DECISION NO. 2011-HPA-0003(c)

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

BEFORE: Lorianna Bennett, Panel Chair

DATE: Conducted by way of written submissions concluding on December 21, 2012

APPEARING: For the Complainant: Self-represented

For the College: Sarah Hellmann, Counsel

For the Registrant: Jonathan Meadows, Counsel

I INTRODUCTION

[1] This matter relates to a complaint filed by the Complainant regarding the medical treatment provided to the Complainant’s late father from the time of his admission to hospital on January 3, 2010 to the date of his passing on January 14, 2010. The Complainant alleges that, in the course of the Registrant’s treatment to her father, he did not follow proper protocol when he took direction from the Complainant’s older sister to discontinue further medical treatment instead of allowing her father to make his own health care decisions.

II ISSUES

[2] The issues I must decide are:

(a) Did the College adequately investigate the complaint against the Registrant?
(b) Was the College’s decision to dismiss the complaint reasonable?
III  BACKGROUND FACTS

[3]  There is no dispute that the Complainant’s father (also referred to herein as the deceased) received medical treatment from the Registrant in early January 2010. There is also no dispute that in the course of treatment, the Registrant sought and obtained consent from the Complainant’s sister regarding her father’s medical treatment.

[4]  The basis behind the complaint is the Complainant’s allegation that the Registrant did not verify that her sister legally had the authority to act as her father’s health care decision maker. The Complainant says her father was competent and able to make his own health care decisions and should have been afforded the opportunity to do so. Had that occurred, the Complainant believes that her father’s final days would have been prolonged.

[5]  The Complainant’s complaint to the College is set out in three letters dated February 9, 2010, February 27, 2008 [sic], March 14, 2010. All three letters explain in extensive detail the circumstances surrounding the deceased’s hospital stay.

[6]  In her first letter dated February 9, 2010, the Complainant says:

...not following proper procedure, or ensuring my father’s safety and rights, and negligently denying my father medical treatment, resulted in the loss of what was most precious to me, my father. Please investigate this matter to ensure it does not happen to another vulnerable senior. More legal information regarding this matter should be provided to [Registrant], and take the time to make sure the process and procedures are done correctly. I would like to see the legal document that exists that authorized my sister to be a health decision maker on behalf of my father, I assume one does not exist...

[7]  In her second complaint letter dated February 27, 2008 (sic), the Complainant says:

...My complaint is to do with [Registrant] did not check or verify that my sister legally had consent to be a health care decision maker, in which she did not. It is considered negligence to deny a patient of medical treatment and without consulting with the patient who is deemed capable (and fully understands everything) of making his own health care decisions...

...The College of Physicians and Surgeons of British Columbia are responsible to the public to oversee that physicians are practicing legal procedures. It is the responsibility of the College of Physicians and Surgeons’ [sic] to obtain and verify that [Registrant] was provided with a copy of the “Representative Agreement” document from my sister prior to neglecting my father of medical treatment...

...it is important that the College of Physicians and Surgeons over see this matter to ensure this does not ever happen to another patient again, and perhaps further education regarding legal matters is needed...

...My purpose of my complaint is to ensure this tragedy never happens to another [sic] patient of being denied the right to make their own decision about their own health care.
I trust the College of Physicians and Surgeons will review this matter to ensure that a patient is never denied their right, or denied to make their own health care decisions when they are capable to do so on their own. This legal “Representative Agreement” document should be accessible and shared with all medical staff, physicians, nursing homes, and family members to ensure health care decision makers have obtained the necessary legal documentation required. Also, I am requesting what preventative measures the College of Physicians and Surgeons decide upon to prevent such tragedies occurring in the future.

[8] In her third complaint letter dated March 14, 2010, the Complainant reiterates many of her concerns and again asks the College to, among other things, investigate the steps the Registrant says he took in regards to his attempts to obtain treatment consent directly from the Complainant’s father as opposed to obtaining health care decisions from the Complainant’s sister.

[9] It is clear to me from reading all three complaint letters that as a result of the actions of the Registrant (whether faulty or not), there has been a complete breakdown in the relationship between the Complainant and her sister, and that the breakdown may have extended to their brother as well. I interpreted this to be the case in my further review of the Complainant’s written submissions.

[10] During the complaint process, the Complainant also filed a complaint with a regional Health Authority. Her complaint alleged that her sister used her Power of Attorney authority inappropriately in that she made health care decisions for the Complainant’s father when he was, in fact, capable of making those decisions himself.

