dated October 26, 2010 regarding a telephone conversation with the
Registrant and the correspondence between the College and the Registrant regarding that statement form part of the investigation of the complaint and whether that information should be considered in the review of the disposition by the Inquiry Committee.

(b) Whether the registrar had jurisdiction to dismiss the complaint pursuant to section 32(3) of the Act.

(c) Whether the investigation conducted regarding the complaint was adequate.

(d) Whether the disposition of the complaint against the Registrant was reasonable.

(e) If the investigation was not adequate or the disposition was not reasonable, what remedy the Review Board should order.

IV RELEVANT LEGISLATION, BYLAWS AND POLICY

[10] The following provisions of the Act are relevant:

26 In this Part:

“serious matter” means a matter which, if admitted or proven following an investigation under this Part, would ordinarily result in an order being made under section 39(2)(b) to (e);

32 (3) Despite subsection (2), the registrar, if authorized by the board, may dismiss a complaint, or request that the registrant act as described in section 36 (1), without reference to the inquiry committee if the registrar determines that the complaint

(a) is trivial, frivolous, vexatious, or made in bad faith,

(b) does not contain allegations that, if admitted or proven, would constitute a matter subject to investigation by the inquiry committee under section 33 (4), or

(c) contains allegations that, if admitted or proven, would constitute a matter, other than a serious matter, subject to investigation by the inquiry committee under section 33 (4).

(5) A disposition under subsection (3) is considered to be a disposition by the inquiry committee unless the inquiry committee gives the registrar written direction to proceed under subsection (2).

39 (1) On completion of a hearing, the discipline committee may, by order, dismiss the matter or determine that the respondent

(a) has not complied with this Act, a regulation or a bylaw,

(b) has not complied with a standard, limit or condition imposed under this Act,
(c) has committed professional misconduct or unprofessional conduct,
(d) has incompetently practised the designated health profession, or
(e) suffers from a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs their ability to practise the designated health profession.

(2) If a determination is made under subsection (1), the discipline committee may, by order, do one or more of the following:

. . .

(b) impose limits or conditions on the respondent's practice of the designated health profession;

(c) suspend the respondent's registration;

(d) subject to the bylaws, impose limits or conditions on the management of the respondent's practice during the suspension;

(e) cancel the respondent's registration;

50.6 (1) A complainant may apply to the review board for a review of a disposition described in section 50.53(1)(c).

. . .

(5) On receipt of an application under subsection (1), the review board must conduct a review of the disposition and must consider one or both of the following:

(a) the adequacy of the investigation conducted respecting the complaint;

(b) the reasonableness of the disposition.

. . .

(8) On completion of its review under this section, the review board may make an order:

(a) confirming the disposition of the inquiry committee,

(b) directing the inquiry committee to make a disposition that could have been made by the inquiry committee in the matter, or

(c) sending the matter back to the inquiry committee for reconsideration with directions.

V BACKGROUND

[11] The Complainant, after suffering increasingly severe headaches for a period of years, was referred by her family physician to the First Hospital for a CT scan of her brain by way of a requisition on which her family physician noted her pertinent history consisted of atypical headaches and peripheral neurological symptoms. A CT scan of her head was conducted at the First Hospital on May 8, 2005 and reviewed by the Registrant on May 10, 2005.
[12] There was a mass approximately 3 cm long and 1 cm wide visible on the image of the 2005 CT scan. It was subsequently determined that this mass was a meningioma, or mass. When he reviewed the image of the scan the Registrant did not notice the brain tumor but, instead, diagnosed the scan as normal and in his report he recorded his findings were that there was no significant focal or diffuse disease shown.

[13] On October 25, 2006, after suffering severe symptoms, the Complainant attended at the emergency department of the Second Hospital and another CT scan of her head was conducted and it revealed the brain tumor which had initially been shown in the image of the CT scan of her head conducted on May 8, 2005 had grown in size.

