DECISION NO. 2011-HPA-146(a); 2011-HPA-147(a)
(Grouped File: 2011-HPA-G17)

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: A Physician

BEFORE: Rex. D. Blane, Panel Chair

COMPLAINANT

COLLEGE

FIRST REGISTRANT

SECOND REGISTRANT

REVIEW BOARD

DATE: Conducted by way of written submissions concluding on July 6, 2012

APPEARING: For the Complainant: Self-represented

For the College: Sarah Hellmann, Counsel

For the First Registrant: No submissions received

For the Second Registrant: Lindsay R. Johnston, Counsel

I DECISION

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

II INTRODUCTION

[2] The Complainant, who is the mother of an adolescent male (the “Patient”), filed a complaint with the College relating to the care of her son subsequent to surgery performed by the First Registrant on September 7, 1999 at a local hospital for a massive right hydronephrosis.
The Complainant was dissatisfied with the disposition of the College’s Inquiry Committee (the Disposition) which was communicated to the Complainant by letter dated August 18, 2011.

III BACKGROUND

The Patient, who was born on April 18, 1997 and who had been diagnosed with a massive hydronephrosis and signs of obstruction with the assistance of a prenatal ultrasound, underwent a right pyeloplasty on September 7, 1999, which was performed by the First Registrant, a specialist in pediatric urology.

When the Patient was seen in follow-up on December 10, 1999, the renal ultrasound had not changed much. There was still a significant degree of right hydronephrosis. However, the debris and blood clots that had been present on earlier ultrasound assessment had cleared, suggesting that the right kidney was draining appropriately.

The Patient was seen again on May 17, 2000 and at that time, while there was still dilatation of the collecting system in the right kidney, the individual components or calyces of the right connecting system had decreased in size. Specifically, the largest had decreased from 5.5 cm to 2 cm in diameter. There was also growth of both kidneys. The First Registrant’s assessment confirmed a good and expected response to the right-sided pyeloplasty and it was recommended that the Patient return in a year. Seen again on May 14, 2001, the First Registrant reported as follows:

This 4-year-old boy underwent a right pyeloplasty for a right pelviureteric junction obstruction in September 1999 and remains well. He has had no urinary symptoms and his examination is unremarkable. He has a rather broad, slightly keloid right flank scar. There are no abdominal masses.....

His ultrasound shows a right kidney 10 cm long and left 7.5 cm indicating bilateral renal growth in the last year. There is still some nonobstructive hydronephrosis present on the right side which will exist throughout his life. I do not believe it is necessary for me to see him again as he does not appear to have any long term threat to renal function.

The Second Registrant first treated the Patient on July 4, 1997 when he was only a few weeks old. By this time the child was already under the care of the First Registrant who was following his right kidney problems. A Dr. A was also involved in the child’s care and had referred him to a Dr. B, a pediatric specialist, for an unrelated matter. Following several visits ending in April of 1998 he did not return to Dr. B until approximately two months prior to surgery. This was not on referral from the Second Registrant but was at the request of Dr. A. By this time the First Registrant had suggested surgery due to an increase in the size of the patient’s hydronephrosis. Dr. B provided counseling services to the family, relating to their surgical concerns.

The Patient was by the time of surgery approximately two and half years old. The Second Registrant had been made aware of his kidney issues at his first office visit but, as his records well indicate, in the course of 20 visits prior to surgery he had provided care only for medical issues unrelated to the Patient’s kidneys.
[9] Following surgery on September 7, 1999 the Patient continued follow up with the First Registrant for approximately 18 months. Post surgical and follow-up reports were, in error, sent to a Dr. C whose name, while bearing a distinct similarity to Dr. B, the pediatrician, had no connection with the Patient. This error was remedied on May 14, 2001 when the Second Registrant received a copy of the last of the follow-up reports. Between the date of surgery and the Patient’s discharge from the follow-up by the First Registrant there were nine recorded visits to the Second Registrant none of which related to the Patient’s kidneys. Hence it does not appear that the Patient and his family were relying on the Second Registrant for advice regarding the Patient’s kidneys. On the contrary, such medical services were, in fact, provided by other physicians.