[11] The regional Health Authority investigated the complaint and responded to the Complainant in a letter dated March 4, 2010. In its response the Health Authority advised that it reviewed the deceased’s chart and also contacted the Registrant who responded to the Complainant’s concerns. After doing so, it found no criticisms of the care provided by the Registrant to the Complainant’s father. The Complainant applied for a review of the Health Authority’s decision.

[12] Turning back to the College, it completed its investigation and review of the complaint pursuant to section 32(3) and 32(5) of the Act and, like the Health Authority, was not critical of the care provided by the Registrant.

[13] The Complainant was dissatisfied with the College disposition and applies to this Review Board for a review.

[14] In her application for review, dated December 20, 2010 and received by the Review Board on January 7, 2011, the Complainant begins by stating that the most important aspect of her complaint is that it is imperative that a physician know Canadian law regarding health care decisions regarding a patient. She goes on to say,

...I ask that legal counsel be obtained when replying, and that all [Registrant’s] incorrect statements be clarified ...[Registrant] did not follow any legal procedure correctly, and nor does he seem to have any legal knowledge pertaining to patient’s rights or health care decision making.
The Complainant’s written submission as well as her reply submission focus in large part on what the Complainant says are inaccuracies contained in the Registrant’s letter dated March 23, 2010 and his medical notes. The other focus of her submissions relates to the Complainant’s request that the Review Board have an opportunity to review a letter mailed to the Complainant from the Registrant as well as documents revealing past complaints against the Registrant. The Complainant then requests that the Review Board dismiss the College’s request for any documents to be redacted.

By way of my written decision dated August 23, 2012, I already addressed the issue of the College’s redacted record pursuant to s.42 of the Administrative Tribunals Act. That issue is now res judicata meaning that it cannot be reopened as it has already been ruled upon.

Pursuant to s. 50.6(6), this review is to be conducted on the record as it now exists.

IV THE REVIEW BOARD’S ROLE ON APPLICATIONS FOR REVIEW

The Review Board’s powers on a review are set out in s.50.6(8) of the Act which states that the Review Board may do one of the following on completion of a review of an Inquiry Committee disposition:

(a) confirm the Inquiry Committee’s disposition;

(b) direct the Inquiry Committee to make a disposition that could have been made by the inquiry Committee in the matter; or

(c) send the matter back to the Inquiry Committee to reconsider the matter with specific directions.

In order for the Review Board to either direct the Inquiry Committee to make a different disposition or send the matter back to the Inquiry Committee to reconsider the matter, the Review Board must first make a finding that the Inquiry Committee’s investigation was inadequate and/or the disposition unreasonable. The scope of the Review Board’s jurisdiction is set out in s.50.6(5) of the Act which reads:

(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; and

(b) the reasonableness of the disposition.

The Review Board’s limitations as set out in s.50.6(5), together with the limited remedies available by the Review Board, are clearly set out for all parties in the Review Board’s letter dated September 12, 2012.

V ISSUE 1: ADEQUACY OF THE INVESTIGATION

The role of the Review Board in assessing the adequacy of an investigation is to determine whether the Inquiry Committee’s investigation provided it with sufficient
information to assess the particular complaint. It is not the role of the Review Board to reinvestigate the complaint or to substitute its decision for that of the Inquiry Committee.

[22] The standard which the Review Board must apply when considering what is “reasonable” or “adequate” has been previously addressed in several Review Board decisions, and more specifically in Review Board Decision No. 2009-HPA-0001(a)-0004(a) para [89]:

The Legislature’s choice of the words “reasonable” and “adequate” make clear that the Legislature has not tasked the Review Board with the role of determining whether the Inquiry Committee has made the “ideal” disposition or conducted the “perfect” investigation. A disposition will only be unreasonable and an investigation will only be inadequate if it falls below the appropriate standard of review.

[23] Applying the Review Board’s role to the facts of this case, what I must consider is whether the College took reasonable steps to investigate and obtain key information from relevant sources. In other words, I will consider:

(a) Has the College conducted an investigation with a degree of due diligence whereby the College has considered and attempted to obtain evidence from the Registrant that is the subject of the complaint?

(b) Has the College considered and attempted to obtain evidence from relevant collateral sources, and in particular evidence that is directly relevant to the subject Registrant and the particular complaint?

