DECISION NO. 2012-HPA-026 (a)

In the matter of an application under section 50.6 of the Health Professions Act, R.S.B.C. 1996, c. 183, as amended, (the “Act”) for review of a complaint disposition made by an inquiry committee

BETWEEN: The Complainant

AND: The College of Physicians and Surgeons of BC

AND: A Physician

BEFORE: J. Thomas English, Q.C., Chair

COMPLAINANT

COLLEGE

REGISTRANT

REVIEW BOARD

DATE: Conducted by way of written submissions concluding on January 23, 2013

APPEARING: For the Complainant: Self-represented

For the College: Sarah Hellmann, Counsel

For the Registrant: Joel A. Morris, Counsel

I DECISION

[1] Upon considering the application made by the Complainant it is my decision that the disposition of the Inquiry Committee of the College is confirmed.

II BACKGROUND

[2] The Complainant is a widow who complained to the College with respect to the adequacy and competency – and indeed, the honesty and integrity - of the care provided by the Registrant to her late husband (“Mr. C”). She has been diligent in attempting to determine what human or institutional errors may have caused or contributed to Mr. C’s death. In pursuit of this goal she has reviewed all hospital records, nurses’ notes, conversations she or others had with relevant persons, correspondence with numerous doctors, Hospital X, Health Authority Care Quality Office, the Patient Care Quality Review Board, the Ministry of Health and the other documents found in the Record.

[3] The Record in connection with this matter is quite lengthy: 1,607 pages, and, in addition, I have considered the Statements of Points (the “S of P”) of the Complainant,

[4] I will attempt to summarize the relevant facts but before I do that it is important that all parties are aware of the limited jurisdiction of the Review Board in matters similar to this.

III JURISDICTION OF THE REVIEW BOARD

[5] The relevant provisions of the Act are s.50.6(5) to (8) which read as follows:

(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 issues under review.

(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.

(emphasis mine)

A. Adequacy of the Investigation

[6] The Review Board has determined in prior decisions that not all complaints will require a College to pursue every possible avenue of investigation, but a Complainant is entitled to an adequate investigation.

[7] The standard I have adopted for assessing the adequacy of the investigation in this matter is whether this complaint was investigated diligently, considering its seriousness, complexity and the availability of evidence. The law applying to the adequacy of an investigation was properly determined in Review Board Decision No. 2009-HPA-0001(a)-0004(a) at paras, [98] and [110]:

[98] 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 key information that would have affected the Inquiry Committee’s assessment of the complaint.

...
[110] 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 harm alleged, the complexity of the investigation, the availability of the evidence and the resources available to the College will all be relevant factors in determining whether an investigation was adequate in the circumstances.

[8] 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 access the particular complaints made against the Registrant. It is not the role of the Review Board to reinvestigate the complaint or to substitute its decision for that of the Inquiry Committee.

B. Reasonableness of the Disposition

[9] The role of the Review Board in assessing the reasonableness of the Inquiry Committee’s disposition of a complaint is whether it falls within the range of defensible outcomes based on the evidence it has before it. A disposition will be reasonable if it addresses the major issue in relation to the facts before it.

[10] The evidentiary standard for assessing the reasonableness of a disposition is based on a review of what was before the Inquiry Committee (the "Record"), along with any additional evidence put before the Review Board that the Review Board considers, upon examination, to be reasonably required for a full and fair disclosure of all matters related to issues under review: s.50.6(7) of the Act.


The reasonableness standard which ought to be applied to the College’s disposition requires deference to the decision of the Inquiry Committee. It is not open to the Review Board to ask itself whether it would have arrived at the same decision as the Inquiry Committee. Rather the test is whether the Inquiry Committee’s decision was reasonably supported by the information that was before it, and whether it can withstand “a somewhat probing examination.

[12] In the Review Board Decision No. 2009-HPA-0001(a)-0004(a), paras. [90] to [94], the Review Board set out a comprehensive description of the applicable law regarding the “reasonableness of the disposition” which I adopt. In regard to the reasonableness of the disposition, the Review Board stated in the above noted decision at para. [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.

[13] The Review Board is not to decide whether the Inquiry Committee’s decision was right or wrong, and administrative law does not require that the disposition be one that
the Review Board would have made. Rather, it must be a disposition that is supported 
by the evidence from the investigation, and one that fits within the range of acceptable 
and rational outcomes.