[10] By March 12, 2010, although the Patient had visited the Second Registrant’s office on approximately 70 occasions none of his clinical records indicate any care or mention of care relating to the Patient’s kidneys. On that date, although the Patient was with regard to renal symptoms, asymptomatic, the Complainant requested an assessment of the Patient’s kidneys. The Second Registrant referred the Patient for a renal sonogram. Thereafter the Complainant had no communication from the Second Registrant for several weeks and assumed that the results of the renal sonogram were satisfactory. At an office visit to the Second Registrant in May 2010, for her own health issues, she asked about her son’s sonogram only to find that nothing had been received and no follow-up had occurred. On May 11, 2010 the Second Registrant informed the Complainant of the results of the sonogram which unfortunately were suggestive of a severe right-sided hydronephrosis. Although asymptomatic, there had been a long term marked deterioration in the Patient’s kidney health.

[11] The Patient was referred to a Dr. D, a pediatric urologist who requested a renal sonogram. The diagnostic report of May 27, 2010 found as follows:

The left kidney shows prompt perfusion, shows mild functional enlargement but exhibits normal parenchymal uptake, transit and drainage.

By comparison, the right kidney appears markedly functionally enlarged with a large region of central photopenia compatible with the hydronephrosis shown on recent sonography. Only a thin rim of peripheral parenchyma appears perfused and functioning and function in this kidney is too poor to permit a reliable assessment of renal tracer handling. The left kidney is calculated to contribute 67% and the right 33% to the total renal function although I suspect this to be an over estimation of the contribution of the right side.

[12] In a clinical note of June 10, 2010 made on behalf of Dr. D, it is indicated that the Complainant felt that there should have been additional follow-up subsequent to the May 14, 2001 (approximate 18 months post surgery) examination by the First Registrant. Three options were suggested by Dr. D with regard to further treatment. The first of which was to do nothing and wait and watch. The second option was to undergo a right nephrectomy (removal) to alleviate the risks of possible injury and rupture to the right side. The third option was to repeat a right pyeloplasty procedure; however, Dr. D felt this would likely not be of great benefit.

[13] Thereafter the Complainant took the Patient for examination by a Dr. E, a urologist in another country, who opined that the right kidney was contributing approximately 15% to total renal function. Dr E’s diagnosis was “Right UPJ Obstruction
(failed pyeloplasty).” Following a further review of the Patient, Dr. D wrote on August 30, 2010 to the Second Registrant, in part, as follows:

Since he was last reviewed, his mother has taken him to [another country] to see Dr. F. [sic] I have not had any notes from Dr. F, but I gather that mother was told that if [the Patient] was a resident [of another country] that Dr. F would put a renal stent in place and remeasure the function of the kidney. I gather that Dr. F was also prepared to do a repeat pyeloplasty depending on the outcome of this assessment.

I again went over the options with mother of an elective nephrectomy versus an emergency nephrectomy should the kidney rupture versus repeat pyeloplasty versus observation. I did indicate that I was not prepared to recommend repeat pyeloplasty as I think this will have a higher complication risk and might have a very significant risk of requiring a subsequent nephrectomy in any event….

She then asked me if I thought [the First Registrant] made a mistake in discharging him from follow up in, I believe that the last ultrasound was in 2001.

I indicated that in my opinion, that represented a standard care, particularly as he was asymptomatic and the ultrasound was improving with time.

She then asked me if I had ever seen a patient with a hydronephrosis this late postoperatively. I indicated that I had not, although I did advise her that I have seen previously untreated patients with severe hydronephrosis such as [the Patient’s] in which a nephrectomy is usually warranted.

I clearly indicated to her that I was not prepared, personally, to consider stent insertion and/or repeat pyeloplasty in this scenario and that she was free to seek another opinion as she wished.

[14] At the request of the Complainant Dr. D referred the Patient to Dr. G a pediatric urologist at a hospital for sick children in another province. This included tele-health conferences on November 26, 2010 and February 23, 2011 with the Patient and his parents. Dr. G noted the three options for future care suggested by Dr. D. A further renal scan done in the Patient’s local hospital suggested a 34% function of the right kidney.