[14] Some, but not all, of the brain tumor was surgically removed and the Complainant received additional treatment for that part of the tumor which could not be removed. As a result of the surgery and subsequent treatment, the Complainant suffers a continuing disability and she is no longer able to continue her practice as a dentist. The Complainant believes that if the brain tumor had been diagnosed in May, 2005 her prognosis would have been significantly better, there would have been alternatives to the invasive surgery to which she was subjected, she would not be disabled and she would still be able to continue practicing as a dentist.

[15] On June 18, 2009, the Complainant wrote to the College and complained the Registrant had failed to diagnose her brain tumor when he reviewed the image of her scan in May, 2005. She stated she had consulted other radiologists and had been reassured that the presence of the tumor on the image of the initial scan of her head was quite easily visible and readable. She asked the College to investigate the Registrant’s misdiagnosis to determine whether it was a departure from the standard of care required of a radiologist and to take steps that would ensure that the Registrant did not make the same type of mistake again.

[16] As is its usual practice, the College wrote to the Registrant on October 15, 2009 requesting his response to the complaint within 15 working days after receipt of their letter. The College requested and received from the First Hospital its records with respect to the May 8, 2005 scan and the Registrant’s report of his review of the image of that scan. As well, the College requested and received from the Second Hospital copies of its records relating to the Complainant’s admission to the emergency department on October 25, 2006, the second scan of her head and the interpretation of the image of that scan.

[17] When it did not receive a response from the Registrant, the College wrote a reminder letter to him on November 6, 2009 again requesting that he provide the information requested in the October 15, 2009 letter. The College did not receive a response from the Registrant until December 23, 2009 when it received a letter from the Registrant dated December 22, 2009. In that response, the Registrant acknowledged that he had read the Complainant’s CT head scan conducted on May 8, 2005 but did not have an independent recollection of having read the scan. He confirmed he had reported that the scan showed no significant focal or diffused disease at that time. In his response, the Registrant stated that there is an error rate associated with diagnostic imaging interpretation reported in the literature, even where all due care is being taken.
The College engaged an expert radiologist to review the image of the May 8, 2005 scan of the Complainant’s head. The expert reported the image showed a mass measuring approximately 3 cm long by 1 cm wide which appeared consistent with a meningioma. In his opinion, the expert stated: “I would not describe the finding as obvious. But it is visible and I believe most radiologists could be expected to perceive it in the ‘average’ practice setting”.

The expert also stated that radiology medical literature contains references to the issue of radiology “misses”. He expressed the opinion that in spite of being a caring and competent physician, a radiologist can still miss findings and that radiologists regularly do miss findings. He stated his belief that most, if not all, radiologists have had the unpleasant experience of being made aware of a finding they missed.

The College, after receiving the expert’s report and reviewing the hospital records it received, wrote a disposition letter to the Complainant dated October 1, 2010. In that letter, the College stated:

In considering this matter, it is clear that [the Registrant] did miss the meningioma which, with the benefit of hindsight, is visible on the CT head scan of May 8, 2005. The challenge for the College lies in determining whether a clinical error, something that regrettably all humans will commit from time to time, equates to a failure to meet accepted standards of care as you suggest.

In its October 1, 2010 letter, the College informed the Complainant that in the Registrant’s 32 years of specialty practice in British Columbia, hers was the first complaint against him. The College stated the review and adjudication of isolated instances of missed findings by diagnostic specialists is a controversial and challenging issue and referred to a commentary enclosed with its letter written by an American academic radiologist which was published in the American Journal of Roentgenology in which he reported a consistent finding of interpretation error in the range of 3.5% to 4%. The College stated that it is a statistical inevitability that harm will come to some patients as it had to the Complainant even when, by all accounts, the radiologist is competent and has approached the interpretation of the critical study to the best of his ability. The College also stated that the Registrant appeared to have approached the interpretation of her CT scan as he would any other and:

In conclusion, while acknowledging the undeniable fact that [the Registrant] missed an important finding and that you have suffered harm as a result, this review found no basis for pursuing disciplinary action against [the Registrant] in this instance.