IV BACKGROUND FACTS

[14] A summary of the recent medical history and clinical course of the deceased Mr. 
C taken from the disposition letter of the College (the “Decision”) addressed to the 
Complainant reads as follows:

To briefly summarize Mr. C’s clinical history, in late December of 1999 he was referred 
to Dr. A because of severe anemia which was thought to be due to iron deficiency and 
most likely involved gastrointestinal bleeding. Your husband has been followed by a 
naturopath, a Dr. B, who had been providing him with herbal medications and elemental 
supplements. When Dr. A saw him, the husband’s hemoglobin was 57, which is 
approximately one third of what it should be. Ultimately investigations identified an 
adeno carcinoma of the cecum, which was poorly differentiated (a poor prognostic 
attribute generally). He underwent surgery for removal of the tumor and was found to 
have positive lymph nodes in the area.

Under the direction of Dr. C, Mr. C received combination chemotherapy. Dr. A performed 
follow-up colonoscopies in 2002, 2005 and 2007, which were normal, showing no 
evidence of recurrence of disease. Mr. C was considered to have been cured of his 
serious bowel cancer.

Mr. C developed gastrointestinal bleeding and attended X Hospital on April 16, 2008. His 
hemoglobin was significantly low and he received blood replacement. He subsequently 
had more bleeding evident in his stool, requiring more blood replacement. Initial 
investigation included gastroscopy which showed a small antral stomach ulcer. 
However, there was no evidence of more extensive ulcer disease.

A routine chest x-ray showed abnormalities in the hilum (the root of the lungs) with 
significant enlargement and a subsequent CT scan showed very severe enlargement of 
lymph nodes in the abdomen. This led to consideration of lymphoma being his likely 
primary diagnosis. Mr. C’s case was discussed with the Registrant on April 29th and it 
was recommended that a fine needle biopsy of one of the retroperitoneal nodes should 
be performed (the nodes at the back wall of the abdomen). This investigation showed 
cells suspicious for large cell lymphoma and a formal consultation with the Registrant 
was requested. It was the Registrant’s opinion that an open biopsy was required and 
arrangements were made for that procedure.

On May 9, 2008, Mr. C developed more significant gastrointestinal bleeding and an 
examination by the Registrant, a gastroenterologist, failed to determine the source of 
blooding.

The open biopsy was arranged for May 12, 2008 and direct examination confirmed the 
presence of massive retroperitoneal lymph node enlargement with some of the lymph 
node described as being the size of baseballs. More importantly, examination of the 
small bowel revealed areas of lymphoma deposits and it was concluded that these were 
the most likely source of recurrent bleeding.

On May 14th, Mr. C showed evidence of further intestinal bleeding. Heparin was 
discontinued. It had been started previously because of other concerns. Ultimately Mr. C
required ten units of packed red blood cells and eight units of fresh frozen plasma for blood replacement.

It was felt that the primary treatment would have to involve chemotherapy as a direct attack on the lymphoma. However, the Registrant believed that it would be appropriate to wait until a tissue diagnosis was received from the Pathology Department. Attempts were to be made to stop the bleeding by blocking the relevant circulation. An angiogram was arranged to be done at Y Hospital.

In the course of the several days that followed, there was some mild bleeding requiring further blood replacement. On May 20, 2008, pathology results were received confirming the presence of an anaplastic T-cell lymphoma, an aggressive form of cancer.

The Registrant spoke to your husband that day, in the presence of his friend. At that time, Mr. C was apparently lucid and agreed to undergo chemotherapy consisting of a combination of cyclophosphamide, vincristine, doxorubicin and prednisone, commonly known by the acronym CHOP. Your husband was informed of the significant side effects of chemotherapy, but was also informed that without chemotherapy he had no chance of surviving this very severe and advanced lymphoma. Mr. C was advised that statistically there was a modest chance of response or even long term survival with this protocol and ultimately he agreed to the treatment. You were not present for that discussion.

Chemotherapy was to have started on May 20, 2008, however, the Chemotherapy Clinic was overbooked that day. The start of the treatment was therefore postponed to the following day, May 21st.

Mr. C had been receiving intravenous cortisone and this was stopped, to be replaced by prednisone, which is also a form of cortisone. Instead, prednisone was provided orally beginning on May 20th. Mr. C was already demonstrating significant edema (fluid retention), affecting the lungs, the abdomen and the tissues beneath the skin generally, plainly visible, for example, in what you describe as “a very swollen scrotum”.

