DECISION NO.  2012-HPA-055(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: Michael J.B. Alexandor, Panel Chair

DATE: Conducted by way of written submissions concluding on October 23, 2012

APPEARING: For the Complainant: Self Represented

For the College: Sarah Hellmann, Counsel

For the Registrant: Self Represented

I  INTRODUCTION

[1] This complaint arises from an office consultation conducted by an orthopaedic surgeon with a patient suffering knee pain and therefore unable to work. Did the doctor provide appropriate treatment, clinically and personally, to the client? The Inquiry Committee of the College says yes. The Complainant disagrees.

II  ISSUES

[2] The two issues before the Review Board are whether the Inquiry Committee:

(a) conducted an adequate investigation of the complaint;

(b) rendered a reasonable decision, or “disposition” in the language of the Act.

III  BACKGROUND

[3] The Complainant is a female home care nurse. She slipped on wet leaves while on her way to a client’s home in November 2010. She fell hard on the right side landing on the knee in a flexed position and the right hip; and had bruised ribs as well for some time. X-rays revealed some mild osteoarthritis with the reported possibility of an impaction injury to the knee and suspected lumbar spine osteoarthritis.
In May 2011, the patient’s general practitioner referred her to an orthopaedic surgeon, the Registrant, with this introduction:

53-year-old female with few months history of right knee pain following injury-fall. Her CT scan and MRI showed Baker cyst and subchondral lesion. I have attached recent MRI for your review. The patient is unable to return to her work duties as community nurse due to severe right knee pain and sensation of pressure in her knee.

The consultation took place at the Registrant’s office on May 12, 2011 which is the only time they met. Accounts of this interaction differ markedly and led to a letter of complaint to the College the next day.

The Registrant’s conduct was complained about as follows:

(a) Incorrect diagnosis given without proper examination, review of x-rays or listening to Complainant’s history;
(b) Left the room twice without explanation;
(c) Failed to provide treatment directives;
(d) Terminated the professional relationship due to lack of trust, shown the door;
(e) Advised in public area that prescription provided could be injected by another doctor, then relented with rude comment;
(f) Violated College code of ethics;
(g) Medical treatment regarded to be improper; and
(h) Complainant confused, embarrassed, sad, humiliated, abused; she was provoked to tears.

The Complainant sought an investigation by the College of this unpleasant experience in order to prevent recurrence of similar abuse and unprofessional conduct toward others.

Highlights from the Registrant’s response to the College in mid-June 2011 are:

(a) Complainant said she slipped on wet leaves, fell and sustained multiple injuries to her back, right hip and right knee;
(b) consultation was restricted to Complainant’s right knee per the referral;
(c) Complainant described her condition as a work-related injury and requested it be documented as such;
(d) completed history and physical examination followed by a review of x-rays and MRI sent with referral letter;
(e) Complainant provided with diagnosis of moderately advanced osteoarthritis (degenerative disease of joint cartilage causing pain and stiffness) and small Baker’s cyst (fluid-filled sac causing bulge and feeling of tightness behind the knee) as specified in her MRI;
(f) in response to question about etiology (causation), Registrant provided opinion that conditions were likely not caused by her accident as it takes considerable time to develop that degree of osteoarthritis. Suggested that
(a) Complainant had previously been treated for osteoarthritis and had developed over many years and that cyst was a byproduct of osteoarthritis;

(g) Complainant became agitated and confrontational stating that she did not experience any knee symptoms prior to the accident. She was adamant that her symptoms were caused by the fall;

(h) Registrant explained he was not consulted to determine causality but rather to provide diagnosis and recommendations for treatment;

(i) Complainant fixated on attributing symptoms to accident and wanted Registrant to document such and that she was unable to work due to her pain;

(j) Registrant explained that issue of causality would be better addressed by her lawyer;

(k) Registrant refused to support her claim as requested in his consultation letter. Tears ensued while questioning why doctor was unwilling to help;

(l) Registrant recommended conservative management of osteoarthritis via weight loss, anti-inflammatories, unloader bracing and hyaluronic acid injections. Prescriptions provided for bracing and hyaluronic acid;

(m) Registrant recommended against surgery on the cyst due to risks;

(n) Complainant became more upset that therapeutic solutions were not recommended;

(o) Complainant returned to the issues of causality and her inability to work. Registrant reiterated that she needed to take up these issues with her lawyer and employer. Explanation of physician role given to no avail;

(p) Complainant made accusatory statements about Registrant. He dismissed her from the office. She refused to leave and continued verbal accost. The heated exchange continued in the hallway, including Registrant direction that injections could be made by another doctor; and

(q) Complainant eventually left. Registrant instructed office staff to flag file to ensure Complainant was not scheduled for appointment in the future.