[15] In a report to Dr. D dated February 23, 2011 Dr. G opined as follows:

My opinion is that I think [the Patient] needs a procedure to be done. I would start with a retrograde pyelogram followed by most likely a right ureterocalicostomy. I would not perform a nephrectomy in a 34% differential renal function kidney, especially because [the Patient] does not seem to have hypertension. Therefore I think it is worth it to save it although I realize that the massively distended kidney can give false elevation of the renal function however I explained that to the parents and I still would prefer to be conservative and perform a ureterocalicostomy knowing that the differential renal function may come down significantly in this particular kidney.

IV COMPLAINT TO THE COLLEGE

[16] On August 20, 2010 the Complainant filed a complaint with the College which included a generally accurate four page chronology with pertinent attached medical records totaling 29 pages. The Complainant referenced her recollection of a
conversation with the First Registrant on May 14, 2001 and alleged that he had stated, at that time, that the Patient had completely recovered and there was no need to continue follow-up of his condition.

[17] The Complainant observed that although the Patient had been under the care of the Second Registrant since July of 1997, he had failed to recommend a check of the Patient’s kidneys. She noted that it was at her request that the Second Registrant agreed to have the renal sonogram which was performed on March 22, 2010. On a visit to the Second Registrant in May of 2010, she asked about the results of the sonogram. It was only after this inquiry that the Second Registrant obtained them. She noted her shock upon learning from Dr. D of the three available options open to the Patient and believed that the First Registrant was wrong in concluding that no further follow-up was required after May 14, 2001. She believed that the physicians should have checked her son’s kidneys on a regular basis. She contended that, since the report of May 14, 2001 stated “there is still some non obstructive hydronephrosis present on the right side which will exist throughout his life”, this was an indication for further follow-up. She recalled her conversation with Dr. D in which he had stated to her that even in 2010 it is still not a current standard of practice to do follow-up beyond that done by the First Registrant in a similar case to that of her son.

[18] It was her belief that patients with chronic kidney disease are often asymptomatic and that a true state of a patient’s health can only be determined through appropriate testing. She expressed concern about her son’s future quality of life and participation in activities including sports. She also noted the negative emotional effect that the current situation had caused her and concluded as follows:

If it is indeed the standard practice to not follow up on patients’ conditions in a situation similar to [the Patient’s], I strongly recommend that the College review and revise this practice to prevent the reoccurrence of such tragic incidents.

I also respectfully ask that the College review the practice of the First Registrant and the Second Registrant, in their care of [the Patient], to see whether any errors and negligence have been committed.

V DISPOSITION OF COMPLAINT BY THE COLLEGE

[19] Following an investigation and a case summary the Inquiry Committee reviewed and considered the complaint and available information on June 27, 2011, minutes of which are included in the 329 page Record. Following this a letter dated August 18, 2011 was sent to the Complainant. This summarized the complaint, the surgery of September 7, 1999 and the subsequent post surgical follow-up. Responses from both Registrants and Dr. D were reviewed as well as extensive medical records. Well prepared submissions of the Complainant were considered which included the opinion of Dr. G subsequent to the video conference consultations. The Disposition concluded with an analysis of the care received by the Patient and stated as follows:

Upon review of all of the available information, the Committee did not consider that the care provided to the [Patient] by the [First Registrant] or the [Second Registrant] had been deficient. It noted that appropriate investigation, treatment and follow-up care had been administered and concurred with [Dr. D’s] comment that the standard of care had been met. The Committee also believed that the medical opinions provided had been
reasonable, stating that an operation or further treatment in the absence of any symptoms was unnecessary.

The Committee recognizes that this advice may difficult for you to accept. Your son underwent major surgery in infancy. As a parent, you naturally expected that it would solve his problems definitively and permanently or, failing that, that the expert team looking after him would proactively monitor the situation and identify further problems at an early stage. The reality, in the Committee's view, is that no surgeon could provide a guarantee of unimpaired renal function in these circumstances and that repeat examination in the absence of symptoms would provide no useful benefit to [the Patient], in the absence of symptoms.