By way of a letter dated October 26, 2010, the Complainant applied to the Review Board for a review of the deemed disposition of her complaint by the Inquiry Committee. A copy of that letter was sent to the College. In her letter to the Review Board the Complainant stated that when the May, 2005 CT scan was conducted she noticed a mass effect and, after receiving the Registrant’s report showing there were no significant findings, she telephoned the Registrant and questioned him on the telephone regarding the mass effect and the existence of any growth. She stated:
He said he would review the scan again as I was on hold. Following reviewing the scan for the second time, he still reported on the phone that there were no significant findings and I should not be concerned.

[23] After receiving a copy of the Complainant’s letter to the Review Board dated October 26, 2010, the College wrote a letter to the Registrant dated November 12, 2010 referring to the Complainant’s description of having spoken to him on the telephone following her receipt of the Registrant’s interpretation of the May, 2005 CT scan and quoted the statement by the Complainant set out above in paragraph [22]. The College asked the Registrant to inform them whether he recalled receiving the Complainant’s telephone call and reviewing his interpretation of the scan as suggested by her in her letter to the Review Board.

[24] On December 31, 2010, the College wrote to the Complainant quoting the following statement from her application for a review:

I placed a call to [the Registrant] directly and questioned [the Registrant] on the phone regarding the mass effect and the existence of any growth. He said he would review the scan again as I was on hold. Following reviewing the scan for the second time, he still reported on the phone there was no significant findings and I should not be concerned.

The College stated that this was potentially relevant and new information which they would be pursuing and that they had written to the Registrant requesting a response to this statement.

[25] Not having received a response to their letter to the Registrant dated November 12, 2010, the College again wrote to the Registrant on December 31, 2010 requesting a response to their letter.

[26] On January 26, 2011, the College received a letter from the Registrant dated the same date in which he stated he did not recall receiving a phone call from the Complainant at any time, or discussing the results of her May, 2005 CT head scan with her. He also stated that it would be very rare for him to be contacted by a patient in this manner and that he estimated that this happens only one or two times per year on average and that he would therefore expect it to stick out in his mind. He stated that if this had occurred he would have followed his general practice in such circumstances, which is to have re-reviewed the scan very carefully and very likely asked one of his radiological colleagues for an independent opinion.

[27] In his response, the Registrant also said he did not think the Complainant could have been able to ascertain what may have appeared on the CT scan as it was being conducted because the technologist consult screen would not be visible to the patient as the scan was being conducted since the patient would be facing away from the technologist. He stated:

As a general practice, the scan would not be shown to the patient. If the patient asked to see the scan, the technician would as a general rule ask for the CT-assigned radiologist to attend in order to explain the scan to the patient. The technicians are not qualified to interpret the scans for the patients, nor do they attempt to do so. If a
radiologist had in fact attended to discuss the scan with [the Complainant] on the date that it was taken, there would likely be some note of that in the medical records.

[28] Copies of the College's letters to the Registrant dated November 12, 2010 and December 31, 2010, the College's letter to the Complainant dated December 31, 2010 and the Registrant's letter to the College dated January 26, 2011 were included in the Record.

[29] The College wrote a letter dated April 13, 2011 informing the Review Board that it was in receipt of new information in the form of a letter from the Registrant and stated:

[The Registrant] advises that he does not recall the telephone discussion with the complainant and thus there is no substantive new information that would impact the Inquiry Committee's decision in this matter.

[30] In her submissions to the Review Board, the Complainant stated that after she had spoken to the Registrant by telephone she was still very concerned and discussed her observation of the CT scan with her brother who is a medical doctor specializing in urology and sought his advice. She stated that her brother then telephoned the Registrant directly and was reassured by him that there was nothing in her CT scan to be concerned about.

VI DISCUSSION AND ANALYSIS

A. Nature of timing of the disposition

[31] For the purposes of this review, it is necessary to determine whether the investigation by the College had been completed and the deemed disposition by the Inquiry Committee had been fully and finally made by October 1, 2010, which is the date of the letter by which the College initially informed the Complainant of the disposition.

