DECISION NO. 2011-HPA-198(a); 2011-HPA-199(a); 2011-HPA-200(a); 2011-HPA-201(a); 2011-HPA-202(a); 2011-HPA-203(a); 2011-HPA-204(a); 2011-HPA-205(a); 2011-HPA-206(a); 2011-HPA-207(a); 2011-HPA-208(a); 2011-HPA-210(a); 2011-HPA-211(a); 2011-HPA-212(a); 2011-HPA-213(a); 2011-HPA-214(a); 2011-HPA-215(a); 2011-HPA-217(a)

(Grouped File: 2012-HPA-G15)

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:

18 Physicians and Surgeons

(Collectively, the REGISTRANTS)

BEFORE:

Lorianna Bennett, Panel Chair

REVIEW BOARD

DATE: Conducted by way of written submissions concluding on March 15, 2013

APPEARING:

For the Complainant: Self-represented

For the College: Sarah Hellmann, Counsel

For the 18 Registrants: Lindsay Johnston, Counsel

I INTRODUCTION

[1] This matter arises out of the Complainant’s dissatisfaction with the Registrants in relation to the medical care, investigations and diagnoses she received for her chronic back pain and other medical conditions. The Complainant alleges the Registrants failed to thoroughly investigate and communicate with respect to her medical conditions. The Complainant further alleges that their misconduct resulted in an incomplete diagnosis to the Worker’s Compensation Board (“WCB”) causing the Complainant’s WCB application to be dismissed, both on the initial review and on appeal. After investigating, the College’s Inquiry Committee dismissed her complaints. The Complainant applies to the Review Board for a review of those dispositions.
II ISSUES

[2] The issues I must decide are:

(a) Did the Inquiry Committee adequately investigate the complaints against the Registrants?

(b) Was the Inquiry Committee’s decision to dismiss the complaints against the Registrants reasonable?

III BACKGROUND FACTS

[3] In 1994, while working, the Complainant suffered a thoracic spinal injury to her neck and shoulder. She reported her injury to WCB. WCB dismissed her application for financial compensation. The Complainant was of the view that the WCB adjudicator dismissed her application before relevant medical reports were received. The Complainant appealed the WCB disposition.

[4] As part of the WCB appeal process, the Complainant was examined by the WCB Medical Review Board with respect to her alleged work related injury and also for other medical conditions. The Medical Review Board examined the Complainant and found that her WCB claim was invalid because of a pre-existing condition, namely scoliosis (dating back to 1975) and back surgery (1990).

[5] The Medical Review Board findings were forwarded to WCB who then dismissed the Complainant's appeal for compensation.

[6] In her May 26, 2010 letter of complaint to the College, the Complainant criticized 21 physicians who had either been involved in, or were asked to consult on medical issues respecting the Complainant’s care. Her criticisms in that letter can be summarized as follows:

...Several investigations have been done of my upper and lower spine but none of the Thoracic area, T5 level (lymphatic drainage). The effects of the lack of proper medical care have cost me many years of working income, and a very poor social life, not to mention the extensive hours my son spent in front of the television because I could not attend to him...

...My experience over the last decade and a half has been fraught with frustration and aggravation due to the highly incompetent, or perhaps lazy, or deceptive practice of many of the members, who are protected by the licensing body...

I have lost many years of earnings, and have lived below the poverty line. But more importantly, I lost the ability to properly care for my child, the biggest blow. The downward spiral began with the incomplete and misdiagnosis of one so-called specialist named [Registrant C]...who gave an incomplete report to the WCB.

How is it possible that some so-called doctor who has never seen you can make an informed decision on a very important matter, by colluding with another physician, to ruin a person's life?! ...
...they can be arrogant, pompous, and all knowing. This has been my impression of the so-called medical practitioners, who look at you and make a diagnosis without a clinical exam or any testing...