The Committee did not comment on the veracity of the [Second Registrant's] statement that you had made no mention to him of [the Patient's] renal issues, as no independent information was available to offer clarification on this point. These interactions took place in the privacy of clinical settings and are therefore not amenable to definitive adjudication.

The Committee expressed sympathy with the very difficult situation you and [the Patient] face, given the lingering uncertainty as to what the best course might be. The Committee noted that expert specialists will not always agree. You have the questionable advantage of several opinions that, on some issues, may be in conflict. The Committee concluded that all of the doctors had made clinical decisions that, on review, were found to have been reasonable and appropriate. These are matters of professional judgment. The nature of [the Patient's] condition is such that there are several acceptable approaches. The Committee agreed with [Dr. D's] analysis.

The Inquiry Committee review found no indication of substandard care or negligence on the part of either the [First Registrant] or the [Second Registrant] and, as such, it concluded that there were no grounds for regulatory criticism.

VI SCOPE OF REVIEW BY THE REVIEW BOARD

[20] The scope of review by the Review Board is set out in s. 50.6 of the Act. The following are relevant subsections that relate to this matter.

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.

(6) A review under this section is a review on the record.

(7) The review board may hear evidence that is not part of the record as reasonably required by the review board for a full and fair disclosure of all matters related to the issue under review.
VII ISSUES

[21] The issues to be decided in this application are:

(1) Was the investigation adequate and the disposition reasonable with regard to each of the Registrants.

(2) In considering the above, what further evidence, if any, should be admitted for the purposes of this review pursuant to s. 50.6(7) of the Act.

A. Application for Admission of Additional Evidence

[22] The Complainant has requested that certain evidence be considered that is not part of the Record. Section 50.6(7) allows the Review Board to consider such evidence if reasonably required for "a full and fair disclosure of all matters related to the issues under review." While s. 50.6(6) requires a review "on the record" the Review Board is not fettered with strict rules regarding new evidence provided the requirements of s. 50.6(7) are met.

[23] In her submissions the Complainant has requested admission into evidence of certain additional documents, which are as follows:

(a) The Patient’s ultrasound report dated May 14, 2001. This is already included in the Record.

(b) Reports of Dr. E, the out-of-country urologist, dated July 13, 2010 and July 30, 2010, both of which are already included in the Record.

(c) A report of Dr. G of the out-of-province hospital dated February 23, 2011. This is already included in the Record.

(d) A letter from Patient Care Quality Review Board (PCQRB) dated May 10, 2011. (Being approximately seven weeks prior to the meeting of the Inquiry Committee). This resulted from a request by the Complainant to the PCQRB. It focused on the issue of the standard of care relating to follow-up of pediatric patients post surgery in circumstances similar to that of the Patient. The Complainant points to the following paragraphs:

The PCQO [Patient Care Quality Office] advised the Board that at the time [the Patient] was being treated for the hydrophrenosis, the “pattern of practice” was customarily to follow up for two years. Patients who were symptom-free and whose kidney function had returned to normal or showed improvement no longer required follow-up.

[The First Registrant] noted in a report on May 14, 2001, “There is still some non-obstructive hydronephrosis present on the right side which will exist throughout [the Patient’s] life. I do not believe it is necessary for me to see him again as he does not appear to have any long term threat to renal function.”

The Board researched peer-reviewed studies published in medical journals after [the First Registrant’s] decision to discontinue any further follow-up in [the Patient’s] case. These studies suggest that a two-year follow-up period was considered generally appropriate at the time. These studies also show follow-up periods for longer than two years were also occurring at the time [the Patient]
was being treated from 1999 to 2001. Taken together, it is evident there were different approaches to follow-up periods – however, it does not appear that ending follow-up examinations at 18 months was considered a standard.

The Board appreciates that you are upset and angry that [the Patient] was not provided with long-term follow up care for his hydronephrosis. However, as this decision was based on an individual’s medical opinion, your question of whether this medical opinion met appropriate standards of care is best addressed by the College…..