[32] It is clear the College considered the statement made by the Complainant in her application for review that she had discussed the Registrant's diagnosis that her CT scan was normal with him and that he had conducted a second review of the image while she was on the telephone to be important new evidence. By writing to the Registrant on November 12, 2010 and again on December 31, 2010 requiring him to respond to this statement, the College re-opened and was continuing its investigation of the complaint, even though the College knew the Complainant had applied for a review of its October 1, 2010 disposition.

[33] The letter which the College wrote to the Complainant dated December 31, 2010 referring to her statement as potentially relevant and new information that the College would be pursuing and which stated they would write to her again after receiving the Registrant’s reply is persuasive evidence that the College did not consider its investigation complete and that, depending on the outcome of that investigation, its initial disposition described in the letter to the Complainant dated October 21, 2010 was subject to change. The fact that the College chose to include its letters to the Registrant dated November 10 and December 31, 2010, its letter to the Complainant dated December 31, 2010 and the Registrant’s response to the College dated January 26, 2011 in the Record is further evidence that the College did not consider its investigation
to be complete or its disposition final until it had received and considered the Registrant’s January 26, 2011 letter of response.

[34] I find that the investigation by the College was not complete until on, or sometime after, January 26, 2011, when the College received and considered the Registrant’s response to the Complainant’s statements regarding her telephone conversation with him. It therefore follows, and I also find, that the decision by the College to confirm the disposition set out in its letter to the Complainant dated October 1, 2010 was a disposition by the Inquiry Committee. That final disposition was not completed and communicated until the College wrote a letter dated April 13, 2011 to the Review Board, copies of which were sent to the Complainant and Registrant. This review therefore considers the full investigation and final disposition, which includes both the October 1, 2010 letter to the Complainant and the April 13, 2011 letter to the Review Board.

[35] In my view, it was appropriate for the College to re-open and continue its investigation when it received new information which raised concerns about the Registrant’s competence or conduct. The filing of an application for review of the disposition of a complaint does not prevent a college from re-opening its investigation to consider new and potentially important evidence. Re-opening an investigation after an application for review has been filed is practical, cost effective and consistent with the duty of a college at all times to exercise its powers and discharge its responsibilities under the Act in the public interest.

B. Jurisdiction of the Registrar

[36] In her complaint which is the subject of this review the Complainant alleges that the image of the CT scan of her head conducted on May 8, 2005 showed that a brain tumor was visible and that the Registrant failed to notice the brain tumor (the “Initial Allegation”). Based on my finding that the investigation was not complete and the disposition was not finally made until on or after January 26, 2011, the complaint also contains the allegation that after being informed of the Registrant’s report that the image of her CT scan was normal, the Complainant spoke to the Registrant by telephone and questioned him regarding the mass effect and existence of any growth, that the Registrant told her he would review the scan again and, following his review of the scan a second time, he reported to her on the telephone that there was no significant findings and that she should not be concerned (the “Second Allegation”). The Complainant takes the position that the facts set out in the Second Allegation justify the College taking action.

[37] The registrar may dismiss a complaint pursuant to either one of subsections (a), (b) or (c) of section 32(3) of the Act. In its submissions, the College states that the decision was made by the registrar pursuant to section 32(3)(c) and I accept this submission. In my view, the decision could not have been made pursuant to section 32(3)(a) because it is clear from the College’s treatment of the complaint that it was not regarded as being trivial, frivolous, vexatious or made in bad faith. As well, it could not have been dismissed pursuant to section 32(3)(b) because the complaint did contain allegations that, if admitted or proven, would constitute a matter subject to investigation
by the Inquiry Committee under section 33(4). I therefore conclude that the dismissal was made by the registrar pursuant to section 32(3)(c).

[38] Section 32(3)(c) only permits the registrar to dismiss a complaint which contains allegations which are subject to investigation by the Inquiry Committee under section 33(4) if those allegations, if admitted or proven, do not constitute a “serious matter” as defined in section 26(1) of the Act. A matter which is not a serious matter is one which, after an adverse determination is made pursuant to section 39(1) of the Act, would ordinarily result in the discipline committee only reprimanding or fining the registrant.

