DECISION NO. 2011-HPA-125(a); 2011-HPA-126(a) (Grouped File: 2011-HPA-G14)

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 and Surgeon

AND: A Physician and Surgeon

BEFORE: Marilyn Clark, Panel Chair

DATE: Conducted by way of written submissions concluding on October 16, 2012

APPEARING: For the Complainant: Self Represented

For the College: Sarah Hellmann, Counsel

For Registrant 1: Lindsay Johnston, Counsel

For Registrant 2: Lindsay Johnston, Counsel

I DECISION

[1] Upon considering the application made by the Complainant under section 50.6 of the Act, it is my decision that the disposition of the Inquiry Committee is confirmed.

II INTRODUCTION

[2] The Complainant filed a complaint with the Review Board on July 22, 2011, with respect to the actions of Registrants 1 and 2 following receipt of an Inquiry Committee decision of the College dated June 16, 2011, in which the College stated that the conduct of the Registrants in the matters complained of was appropriate.

[3] The complaint relates to the care provided to the Complainant’s late common-law husband, [the “Deceased”], while in hospital where Registrant 1, a urologist, provided care; following transfer to a private hospital, Registrant 2 was among the attending physicians who provided care.
[4] In her application for review, the Complainant states she wants to know “why this patient was neglected by the Doctors and medical staff” and states she is seeking more answers, asserting the College did not do a thorough investigation.

III BACKGROUND

[5] The Deceased was admitted to hospital on March 24, 2009, with what has been described as a “complex pleural effusion”. According to a consulting physician, he:

…suffered from chronic Parkinson’s disease. He had a related problem of dysphagia and was deemed to be a significant aspiration risk. He also had severe pulmonary disease with evidence of asbestosis and recurrent pleural effusions, and had undergone a recent decortication of his right lung at [the large urban hospital]. He also had other significant underlying medical problems including significant coronary artery disease with chronic atrial fibrillation and evidence of previous myocardial infarction, and also significant hepatic necrosis felt likely secondary to severe right heart failure.

[6] While a patient in hospital, he was treated for post-operative urinary retention and a catheter was inserted. The Deceased removed the catheter himself while the balloon was inflated. The urology resident inserted a new catheter and instructed that he be observed for two hours and if there were no signs of bleeding, he could be discharged as planned that day, April 17, 2009.

[7] On April 17, 2009, he was discharged as scheduled by his attending physician and transferred to a private hospital where the attending physician, Registrant 2, did scheduled rounds two days of the week on Mondays and Thursdays and on the request of the nursing staff. The Complainant wonders why he was transferred to a facility “with no medical care especially with the bleeding”.

[8] Registrant 2 reports that from April 18 until April 28, 2009, when Registrant 2 went on vacation the Deceased was “well and in no distress”. Registrant 2’s locum visited the Deceased on April 30, 2009 and reported a cough and the fact that the Deceased had fallen out of bed but identified no other concerns.

[9] On the morning of May 3rd, 2009, the Deceased was found unconscious. He was transferred to hospital where he declined very quickly and died soon thereafter, apparently of sepsis, “likely related to the urinary tract disease”, according to the review done by the Community Care Medical Director of the local health authority who provided an opinion to the hospital on the care provided to the Deceased.

[10] The Autopsy Report provides the final diagnosis as follows:

(1) Ulceration of the prostatic urethra.
(2) Post-op changes of pleural decortication.
(3) Presence of pleural plaques, consistent with asbestos exposure.
(4) Extensive coronary artery disease with evidence of old myocardial infarction and focal features possibly suggesting early myocardial infarction.
(5) Hepatic necrosis with features consistent with severe right heart failure.
[11] In summary, the pathologist states:

Knowing that this patient had Klebsiella and Gram-negative sepsis, I feel this is likely of bladder/urethral origin with the erosion of the prostatic urethra suggesting a predisposition for this site to allow entry of organisms into the blood.

There is circumstantial evidence of significant coronary artery disease and some microscopic features that might suggest an early myocardial infarction that may have contributed to this patient’s death.

[12] The Complainant has many questions relating to the Deceased’s care, many of which relate to the removal of the catheter by the Deceased and the resulting re-insertion. Among them:

(a) Why did Registrant 1 not scope the Deceased to confirm there was no damage to the urethra following the removal of the catheter by the Deceased?

(b) Why was he discharged to a facility without medical care? and

(c) Why was the Deceased not provided with medication in the event of infection upon transfer to the private hospital?

A. Registrant 1

[13] Registrant 1 first had contact with the Deceased on April 16, 2009, when the urology team was consulted with respect to urinary retention. The Deceased had first been admitted to the hospital on March 24, 2009 for a lung procedure.

[14] Registrant 1 was consulted on April 16, 2009 after a urology resident, along with a student, assessed the Deceased. The diagnosis by the urology team was “post-operative urinary retention due to a combination of neurogenic bladder (secondary to Parkinson’s Disease) and perhaps an obstructive component.” According to Registrant 1:

Upfront transurethral resection (TUPR) was not considered for many reasons, primarily because of the patient’s longstanding neurologic disease, and lack of prostate enlargement. . . Upfront TUPR is associated with a high incidence of urinary incontinence in patients with neurogenic bladder secondary to Parkinson’s Disease.

[15] In response to the Complainant’s questions with regard to why the Deceased was not prescribed an antibiotic, Registrant 1 writes:

Because the catheter was draining well and no systemic signs of infection were present, it was decided the patient would be reviewed as an outpatient. Antibiotics are not recommended in patients with chronic indwelling catheters due to concerns of development of resistant organisms. Hence, plans to leave the catheter in place were made with changes of the catheter every six weeks as per standard homecare protocol. This procedure is not unusual and commonly done in patients that have failed trial of voiding as an inpatient. The patient thus had a planned outpatient visit with me in my office.