The letter also contains the following paragraph:

The Board has suggested that PHSA [Provincial Health Services Authority] consider reviewing clinical patterns of practice and any clinical practice guidelines in place for follow-up of pediatric patients with hydronephrosis to determine whether they remain appropriate. That said, the Board notes that clinical practice guidelines are usually population-based, and agrees with the PCQO that, regardless of the standard established, the treating physician is responsible for clinical decisions about diagnosing and treating an individual patient…..

Although the Complainant did not provide this letter to the Inquiry Committee I see it as being relevant to her concern (para [18] above) that there be ongoing review of clinical patterns of practice in circumstances similar to that of her son.

(e) Letter from Dr. G to Dr. H dated November 14, 2011. After careful consideration of this letter I find that it is not of probative value with respect to the matters under review and is not reasonably required pursuant to s. 50.6(7).

(f) Letter from Dr. G to Dr. H dated November 21, 2011. After careful consideration I find that this letter contains a duplication of information with respect to the matters under review and it is not reasonably required pursuant to s. 50.6(7).

(g) The Patient’s medical report dated November 21, 2011 for the period November 15 to 21, 2011 from the out-of-province hospital indicates the responsible physician as being Dr. G. This report is subsequent to the Disposition of the College and, while it confirms ongoing treatment of the Patient, it does not provide any opinion relating to the appropriate standard of care with respect to the follow-up post surgery of September 1999 by the First Registrant.

[24] In result, only the letter referenced in paragraph [23](d) above is admitted supplementary to the Record and for the purpose indicated.

B. Adequacy of the Investigation

[25] The Review Board has considered the question of adequacy of the investigation in a number of previous decisions including decision No. 2009-HPA-0001(a)-0004(a), paragraphs [97] and [98] are as follows:
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.

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.

The letter of August 18, 2011 from the College to the Complainant together with the Record identifies the documentation that was considered by the Inquiry Committee prior its Disposition.

In her submission to the Review Board the Complainant stated that the College should not have relied upon the opinion of Dr. D with respect to the proper standard of care relating to her son because of possible conflict of interest. The Complainant also felt that, while the report of the First Registrant dated May 14, 2001 was before the Inquiry Committee, the Committee should have reviewed the ultrasound of the same date. The Complainant considered that the Inquiry Committee should have consulted a pediatric urologist other than Dr. D. regarding the appropriate standard of care.

In fact, the Complainant herself consulted other pediatric urologists including Dr. E in another country and Dr. G in another province, however their reports did not include any comments relating to the applicable standard of care in British Columbia at the relevant time.

Dr. D’s opinion that most pediatric urologists would not have arranged additional follow-up was first expressed in clinical notes dated June 10, 2010 made on behalf of Dr. D. This was in response to the Complainant’s request concerning the appropriate standard of practice with regards to patients in her son’s situation. (See para. [12] above)

In his letter dated August 30, 2010 to the Second Registrant, Dr. D stated as follows:

She then asked me if I thought [the First Registrant] made a mistake in discharging him from follow-up in, I believe that the ultrasound was in 2001.

I indicated that in my opinion, that represented a standard of care, particularly as he was asymptomatic and the ultrasound was improving with time.

Certainly by August 30, 2010 the complaint had already been made to the College. However Dr. D’s letter to the College of February 3, 2011 did not provide a gratuitous opinion with respect to the standard of care in question but was supplementary to the previous opinions, the first of which was provided on June 10, 2010. The Record does not disclose any bias or conflict of interest on the part of Dr. D as suggested by the Complainant, and the Inquiry Committee was entitled to consider
Dr. D’s opinion as part of its investigative and decision making process. Dr. D’s letter to the College concluded as follows:

I would expect that most pediatric urologists would carry out or arrange for follow-up for 1-3 years, with longer term follow-up should any symptoms develop.

[32] In these circumstances I find that there was no requirement that the College consult with other pediatric urologists. If the Complainant wished additional medical opinion to be considered by the College she was both entitled and obligated to provide it. As noted, the medical opinions she provided did not address the appropriate standard of care in British Columbia.

[33] The ultrasound of May 14, 2001 was part of the Record. Its purpose was to make a comparison with the previous post operative ultrasounds and particularly that of May 17, 2000. The Complainant suggests the May 17, 2001 ultrasound is indicative of a “worsening” of [her son’s] condition. While this is her opinion it is not supported by the medical evidence.