[39] When determining whether a matter is a serious matter for the purposes of section 32(3)(c), the registrar may not assess the sufficiency of any evidence regarding the allegations or make any assessment regarding the credibility of any potential witness. The registrar must, for the purpose of determining whether or not a matter is a serious matter, assume that the allegations are true and will be proven or admitted.

[40] When making my decision as to whether the registrar had jurisdiction to dismiss the complaint which is the subject of this review, I considered Review Board Decision No. 2010-HPA-0198(a) where it was held that the registrar may dismiss a complaint pursuant to section 32(3)(c) even if the allegations, if admitted or proven, would be a serious matter if the registrar determines the evidence is not sufficient to support the complaint. That decision is not consistent with the decision of a five person panel of the Review Board in Decision No. 2011-HPA-0018(a), which stated at para. [64]: “Section 32(3)(c) is very clear that the Registrar is only to assume jurisdiction based on the allegations.” I respectfully prefer and adopt the analysis of the five person panel in 2011-HPA-0018(a) for the reasons set out below.

[41] First, the analysis in Decision No. 2011-HPA-0018(a) accords with the text of section 32(3)(c), which plainly requires the registrar to assume the allegations are admitted or proven if dismissing a complaint under that subsection. The expression “if admitted or proven” must be given meaning and cannot in my respectful opinion be read out of the section.

[42] Second, the analysis in Decision No. 2011-HPA-0018(a) respects the legislative intent, reflected in the text and the larger legislative structure, that when a complaint is a serious matter as defined in section 26(1) its dismissal on the merits is reserved for the Inquiry Committee unless the registrar dismisses the complaint under section 32(3)(a) or (b).

[43] Third, the concern about outlandish and fabricated allegations, which appears to form a key basis for the view expressed in Decision No. 2010-HPA-0198(a) can, and should be, addressed under section 32(3)(a), which allows the registrar to independently dismiss complaints he finds, after investigation, to be trivial, frivolous, vexatious or made in bad faith. Section 32(3)(a) employs legal terms found in numerous statutes applied by courts and administrative tribunals which are capable of explanation in plain language. If, as suggested in Decision No. 2010-HPA-0198(a), registrars are reluctant to rely on section 32(3)(a) for fear of upsetting complainants, it may be that they need advice regarding the manner in which those findings are best expressed. In any event, that reluctance is not a legitimate basis on which the
interpreter may alter the text of section 32(3)(c) or the structure of the Act. Administrative interpretation allows for creativity, but not legislative amendment, which is the exclusive role of the legislator.

[44] A registrar always has the authority to assess the evidence which does or does not support any facts alleged by the complainant when he or she has jurisdiction to dismiss a complaint pursuant to section 32(3)(c). That jurisdiction is limited to complaints which contain allegations that, if admitted or proven, would not constitute a serious matter. When he has jurisdiction, the registrar may assess evidence in the same manner as an inquiry committee may do within its broader jurisdiction pursuant to section 33 of the Act. As previously confirmed by the Review Board in several decisions, including Decision No. 2011-HPA-0036(b) described below in paragraph 49, this assessment can be undertaken as part of the screening function of a college without usurping the role of its discipline committee as the ultimate finder of fact. The role of the Inquiries, Complaints and Reports Committee (or “ICRC”) under the Regulated Health Profession Act, 1991 of Ontario, which is the equivalent of an inquiry committee in British Columbia, was recently clarified by the Superior Court of Justice of Ontario in Reyhanian v. Health Professions Appeal and Review Board, 2013 ONSC 297 at paragraph 20 where the Court stated:

We do accept that the ICRC is not an adjudicative body and does not make findings of credibility, per se. However, it does not flow from that proposition that the ICRC must refer to discipline any case in which there are disputed issues of fact, on the theory that if the complainant were believed, professional misconduct would be established. Rather, the ICRC is entitled to take a critical look at the facts underlying the complaint and the evidence that does and does not support it, along with a myriad of other issues (such as, the record of the respondent, special circumstances surrounding the incident, policy concerns, the capacity of the discipline committee, among others). The factual record revealed from the investigation must necessarily be apart of that analysis.