[24] In her application for review, the Complainant makes no suggestions that there was anything inadequate about the College’s investigation. Rather, her concerns focus on what she says are shortcomings in the way physicians deal with health care decisions made pursuant to Representation Agreements.

[25] The focus of the Complainant’s submissions dated October 10, 2010 [sic] is on what she says are inaccurate details in the Registrant’s medical notes. She also expresses concern about the redacted record which the College produced.

[26] In their written submissions, both the College and the Registrant address the issue of adequacy of the investigation, and both suggest that the College’s investigation was adequate.

[27] The Complainant had a final opportunity to respond and did so by way of further written submissions dated December 20, 2012. In those submissions, the Complainant still makes no comments regarding the adequacy of the College investigation and again focuses on the criticisms she has of the Registrant’s decision as to from whom he was to take health care instructions.

[28] Turning to the issue of adequacy of the investigation, I will outline the steps taken by the College in the course of their investigation. They are as follows:

(a) The College received the following letters of complaint from the Complainant and forwarded them on to the Registrant for his response:
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(i) Complaint letter dated February 11, 2010;
(ii) Complaint letter dated February 27, 2008 (sic); and
(iii) Complaint letter dated March 14, 2010

(b) The College received from the Complainant (and reviewed) the letter dated March 4, 2010 from the Health Authority;

(c) The College received from the Complainant (and reviewed) the rebuttal letter that the Complainant filed with the Health Authority Review Board;

(d) The College provided the Registrant with all relevant documentation submitted by the Complainant and asked the Registrant to respond;

(e) The College received and reviewed the Registrant’s response which was dated March 23, 2010;

(f) The Registrant’s response included a copy of the correspondence that he had received from the Patient Care Quality Officer at the Health Authority which, in turn, attached copies of a letter the Complainant’s sister had sent to the same Care Quality Officer. The enclosures included a Representation Agreement signed by the deceased on June 4, 2005 that appointed the Complainant’s sister to be his representative with the Complainant’s son appointed as the monitor;

(g) The College reviewed the deceased’s hospital records of approximately 177 pages copied from the complete file on the deceased’s admission to hospital on January 3, 2010 until he expired there on January 14, 2010.

[29] Given the steps taken by the College, it is clear to me that the College obtained sufficient information to allow it to reasonably assess the complaint, and in doing so performed a comprehensive and adequate review. As such I find that the investigation was adequate and that it did not fall below the appropriate standard of review.

VI ISSUE 2: REASONABLENESS OF DISPOSITION

[30] It is not the Review Board’s role to decide whether the College’s decision was right or wrong. Nor is it the Review Board’s role to make a finding of misconduct or to discipline a member of any college.

[31] Rather, the Review Board’s focus after considering the issue of the adequacy of the investigation, is then on whether the College or Inquiry Committee’s disposition was reasonable. In considering the reasonableness of the disposition, the Review Board must determine whether the disposition falls within the range of defensible outcomes based on the evidence the Inquiry Committee had before it.

[32] In its disposition letter, the College recognized that, undoubtedly, there existed a communication gap between the Complainant and her sister regarding their different understandings over the sister’s ability to make health care decisions for their father:

Whether that communication gap existed from what your sister said, or from what you heard her say, is not for us to determine…Again much of the content of your sister’s
communications to you, as you understood/recollected those, was at variance with the facts as those are displayed in the hospital records.

Furthermore, it would seem that much of your concern would have been put to rest even during your father’s final days had [sister] made you aware of the existence then of the long-standing Representation Agreement…

[33] The College then went on to dispose of the complaint saying that it did not consider the allegations concerning the Registrant to be sustainable. I find this disposition to be reasonable in light of the evidence before the College.

[34] In closing, I wish to extend my sympathy to the Complainant not only for the loss of her father but also for the resulting breakdown of her relationship with her sister. It is extremely unfortunate for all the family members involved that such a misunderstanding existed and that there was not better communication between the siblings. I can only express my hope that over time this family will be able to share their loss as one, and that they will be able to reconcile their differences and restore their relationship.

VII ORDER

[35] For the reasons given above, and given my finding that the College investigation was adequate and the disposition reasonable, I confirm the College’s disposition regarding this Registrant.

[36] In making this decision, I have considered all of the evidence and submissions before me, whether or not specifically reiterated herein.

“Lorianna Bennett”
Lorianna Bennett, Panel Chair
Health Professions Review Board

March 11, 2013