[34] The Complainant alleged that the Investigation by the College was deficient with respect to the Second Registrant’s position that up until the Complainant’s request for re-evaluation in 2010 there had been no discussion over the years concerning her son’s kidneys. This was contrary to her recollection. In its Disposition the College states:

The Committee did not comment on the veracity of [Dr. E’s] statement that you had made no mention to him of [the Patient’s] renal issues, as no independent information was available to offer clarification on this point. These interactions took place in the privacy of clinical settings and are therefore not amenable to definitive adjudication.

[35] While one may well have expected that the matter of the Patient’s kidneys would have been at least mentioned over a period of approximately 13 years of care by his family doctor there was, in fact, no such reference in the Second Registrant’s clinical notes. Under the circumstances I find there was no further information reasonably available and that the investigation by the College concerning the Second Registrant was adequate. I also find that in the investigation by the College concerning the First Registrant reasonable steps were taken to obtain key information such that the investigation was also adequate.

C. Reasonableness of the Disposition

[36] The Review Board has considered the question of reasonableness of the disposition of a complaint in a number of previous decisions including No. 2009-HPA-0001(a)-0004(a) which reflects the law in determining reasonableness at paragraphs [91] and [92]:

[91] In Dunsmuir v. New Brunswick, 2008 SCC 9 at paras. 47 and 49, the Supreme Court of Canada had earlier stated as follows:

Reasonableness is a deferential standard animated by the principle that underlies the development of the two previous standards of reasonableness: certain questions that come before administrative tribunals do not lend themselves to one specific, particular result. Instead, they may give rise to a number of possible, reasonable conclusions. Tribunals have a margin of
appreciation within the range of acceptable and rational solutions. A court conducting a review for reasonableness inquires into the qualities that make a decision reasonable, referring both to the process of articulating the reasons and to outcomes. In judicial review, reasonableness is concerned mostly with the existence of justification, transparency and intelligibility within the decision-making process. But it is also concerned with whether the decision falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law...

Deferece in the context of the reasonableness standard therefore implies that courts will give due consideration to the determinations of decision makers. As Mullan explains, a policy of deference “recognizes the reality that, in many instances, those working day to day in the implementation of frequently complex administrative schemes have or will develop a considerable degree of expertise or field sensitivity to the imperatives and nuances of the legislative regime”: D.J. Mullan, “Establishing the Standard of Review: The Struggle for Complexity?” (2004), 17 C.J.A.L.P. 59, at p. 93. In short, deference requires respect for the legislative choices to leave some matters in the hands of administrative decision makers, for the processes and determinations that draw on particular expertise and experiences, and for the different roles of the courts and administrative bodies within the Canadian constitutional system.

[92] In our view, these passages reflect the approach the Review Board should take in reviewing the reasonableness of an inquiry committee’s disposition. 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.

(emphasis added)

[37] The Complainant made further detailed submissions to the Review Board supported by additional documentation. She emphasized her recollection that the First Registrant told her that her son had “completely recovered” and that there was no need for additional follow up. The First Registrant, who is now retired, addressed that issue in a response letter to the College by doubting that the Patient’s kidney could have recovered 100% of function. It was open to the Inquiry Committee to conclude that based upon the medical evidence and particularly the First Registrant’s report of May 14 2001, it was unlikely that the First Registrant would have advised the Complainant that there was “no problem” with [the Patient’s] kidney or that his kidney was “normal”.

[38] The Complainant continued to take issue with the finding of the Inquiry Committee regarding the post surgical standard of care relating to her son. In fact, the only evidence before the Inquiry Committee relating to this issue was that of Dr. D. As previously noted, neither the letter from Dr. E in another country nor Dr. G’s reports from the out-of-province hospital expressed any opinion with respect to appropriate standard of care in British Columbia following the Patient’s surgery in 1999.