While the provisions of the Ontario statute which deal with the ICRC differ in several respects from the provisions of the Act which deal with the powers of the registrar and the inquiry committee of a college, I believe the principles stated by the Court in Reyhanian are applicable to registrars and inquiry committees governed by the Act.

[45] While I would have accepted that this was not a serious matter within the meaning of the Act if the only factors being considered were the Initial Allegation, the Registrant’s complaint history, the report of the expert engaged by the College and the medical literature regarding misdiagnosis by radiologist, I have concluded this is not the case when the Second Allegation is added to the complaint.

[46] If the Second Allegation is presumed to be admitted or proven, which it must be, and it is not frivolous, vexatious or made in bad faith then it is unlikely that this complaint would ordinarily result in a fine or reprimand.

[47] In its October 1, 2010 disposition letter the College stated that the Act and relevant court precedents anticipate educational and remedial actions being taken in response to clinical errors. Therefore, if it were admitted or proven that it had been drawn to the Registrant’s attention that there was a concern regarding his initial interpretation of the image of the May, 2005 CT scan and that he again reviewed that
scan and failed to notice what the expert described is a visible mass which most radiologists could be expected to perceive, it is my view the College would ordinarily require that educational or remedial action be taken. If the matter proceeded to a hearing before the discipline committee, this would most likely result in an order being made pursuant to section 39(2)(b) imposing educational or remedial conditions, or both, on the Registrant.

[48] I therefore find that the Second Allegation is an allegation subject to investigation by the Inquiry Committee under section 33(4) which, if admitted or proven, would be a serious matter. The registrar therefore had no jurisdiction to dismiss the complaint pursuant to section 32(3)(c) and it could only be disposed of by the Inquiry Committee pursuant to section 33(6) of the Act.

C. Adequacy of the investigation

[49] I adopt the following statement by the panel in Review Board Decision No. 2011-HPA-0036(b) at paras. [84] and [85] of the nature of the investigation which a college should conduct when it is faced with conflicting evidence:

When the Review Board is assessing an Inquiry Committee decision dismissing a complaint, the Review Board’s assessment must - consistent with the deference properly owing to the Inquiry Committee - be able to address whether, in the face of conflicting evidence, the Inquiry Committee ought to have done more, not for the purpose of pretending to be the Discipline Committee, but rather for the purpose of properly exercising its evaluative role as the Inquiry Committee. If missing information or a missing line of investigation could realistically have made the difference between the College dismissal decision that was made, and one of the other options in s. 36(1), it seems obvious that the Review Board must have the ability to require it. Otherwise, the Review Board would be abdicating its role in deciding whether to confirm the complaint, sending the matter back to the Inquiry Committee for reconsideration with directions, or directing the inquiry committee to make a disposition that could have been made

As the Review Board has frequently noted, a complainant is not entitled to a perfect investigation. Whether the missing evidence or missing line of inquiry is important enough to render the investigation inadequate or the disposition unreasonable is, for the Review Board, a question of judgment in each case. The fundamental point, however, is that just because an issue of “credibility” may be involved does make the issue off limits for the Inquiry Committee or the Review Board.

[50] The Second Allegation was very significant and changed the entire complexion of the complaint from one that the College viewed as an isolated misdiagnosis to one which might involve incompetence or professional misconduct.

[51] While a registrar or an inquiry committee may dismiss a complainant’s allegation as being incredible or unreliable, there is no suggestion in the letter the College wrote to the Review Board dated April 11, 2011 that the Second Allegation was considered unbelievable or unreliable. In this case, the Second Allegation raised serious issues regarding the competence or conduct of the Registrant when he conducted the alleged review of his interpretation of the scan. This is why the College reopened its investigation. The Registrant’s response to the Second Allegation consisted of
statements of what would generally or usually occur and does not set out any actual recollection of what did or did not occur and therefore he did not deny that events occurred in the manner described by the Complainant.