[7] The specifics of the Complainant’s complaints as they relate to the various Registrants named in this review are detailed, and the Complainant has undoubtedly gone to great lengths to identify her concerns which are set out in her 126 page (excluding attachments) Statement of Points. Those concerns can be summarized as follows:

(a) Registrant A: Examined the Complainant for nerve sensitivity with the pin prick test and jabbed at the Complainant very aggressively. The Complainant says that Registrant A stated, “I haven’t had my jollies today” during his examination.

(b) Registrant B: The Complainant was referred to Registrant B for a hernia but says he was unable to detect a hernia and thus was of no help. She says he stated he could only deal with one thing at a time when she asked him to explain what macrophage is.

(c) Registrant C: A specialist who claimed he had no knowledge of why the Complainant was experiencing neurological symptoms. The Complainant alleges that Registrant C failed to view the body scan film that was sent to him from another hospital by the request of the family doctor she was seeing at the time. As a result the Complainant says that Registrant C provided an incomplete report to WCB when he diagnosed her as having mechanical back pain secondary to degenerative disc disease of her lumbar spine. In her Reply, the Complainant states:

...The downward spiral began with the incomplete and misdiagnosis of one so-called specialist named [Registrant C], an Orthopedic Specialist, who gave an incomplete report to WCB.

(d) Registrant D: a neurologist whom the Complainant alleges was too busy to examine her during her appointment due to time constraints. The Complainant says that he became agitated because she declined his offer for medication with minimal consultation, and then told her that he could not treat her. The Complainant further says that he walked out of the office during her appointment and she was left wondering if he would return. The Complainant says she complained about his professionalism, and only after that did he order tests which left her with compromised memory and cognitive function for at least six months or more. The Complainant adds that the tremors that she experienced were not addressed by Registrant D.

(e) Registrant E: claimed she could not help the Complainant. The Complainant says that Registrant E did not examine her, she did not prescribe any medication or appear too concerned, nor did she seem too concerned about the disabling pain in the Complainant’s left hip and leg.
(f) Registrant F: is a doctor at a clinic near the Complainant’s home whom the Complainant saw several times between 2005 and 2007 for various matters. The Complainant alleges he was dismissive and incompetent and diagnosed her with mental/emotional problems as opposed to physical problems.

(g) Registrant G: The Complainant states that Registrant G had no concerns about the green phlegm that the Complainant had been coughing up for years and concluded that it was “post nasal drip”. The Complainant adds that Registrant G did not even open up the Complainant’s chart. Despite this, the Complainant says she has since been diagnosed with right side sinus disease.

(h) Registrant H: did not give the Complainant more than two minutes of her time. The Complainant says that Registrant H minimized her debilitating pain and failed to address her concerns.

(i) Registrant I: The Complainant states that Registrant I inappropriately suggested that she had no grounds for a claim because of a three week delay in reporting to the WCB. The Complainant adds that Registrant I was a bully who blamed her injury on her carrying her son and alleged stress with her boyfriend.

(j) Registrant J: a neurologist who gave his written opinion that the Complainant was experiencing pseudo symptoms, but in his office told her it was in her head. The Complainant does not recall him examining her and found him to be unprofessional.

(k) Registrant K: the Complainant was dissatisfied with Registrant K for several reasons including:

   (i) he would not look the Complainant in the eye during her first visit and the Complainant found this to occur again when she brought her son to him;
   (ii) she says he refused to do a test to see if she was menopausal;
   (iii) he improperly did a pap test and appeared embarrassed while conducting the test;
   (iv) he prescribed Naproxen despite the Complainant telling him that she experienced adverse effects with that medication;
   (v) he failed to send her for a heart test;
   (vi) he continued to prescribe Ativan to her, a drug which the Complainant believes is harmful;
   (vii) he referred her to a Mental Health authority, without her knowledge and without previous discussion about any mental health issues;
   (viii) failed to share the contents of the report with her claiming it was “confidential”; and
   (ix) he would not fill out the forms from the Ministry for a supplemental benefit.
(l) Registrant L: refused to perform a “liver function test”, and dismissed her concerns as she walked away.