Blood clotting abnormalities had been detected prior to and during the very significant blood replacement. Consideration was given to the possibility of a pulmonary embolus (blood clot to the lungs). Pulmonary embolism is a recognized complication of advanced cancer. A CT scan was done to further elucidate this. No evidence of pulmonary embolism was found.

Fluid drawn off the chest was found to contain lymphoma cells. This explained Mr. C’s lung abnormalities.

May 21st, when the chemotherapy was started, Mr. C’s clinical status was deteriorating. There was no other option available but to initiate and continue the chemotherapy and hope that it would control the lymphoma. At that point, improvement more generally (fluid retention, lung impairment, and other significant concerns) would only be possible if treatment of the lymphoma proved effective.

The Registrant was notified of Mr. C’s condition but was not present in the hospital at that time. Mr. C had a very rapid heartbeat, was short of breath and had abdominal pain. All of these symptoms and clinical signs were present before chemotherapy was initiated. He also required supplemental oxygen.

Mr. C’s condition continued to deteriorate and he suffered a cardiorespiratory arrest and passed away the morning of May 23, 2008.
In response to the Decision, the Complainant submitted that the College had not appropriately dealt with:

(a) her allegations that the Registrant has lied on several occasions to most of the people involved in the care of her husband and had made false medical reports; and

(b) her allegation that the Registrant breached the Rules Regulations and Protocols of the Canadian Cancer Agency.

C. Statement of Points (“S OF P”) of Complainant

In her S of P the Complainant alleged the College did not have the required documentation before making their report and that there is now a cover up between the Hospital X Health Authority Patient Quality Office and Patient Records of Hospital X regarding missing documents of the Registrant.

The Complainant then meticulously in relation to the Decision reviews the 1,601 page Record and then proceeds to allege, over 11 pages, 32 errors under the headings: Reference Page, Procedure / Protocol, Error and Comments / Corrections.

Further, in relation to the Registrant and his lawyer she alleges the Record did not reflect the events as they occurred as she lists, over 28 pages, 60 errors, falsehoods and misinformation listed for correction under the headings: Reference Page, Procedure / Protocol, Description and Comments.

The substance of the Complaint’s submission appears to be is her belief her husband suffered an allergic reaction to prednisone and doxorubicin which she alleges were administered to her husband inappropriately and caused his death.

Although the application for review was only made in relation to the Registrant, it should be noted that negative allegations were also made against the following registrants: Dr. D, Dr. E, Dr. F and Dr. A. In its Decision the Inquiry Committee analyzed and commented on the respective involvement of these doctors.

D. Investigation by the College

The Complainant wrote nine letters to the College between July 22, 2010 and July 27, 2011. Copies of these letters were provided to the Registrant and Doctors A, B, C, D, E, F, G and H all of whom were requested to respond.

All of the doctors did respond and copies of those responses were forwarded to the Complainant.

Mr. C’s medical records at Hospital X were also reviewed.

The Inquiry Committee considered the nine letters from the Complainant, five responses from the lawyers of the Registrant, one response from Dr. E, two responses from Dr. D, two responses from Dr. F, one response from Dr. G, three responses from Dr. A and two responses from Dr. H.
Based on the volume and detail of responsive information provided to the Inquiry Committee, it is my view that the Inquiry Committee, which was comprised of seven medical doctors and three public members, conducted a more than adequate investigation.

E. Was the decision a reasonable decision?

Before I begin to analyze the disposition of the various allegations of the Complainant by the Inquiry Committee it should be noted that there are references by Drs. A, D and F in the Record to the attempts by the Complainant to have the cause of death changed from natural causes to accidental as this could make a difference in the insurance coverage. The belief has been expressed that this factor was a driving force behind the efforts of the Complainant.

I also reiterate as set forth in preceding paragraphs [9] to [13] above that my function is not to decide if the Inquiry Committee was right or wrong, nor to rehear the matter, but rather to determine whether the disposition fits within a range of rational outcomes supported by the evidence compiled in the course of the investigation.

I will deal with the major allegations one by one and then quote the analysis of the Inquiry Committee.

The allegation of the Complainant was that the death of Mr. C was caused by the inappropriate prescription of prednisone. The analysis of the Inquiry Committee was:

The Committee found no evidence that Mr. C suffered an allergic reaction to prednisone. His severe symptoms had clinical signs and his rapid deterioration and death were the result of rapidly progressive lymphoma which had spread extensively before it was diagnosed. The Committee found in its review that the symptoms you attribute to a “severe allergic reaction” (among them, “…rapid weight gain, mental confusion, enlarged scrotum…, and inability to sit up”) were due to lymphoma.