[16] The Complainant asked why Registrant 1 had not performed a cystoscopy. Registrant 1’s response to that suggestion:
... the catheter was placed “without difficulty” with good urine drainage (as revealed in the resident’s and nurses notes) suggesting proper placement. I do not believe that any damage occurred with the re-catheterization; any injury that was present was likely due to the catheter that was removed with the balloon inflated. A cystoscopy would be indicated in order to aid in a difficult catheterization, and due to the resident’s ease of catheterization and clear urine drainage, cystoscopy was not performed at that time. Cystoscopy, in my opinion, may have further traumatized the urethra, and usually is not performed at time of urethral injury if a catheter has been placed.

[17] Registrant 1 only had contact with the Deceased on April 16 and 17, 2009, so was only able to respond to the Complainant’s queries with respect to the services provided by himself and the Urology team. He does note that the Urology resident reported he was called sometime on April 17th and made the following notation: “reinserted the catheter on April 17th, 2009: 18Fr catheter inserted without difficulty and draining well”. In addition, the Urology team noted that “the catheter was draining well, and there was no noting of any distress”.

B. Registrant 2

[18] The Complainant is critical of Registrant 2 for not recommending the Deceased be returned to hospital for a chest x-ray and for failing to send his amber to dark yellow urine to a lab.

[19] Registrant 2 was the attending physician at the private hospital to which the Deceased was transferred upon discharge from the urban hospital. Registrant 2 advises that he visits the patients at that facility on Mondays and Thursdays and participates with other health professionals at a care conference on Tuesdays. In addition, he reports he is available to respond to issues brought to his attention by the nurse at the facility at any time, including visiting patients if required.

[20] The Deceased was seen by Registrant 2 on three occasions and reports that at each visit “he was well and unchanged from the time of his admission”. With respect to referring the Deceased back to hospital, he advises that “there were no clinical indications” to do so.

[21] Registrant 2 states that “the normal range of the colour of urine is from pale yellow to deep amber.”

[22] Many of the concerns the Complainant asked be addressed related to the policies of and the care provided by the private hospital. Neither the College nor Registrant 2 were in a position to respond to those concerns.

IV ANALYSIS

[23] The options available to the Review Board after considering the adequacy of the investigation and the reasonableness of the disposition are codified in 50.6(8) of the Act:

(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.

C. Adequacy of the Investigation

[24] In determining the adequacy of the investigation and the reasonableness of the disposition, I turn to the decision of the Review Board articulated in Decision No.2009-HPA-0001(a);2009-HPA-0002(a);2009-HPA-0003(a);2009-HPA-0004(a) at paragraph [97] and [98] in which the panel identified the extent to which a College must investigate a complaint:

[97] A complainant is not entitled to a perfect investigation, but he or she is entitled to an adequate investigation. Whether an investigation is adequate will depend on the facts. An investigation does not need to have been exhaustive in order to be adequate, provided that reasonable steps were taken to obtain the key information that would have affected the inquiry committee’s assessment of the complaint.

[98] The degree of diligence expected of the College – what degree of investigation was adequate in the circumstances – may well vary from complaint to complaint. Factors such as the nature of the complaint, the seriousness of the harm alleged, the complexity of the investigation, the availability of evidence and the resources available to the college will all be relevant factors in determining whether an investigation was adequate in the circumstances.

[25] The College had for review;

(a) responses from each of the Registrants;
(b) a response from the locum who replaced Registrant 2 when he went on vacation;
(c) a letter from the Community Care Medical Director of the local health authority who reviewed the care at both the urban hospital and the private hospital; and
(d) hospital records from the urban hospital, the private hospital and the facility where the Deceased died.

[26] I agree with Counsel for the Registrants who stated:

Based on a review of all the documentation in the College’s Record, and having regard to the nature of [the Complainant’s] allegations about the registrants, the College took reasonable steps to obtain the key information to inform its assessment of [the Complainant’s] complaints and to satisfy themselves that the registrants provided appropriate care to [the Deceased]. It is submitted that there is nothing further it could have done to “adequately” investigate the complaint.

D. Reasonableness of the Disposition

[27] The second part of the Review Board’s mandate is to determine whether the disposition of the complaint on the part of the Inquiry Committee is reasonable.
[28] In the Decision referenced in paragraph [24] above, the Panel stated at paragraph [92]:

> While the Review Board's application of the test will necessarily reflect its expertise as a specialized administrative tribunal rather than a Court, the Review Board's focus is nonetheless not to step into the shoes of the Inquiry Committee, but rather to determine whether the Inquiry committee's disposition falls within the range of acceptable and rational solutions, and is, viewed in the context of the whole record, sufficiently justified, transparent and intelligible to be sustained.

[29] Of the issues the Complainant was seeking to have investigated, the actions of health professionals who are not registrants of the College, and the policies of the private hospital, are not within this College's jurisdiction. The College only has jurisdiction in respect of its registrants. It is noted that the Complainant has filed other complaints, most notably with the Patient Care Quality Review Board.

[30] As difficult as it is to lose a loved one and to ensure that everything that could have been done was done, I find that the disposition of the College is reasonable and falls “within the range of acceptable and rational solutions”.

V CONCLUSION

[31] It is my view that, given the circumstances, the disposition by the College fell within a reasonable range of possible outcomes. I am, therefore, confirming the decision of the Inquiry Committee.

[32] In making the decision, I have considered all of the submissions whether or not they are specifically referred to in these reasons.

“Marilyn Clark”

Marilyn Clark, Panel Chair
Health Professions Review Board

January 25, 2013