(m) Registrant M: the Complainant says she was referred to him because of “chronic cough and rhinitis complaints”. In his report he commented on the Complainant’s “apparent eating disorders” which she found disturbing, incorrect and irrelevant.

(n) Registrant N: a neurologist who provided no answers to the Complainant in respect of her low back pain complaints and “overheating”.

(o) Registrant O: a dermatologist whom the Complainant says prescribed her something for her head instead of her skin condition. The Complainant alleges that he failed to do any kind of skin testing to establish the cause of her condition.

(p) Registrant P: a specialist in infectious diseases who apparently expressed to the Complainant that she could be suffering from “cutaneous larvae migrans” yet provided a diagnosis of “some features of delusional parasitosis”. She says he, too, failed to do any kind of skin testing to establish what was really going on.

[8] While her complaint letter was under review by the College, the Complainant expressed concern regarding two further registrants, namely Registrants Q and R as follows:

(a) Registrant Q: the Complainant saw Registrant Q with regard to wax build up in her ears and asked for it to be syringed. The Complainant was not happy with the tone of his interactions with her.

(b) Registrant R: the Complainant expressed criticism with Registrant R’s failure to provide documentation certifying the Complainant’s “fitness and health” which was required by the Complainant to complete her diploma as a Child and Youth Care Counsellor.

[9] In her 76 page Reply, the Complainant reiterates her allegations against the various Registrants as she responds to the Statement of Points prepared by both the College and the Registrants.

[10] The Inquiry Committee investigated all of the complaints put forward by the Complainant in her initial complaint letter, and in doing so requested and received responses from all of the Registrants. Each Registrant defended his/her actions and findings, and further alleged proper care and procedure.

[11] After reviewing all of the responses and concluding their investigation, the Inquiry Committee determined that no further action was necessary regarding the Registrants.

[12] The Complainant now applies to the Review Board challenging the adequacy of the investigation and the reasonableness of the disposition.
Additionally, the Complainant seeks to introduce new evidence with her Statement of Points. The new evidence consists of the Health Professions Act, the CMA Code of Ethics, Bylaws, two of the College’s Professional Standards and Guidelines, a copy of a bone scan image previously delivered to the College, excerpts from Gray’s Anatomy for Students, a physiotherapist report and witness statements from an acquaintance of the Complainant.

IV THE REVIEW BOARD’S ROLE

Section 50.6(8) of the Act sets out the Review Board’s powers following a review of an Inquiry Committee disposition. Specifically, the Review Board can:

(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. These limits are set out in s.50.6(5) of the Act.

As part of the review process, the Review Board may also consider any applications to consider new evidence.

V ADMISSIBILITY OF NEW EVIDENCE

In considering the Complainant’s application to introduce new evidence, the Review Board is guided by s.50.6(7) of the Act which enables the Review Board to receive and accept additional relevant evidence to the extent that it is required for a full and fair disclosure of all matters related to the issues under review.

The Review Board is also guided by previous Review Board decisions dealing with this issue. In Review Board Decision No. 2009-HPA-0001(a) – 0004(a) at paras [71] – [72], the review panel stated:

...What is “reasonably required” for a “full and fair disclosure of all matters related to the issues under review” is a decision for the Review Board, acting in good faith, to decide on a case by case basis, according to the matters at issue on a particular review. In this case, we have admitted some fresh evidence and rejected evidence that has no relevance to the issues we are called upon to decide. That decision was based on our review as to whether the evidence was reasonably required to fully and fairly deal with issues under review. To make that determination in this case, we first assessed whether the new evidence is relevant. If it is then we asked generally:

(a) How relevant is the material to the matters at issue on the review?
(b) Would it be fair to all parties to admit it?

(c) Does admission of the information render the disclosure more full or complete so as to enable the Review Board to render a full, fair and proper decision?

[72] The weight we assigned to the factors considered depended on the evidence in question.

[19] Applying these guidelines, and after considering the submissions of all parties regarding the admissibility of the new evidence, I find the Health Professions Act, the CMA Code of Ethics, Bylaws, the College’s Professional Standards and Guidelines, and bone scan image relevant and admissible.