The allegation of the Complainant was that a CT scan had been ordered because of the administration of prednisone. The analysis of the Inquiry Committee was:

As you suggest, the CT scan which Mr. C underwent was to exclude the possibility of pulmonary embolism. It was not ordered because of any concern about the use of prednisone. It was later determined that Mr. C had lymphoma, complicated by fluid collections in his chest.

The allegation of the Complainant was that the prednisone was administered without food. The analysis of the Inquiry Committee was:

Prednisone may sometimes be irritating to the stomach lining and is therefore often given with food. However, the absence of food is not a contraindication to the use of this drug, especially in the urgent circumstances Mr. C was in. The Committee concluded that it was reasonable and appropriate to give prednisone without food in these circumstances.
The allegation of the Complainant was that her husband became allergic to latex derived from the bags containing donated blood. The analysis of the Inquiry Committee was:

The experienced physicians on the Committee respectfully concluded that this is speculation, not supported by scientific evidence. You refer to research and articles from 1913 and 1945. The Committee concluded that these are not concepts accepted in current practice.

The allegation of the Complainant was that the Registrant lied to the Patient Care Quality Review Board. The analysis of the Inquiry Committee was:

You will note from the responses that the Registrant did not submit a report to the Patient Care Quality Review Board, nor did he have conversations with them. It appears the work of the Patient Care Quality Review Board was based primarily on a review of the medical records, including consultation reports dictated at the time care was provided by the Registrant specialists.

The allegation of the Complainant was that the Registrant “creatively weaves the lies with reality to alter his world”. The analysis of the Inquiry Committee was:

Based on a review of the extensive documentation available, the Committee found that the Registrant’s responses to the College are consistent with what was documented in the medical record at the time care was provided. The Committee found no evidence of untruths in the Registrant’s responses.

The allegation of the Complainant was that her husband did not have the capacity to consent to chemotherapy. The analysis of the College was:

The Committee is satisfied that, based on advice given by the Registrant, Mr. C verbally consented to initiation of chemotherapy for the advanced lymphoma he knew he had. Given that immediate initiation of chemotherapy was Mr. C’s only hope of even short term survival, the Committee concluded that it was reasonable for Mr. C to give consent in the circumstances and appropriate for the Registrant to offer it. The Committee acknowledges that Mr. C’s friend was present during this discussion and that you were not.

The overall conclusions of the Inquiry Committee in regard to the Registrant were:

In considering the Registrant’s care of Mr. C, the Committee noted the complexity of the task facing a medical oncologist in the circumstances Mr. C was in. Your husband presented with significant gastrointestinal bleeding and signs suggesting more general illness. A diagnosis of advanced lymphoma was made quite promptly. This review found that the Registrant provided care that was reasonable and appropriate and consistent with what is expected of a medical oncologist practicing in British Columbia. Under the Registrant’s direction, the diagnosis was confirmed and staging was confidently established. There really were only two options available to Mr. C. and the Registrant - supportive care and certain early death and aggressive chemotherapy with a small prospect of some response. The Registrant maintains that is was his understanding that Mr. C chose that latter…

Having considered all of the information available, therefore, the Inquiry Committee found no basis for regulatory criticism of the care provided by the Registrant. Mr. C died
of aggressive lymphoma that was at an advanced stage at the time of diagnosis. He died of natural causes. The Committee found no indication that his death was hastened by complications of medical care.

[37] I acknowledge that I have quoted extensively from the Decision but given the allegations and given my task of determining if the Inquiry Committee has made a reasonable disposition, I consider that to be appropriate in the circumstances. I have already found that the Inquiry Committee conducted an adequate investigation. Are the responses of the Inquiry Committee to the allegations within the range of an acceptable and rational outcome that is sufficiently justified, transparent and intelligible to be sustained? Each response quoted above shows that the Inquiry Committee reached a rational conclusion – in fact, perhaps the only or the most compellingly rational conclusion – based solely on the evidence before it. In my view, after a review of the Records and the S of P’s of the parties, the result was a reasonable disposition.

V CONCLUSIONS

[38] Obviously the Complainant had a great love for her husband and her diligence is to be admired. It seems incontrovertible, however, that the clear weight of evidence as compiled in what was a thorough investigation points toward death from natural causes.

[39] For the reasons given above, I confirm the Inquiry Committee’s disposition regarding the Registrant.

[40] 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.

"J. Thomas English"

J. Thomas English, Q.C., Chair
Health Professions Review Board

June 4, 2013