[52] As discussed in greater detail in my analysis of whether the disposition was reasonable, the registrar unreasonably concluded that the Second Allegation was not substantive information because the Registrant’s response did not support the Complainant’s version of what events occurred. The registrar failed to appreciate that in order to make a provisional assessment of the two versions of the events, it was necessary to make further inquiries regarding the conflicts between the two versions.

[53] In my view, the only reasonable course of action which could have been taken by the registrar or, if they dealt with the complaint, the Inquiry Committee, would have been for the registrar or Inquiry Committee to instruct the staff of the College to make follow up enquiries which, at a minimum, would have involved asking the Complainant to respond to the Registrant’s version of events and to allow her an opportunity to provide any further detail which would support her version of events. It is noteworthy that during the course of this review, the Complainant did provide additional information regarding her version of the events which consisted of the involvement of her brother, a medical doctor.

[54] In order to reasonably dispose of the complaint, the registrar or, if it dealt with the complaint, the Inquiry Committee, needed to obtain more information than what is included in the Record with respect to the Second Allegation, given the serious nature of it, and I therefore find that the investigation conducted regarding the complaint was not adequate.

D. Reasonableness of the disposition

[55] The Review Board in Decision No. 2011-HPA-0018(a) considered the authority of a registrar to dismiss a complaint pursuant to section 32(3) of the Act. I adopt the following statement made by the panel at para. [31]: “A disposition made without authority is unreasonable because it has no legal justification and does not produce an outcome that is defensible in law.”

[56] Since I have found that the registrar had no jurisdiction to dismiss the complaint pursuant to section 32(3)(c), it follows that the deemed disposition of this complaint by the Inquiry Committee was not reasonable.

[57] I have also considered whether, in the circumstances, the dismissal of the complaint by the registrar would have been reasonable if the registrar did have jurisdiction to do so.

[58] In its December 31, 2010 letter to the Complainant, the College categorized the Second Allegation as “potentially relevant and new information” which the College would be pursuing.

[59] In his January 26, 2011 response to the Second Allegation the Registrant stated that he did not have any recollection of receiving a telephone call from the Complainant
at any time or discussing the results of her May 2005 scan with her but he implied that the Second Allegation was likely not correct based on certain general or usual procedures and practices described in his response. It is significant that the Registrant did not deny that the alleged conversation took place.

[60] Based on the Registrant’s response to the Second Allegation the registrar concluded that despite the Second Allegation there was no substantive new information regarding the complaint. This was expressed as follows in a letter the College sent to the Review Board dated April 13, 2011: “[The Registrant] advises that he does not recall the telephone discussion with the complainant and thus there is no substantive new information that would impact the Inquiry Committee’s decision in this matter.”

[61] The passage quoted from the April 13, 2011 letter sent by the College to the Review Board shows that the registrar’s finding that there was no substantive new information was based solely on the response by the Registrant. The clear implication is that the registrar concluded that only evidence from the Registrant could be substantive and that the Complainant’s evidence was not substantive and should be given no weight. The April 13, 2011 letter from the College to the Review Board shows that the registrar failed to engage in any evaluation of the Second Allegation. The registrar simply accepted the Registrant’s response and, based on that response, concluded there was no substantive new information.

[62] While the Review Board appreciates that the ability of colleges to deal with complaints is constrained by their available resources, their inquiry committees have an obligation to evaluate evidence and potential evidence before making a decision pursuant to section 32 or 33 of the Act. They are not powerless when faced with conflicting evidence, as discussed in Review Board Decision No. 2011-HPA-0036(b) quoted above in paragraph [48].

[63] A college is not forced to dismiss a complaint merely because there are differing versions of events or, as in this matter, the Complainant asserts that certain events took place while the Registrant does not recall the alleged events but takes the position it is unlikely they occurred.

[64] If the registrar concluded it was appropriate to dismiss the complaint notwithstanding the specificity of the Second Allegation and the generality of the Registrant’s response to that allegation, the registrar was obliged to provide a reasoned explanation for that conclusion.