[20] With respect to the information from Gray’s Anatomy, it is general in nature and far below the threshold of knowledge that the regulatory body and the Registrants acquire from their years of medical experience and practice.

[21] Further, as the Review Board has no jurisdiction to interpret (or reinterpret) the Complainant’s medical records, the Gray’s Anatomy information serves no purpose. As such, I find this information irrelevant and not admissible.

[22] With respect to the physiotherapist report, I agree with the submissions of the College and Registrants that the Complainant’s physical pain is not in issue, and therefore I do not consider this information to be of any assistance in the Review Board’s analysis of whether the investigation was adequate and the disposition reasonable.

[23] With respect to the character statement in support of the Complainant’s integrity and the duration of her physical abilities, I also find this information of no assistance as it has no bearing on whether the investigation was adequate and the disposition reasonable.

VI ADEQUACY OF THE INVESTIGATION

[24] Turning now to the adequacy of the investigation, I reiterate that it is not the Review Board’s role to reinvestigate these complaints, nor is it the Review Board’s role to perform a "trial de novo".

[25] Rather, the Review Board’s role is to assess the adequacy of the Inquiry Committee’s investigation based only on the written record.

[26] In limiting itself to the written record of the College’s investigation and disposition, the Review Board must determine whether the Inquiry Committee’s investigation provided it with sufficient information to assess the particular complaints.

[27] The adequacy of the investigation depends on the particular facts of each case. Having said that, the Review Board has identified the following factors as relevant to an assessment of the adequacy of an investigation:
(a) Nature of the complaint;
(b) Seriousness of the harm alleged;
(c) The complexity of the investigation, the availability of the evidence; and
(d) The resources available to the College.

[28] 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.

[29] 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 that would have affected the Inquiry Committee’s assessment of the complaint. In other words:

(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 Registrants that are the subject of the complaints?

(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 Registrants and the particular complaints?

[30] In her application for review dated November 2, 2011, the Complaint suggests that the College investigation was lacking, in part because the College failed to consider certain medical records from one of the Complainant’s physician’s during a time when she was in significant distress.

[31] Additionally, the Complainant says that the College failed to investigate as to why her treating physician’s did not further investigate into her thoracic spine history. She alleges that her thoracic spinal history was ignored/dismissed by the WCB Medical Review Panel as insignificant, claiming a normal scan.

[32] The Complainant submits that the College choose to overlook the available evidence (ie: evidence of other physicians and rehabilitation specialists who were able to do proper assessments and whose records were included as supportive documentation) in favour of a dismissal. In doing so, she makes reference to her detailed statement of points which contains her notes and recollection of interactions she had with at least 21 registrants over the years, and she reiterates many of her initial allegations of alleged inadequate medical care.
In her statement of points dated January 8, 2013, the Complainant does not provide any additional submissions regarding the adequacy issue except to state that she continues to question the adequacy of the investigation.

In her Reply dated April 25, 2013, the Complainant more fully addresses her concerns regarding the adequacy of the investigation, in part, by restating her concerns regarding her interactions with each Registrant. Additionally she says:

...I understood that the process of reviewing the Record containing all of the medical practice records and communication from the registrants, forwarded by the College, was to dispute the College’s Disposition, showing that the investigation was not adequate, and the disposition not reasonable, based on the medical records and what the physicians had communicated in their response letters to the College. It was apparent that the College had overlooked some significant information, which was provided for the investigation...

In order to dispute the disposition I provided in detail, an account of my interactions with each of the 18 registrants that I complained about, including, referenced opinions from other qualified physicians/practitioners, cited discrepancies, and referenced medical reports from medical institutions that I believed to be relevant evidence. This apparently was not sufficient...

...I found the College’s summary of my complaints and the responses of the registrants to be quite simplistic, although the College claimed ‘the investigation was relatively complex...’