[39] I have admitted into evidence a letter from the Patient Care Quality Review Board to the Complainant dated May 10, 2011. Although this letter preceded the date of the Inquiry Committee it does not appear to have been submitted to the College. In my
opinion the relevancy of this document can only be considered in relation to the Complainant’s secondary position that there should be a review of the standards of practice relating to post-surgical follow-up under circumstances similar to that of her son. Peer-review studies indicating follow-up periods for up to two years in certain cases and for longer than two years were occurring at the time the Patient was being treated between 1999 and 2001. The letter suggests that it does not appear that limiting follow-up examinations to 18-months was considered a “standard”. Dr D’s opinion before the College suggested a follow-up period of one to three years. The Inquiry Committee noted that expert specialists will not always agree and that ultimately clinical decisions are significantly a question of professional judgment. I find that upon consideration of all of the evidence available to the College, the Inquiry Committee’s findings that there was no sub-standard of care or negligence on the part of the First Registrant falls within the range of acceptable outcomes and is sufficiently justified, transparent and intelligible to be sustained.

[40] The Second Registrant, the Patient’s family doctor, provided a detailed response which was considered by the Inquiry Committee. His position was that he relied upon the First Registrant’s recommendations in 2001 that no further follow-up was required. With respect to the considerable delay in obtaining the results of the sonogram, the Second Registrant placed the onus on the Patient and his mother. In his office, it is up to the patient to ensure that reports are received in a timely way. The Second Registrant pointed out that he had a poster in examination rooms and his waiting room stating that patients should come back to his office after two weeks after the investigation for follow-up. This, in his opinion, mitigated his requirement to do follow-up on reports such as in this case. While it seems unlikely that a delay of two months impacted the future care and the treatment of the Patient, there are undoubtedly circumstances where such delays could have serious consequences. While the “poster system” as used by the Second Registrant is not without merit as a back-up system, it, in my view, should not operate as a primary tool in fulfilling a physician’s appropriate standard of care. The Complainant does not suggest, and fortunately there is no evidence to indicate, that the delay in obtaining the results of the sonogram was significantly harmful to the Patient.

[41] In concluding its analysis of care received, the College stated as follows:

The Committee expressed sympathy with the very difficult situation you and [the Patient] face, given the lingering uncertainty as to what the best course might be. The Committee noted that expert specialists will not always agree. You have the questionable advantage of several opinions that, on some issues, may be in conflict. The Committee concluded that all of the doctors had made clinical decision that, on review, were found to have been reasonable and appropriate. These are matters of professional judgment. The nature of the Patient’s condition is such that there are several acceptable approaches. The Committee agreed with [Dr. D’s] analysis.

[42] I find that the Complainant has done all that she reasonably can in relation to the medical care of her son. She has in fact gone beyond the call of duty in her efforts and concerns for his future health. It is evident from the information provided by the Patient Care Quality Review Board that there are ongoing studies and reviews with respect to the standard of care in circumstances similar to that of the Patient. The First Registrant, although retired and no longer a member of the College, himself agreed that the guidelines for follow-up after surgery for congenital hydrophrenosis would be a good subject for further investigation. I strongly agree with this suggestion. While this inquiry
did not focus on the present standard of care I believe that it is in need of clarification. The PCQRB indicated a “pattern of practice” was customarily to follow up for a minimum of two years in patients who were apparently symptom free. There are indications that this may still be the standard of care today. While there appear to be ongoing studies, I believe that the College and other appropriate agencies within the Province should review Clinical Practice Guidelines and having done so, ensure that there is a heightened awareness of them.

[43] I, like the Complainant, am concerned that standards of practice have regard to long term follow up beyond that of the post-surgical care period such that a patient with a childhood history as in this matter, may be recommended for review at some time prior to adolescence or adulthood.

[44] However, the result and bearing in mind the scope of the Review Board’s review, I find that the Disposition of the College is reasonable and does fall within the range of rational and acceptable outcomes and is sufficiently justified, transparent and intelligible to be sustained with respect to both Registrants.

VIII  CONCLUSION

[45] In making this decision I have considered all available information documentation and submissions whether or not specifically referred to in confirming the Disposition of the College.

“Rex D. Blane”

Rex D. Blane, Panel Chair
Health Professions Review Board

May 3, 2013