[65] The Second Allegation clearly contained substantive new information, which is why the College re-opened its investigation of the complaint. When it received the Second Allegation, the College did not consider it to be trivial or frivolous or inherently unreliable. While the Registrant’s response to the Second Allegation raised questions regarding its accuracy, he did not deny the specific allegation and his response could not support a finding that there was no substantive new information. The conclusion by the registrar that there was no substantive new information in the absence of any support for this position in the Record or in the April 13, 2011 letter communicating the disposition was not reasonable. I therefore find the registrar’s disposition of the complaint was not reasonable.
E. Remedy

[66] As has been noted in several previous Review Board decisions, section 50.6(8) of the Act gives the Review Board broad remedial discretion.

[67] The Review Board has recognized that it would not be in the public interest to send matters back to an inquiry committee in cases where the decision by the registrar was unreasonable only because the registrar lacked jurisdiction to dismiss the complaint where the investigation was clearly adequate and the disposition was otherwise reasonable. Therefore, even when the Review Board finds the registrar has dismissed a complaint without authority the Review Board may confirm the disposition if it is confident the outcome would have been the same if the decision has been made by the inquiry committee. I agree with the following statements made by the panel in Review Board Decision No. 2010-HPA-0002(b) at paras. [29] and [30]:

Sending a complaint back to the Inquiry Committee for reconsideration under s. 50.6(8)(c) is the only just and appropriate remedy where, as in Decision No. 2009-HPA-0045(a), the matter did not otherwise fall within the Registrar’s mandate under s. 32(3) and it could not be said with confidence that the Inquiry Committee would have reached the same result.

But where the Review Board finds (as I find to be the case here) that a complaint did fall within the Registrar’s mandate to dismiss under s. 32(3), and would reasonably have been dismissed on that basis by the Registrar, the situation is entirely different. In this kind of case, it is just and appropriate for the Review Board to confirm the ultimate disposition despite the error. Justice does not warrant the further cost, delay and technicality that would be entailed by sending matters back to the Registrar only to give rise to the same result.

[68] I have found that the investigation respecting the complaint was not adequate. As well, the Second Allegation contained substantive new information which raised significant concerns regarding the competence or conduct of the Registrant which was not fully answered in the Registrant’s response. The decision to dismiss the complaint was not explained by any clear and rational explanation.

[69] I am not confident the Inquiry Committee would have made the same disposition as the registrar if the Inquiry Committee had dealt with the complaint pursuant to section 33(6) of the Act. In addition, if this matter is sent back to the Inquiry Committee and they conduct a further investigation which is adequate and provide a reasoned and sound basis for their disposition of the complaint, I cannot predict what that disposition will be. This is therefore not a case where it would be appropriate to confirm the disposition.

[70] I have therefore concluded that the proper order to make is to send the matter back to the Inquiry Committee with directions.

VII CONCLUSION

[71] In making this decision, I have considered all of the evidence and submissions before me, whether or not specifically reiterated herein.
For all of the reasons set out above, I order that the matter of the complaint against the Registrant be sent back to the Inquiry Committee with the following directions:

(a) That the disposition be made by the Inquiry Committee pursuant to section 33(6) and not by the registrar pursuant to section 32(3).

(b) That the Inquiry Committee conduct a further investigation by making inquiries of the Complainant regarding the allegations set out in her October 26, 2010 letter to the Review Board in support of her application for review. The Inquiry Committee should consider whether those inquiries can best be conducted orally but the Inquiry Committee may conduct them in writing if it chooses to do so.

(c) Based on the additional information which arose during this review the Inquiry Committee may make such inquiries as it considers appropriate to determine whether the Complainant’s brother did discuss the image of the CT scan of the Complainant’s head with the Registrant and, if so, what the nature of that discussion was.

The directions set out in paragraph [72], above, will not limit the Inquiry Committee’s investigation or otherwise fetter its discretion to make any additional inquiries or to obtain any other reports, opinions or assessments which it considers appropriate.

"Donald A. Silversides"

Donald A. Silversides, Q.C., Panel Chair
Health Professions Review Board

September 5, 2013