...It is glaringly apparent that physicians write (omit) whatever they want in their clinic notes and this is accepted by the College without question, as being factual and honest. In my statement of points I gave a detailed account of what transpired at visits to the physicians I saw, and cited their dishonest statements and claims, but apparently it was considered irrelevant in favour of the registrants...

...For the College to claim that ‘The medical records support the responses provided by each physician...’ raises the question whether they indeed did an adequate investigation.

Turning then to the issue of whether the College conducted an adequate investigation, I will outline the steps taken by the College. They are as follows:

(a) The College wrote to each of the Registrants requesting information about the their interactions with the Complainant and asking them to address the identified concerns;

(b) The College received and reviewed the response received from each of the 18 Registrants;

(c) The College received and reviewed various medical records received from the Registrants;

(d) The College wrote to the Complainant requesting her consent to access additional medical records from registrants who were not the subject of her complaints but who had relevant information to contribute based on their involvement at some point in the Complainant’s medical care;
(e) The College received additional supplement materials from the Complainant and from other registrants;

(f) Upon receipt of all additional material, the College forwarded same to each of the Registrants listed in the complaint for their further review and comment; and

(g) the Registrar reviewed all of the documents and responses received from each Registrant, and assessed whether the Registrants had answered the allegations made against them, and whether they had met the requisite standard of care expected of them.

[36] The document review consisted of a large volume of the Complainant’s clinical information spanning 16 years. All of that information is contained in the record before the Review Board, and it consists of approximately 781 pages.

[37] Given the volume of material before the Registrar, the number of Registrant’s involved, the time span over which reviews had to be undertaken, and the broad nature of the allegations, the investigation was undoubtedly complex, time consuming, and subject to limited administrative and financial resources.

[38] Taking all of this into consideration, I find that by all accounts the investigation was adequate such that it did not fall below the standard of review.

VII REASONABLENESS OF THE DISPOSITION

[39] It is not the Review Board’s role to opine on the diagnosis provided by each Registrant. Nor can the Review Board decide whether the College’s decision was right or wrong. Further, the Review Board cannot make a finding of misconduct or discipline a member of any college.

[40] Rather, the Review Board’s focus after considering the issue of the adequacy of the investigation is to determine whether the College or Inquiry Committee’s disposition was reasonable.

[41] 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 it had before it. If the Review Board finds that the disposition was not reasonable, then s.50.6(8) gives the Review Board authority to send the matter back to the Inquiry Committee to reconsider the matter with specific directions. This is exactly what the Complainant is asking for in terms of the relief sought.

[42] Both the College and the Registrants contend that the College disposition was reasonable and ought to be confirmed. Specifically, they allege that the clinical records depicted professional conduct, including documented examinations of the Complainant. Both the College and Registrants further contend that all of the recommended treatment and referrals for further investigation were warranted.
[43] Most, if not all, of the Registrants’ responses were in direct conflict with the Complainant’s recollection of events. As pointed out by the College, where this occurred the College evaluated the available evidence and was able to determine that the notes of the Registrants and consultation reports made contemporaneous to the events in question were reliable and accurate reflections of what transpired.

[44] In preferring the evidence of the Registrants over that of the Complainant, the College says it did not question the veracity of the Complainant’s version of events, but rather felt that her evidence did not substantiate her allegations that the Registrants had not met the requisite standard of care, conduct and medical knowledge.

[45] In consideration of all the evidence and the extensive record before me, I concur that the Complainant’s evidence falls short of substantiating her allegations of medical incompetence, and I am satisfied that the College disposition falls within the range of possible, acceptable outcomes which are defensible in respect of the facts and the law.

[46] In closing, I wish to extend my sympathy to the Complainant for the chronic pain she has endured over the past several years, and I sincerely hope that the pain relief she has experienced through her more recent trials of alternative medicine will continue.

VIII ORDER

[47] 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 the 18 Registrants.

[48] In making this decision, I reiterate that I have considered all of the information and submissions before me, whether or not they are referred to in these reasons.

“Lorianna Bennett”

Lorianna Bennett, Panel Chair
Health Professions Review Board

July 30, 2013