[9] The Registrant concluded his response by refuting and denying all the points raised in the complaint. He has no recall about any abrupt behavior entering and leaving the room twice. The issue of causality comprised a significant portion of the time to assess and counsel the Complainant. Several efforts were made to explain and educate the Complainant that it was not his role to address causality. He repeatedly tried to educate the Complainant about her condition in terms of management but she perseverated on causality and her inability to work, requesting that he state the same in his consultation report.

[10] The Summary section of the Registrant’s consultation letter said:

[The Complainant] attributes her right knee pain to an injury sustained at work in November 2010. X-rays and MRI have identified tricompartmental osteoarthritis with no associated meniscal tears or ligamentous injury. I recommend conservative management with weight loss, anti-inflammatories, bracing and hyaluronic acid injections. [The Complainant] was more concerned about causality than management of
her osteoarthritis. She was adamant that I support her WCB claim by attributing her arthritis to her injury. I refused and she became very argumentative. She also demanded that I treat her Baker’s cyst. I recommended against surgical excision as surgery within the popliteal fossa carries inherent risks due to the proximity of the surrounding neurovascular bundle. In addition, the Baker cyst will likely recur after excision. I provided [the Complainant] with a prescription for an Unloader Brace and Durolane. She continued to be very demanding and aggressive despite multiple attempts to educate and reason with her. I will not continue with her care.

[11] On July 7, 2011 the Complainant wrote the College refuting points in the Registrant’s letter referred to in paragraphs [8] and [9] above. She expressed shock and disappointment about wild and untruthful remarks. She denied inquiring about the etiology of osteoarthritus and denies insisting on support of her WCB claim. The accusatory statements insulted her intelligence, she said. A proper physical examination was not performed by the Registrant and he made a considerable effort fabricating tests not performed. She denied accosting him verbally, felt he behaved impolitely and stood by all her statements. Lastly, she said a supervised face-to-face meeting was overdue.


[13] The Inquiry Committee reviewed all correspondence and medical records pertaining to the complaint at its meeting on November 21, 2011. The Committee directed that no further action be taken pursuant to section 33(6)(a) of the Act.

[14] The disposition was communicated to the Complainant by letter dated February 3, 2012 with the following observations:

(a) the Inquiry Committee did not accept the contentions that the Registrant failed to perform an appropriate history-taking, did not review the medical records and did not perform a physical examination. The consultation report outlines a full consultation;

(b) the conduct issues raised were at variance between Complainant and Registrant. The leaving and re-entering the examination room were noted as “difficult to explain”;

(c) the Committee accepted that it was not necessary for the Registrant to ask if pain was experienced during the physical examination because the reaction was screaming and pulling away, and such reactions did not require verbal confirmation;

(d) it was clear to the Inquiry Committee that the Complainant disagreed with the Registrant’s assessment that osteoarthritis (and not rheumatoid arthritis, as the Complainant said in her complaint) was contributing to pain and that the progression of the Baker’s cyst was not a result of the fall;

(e) The option of securing a second opinion from another qualified surgeon for a contrary assessment was flagged; which, in concert with legal advice, could challenge the Registrant opinion in a WCB application;

(f) The Inquiry Committee accepted the Registrant’s decision to end the doctor/patient relationship. An impasse arose when the Complainant insisted the pain resulted solely from the fall and the Registrant disagreed. Based on
the differences in opinion regarding symptom review and diagnosis, the Inquiry Committee accepted it would not have been possible for the Registrant to continue treating a condition the Complainant did not recognize; and

(g) The Inquiry Committee concluded that none of the issues raised in the complaint could be substantiated by the evidence before them and directed no further action be taken.

[15] On February 29, 2012, the Complainant applied to the Review Board for review of the College disposition. Reasons allege the College was biased in favor of the Registrant by ignoring the improper behaviour of the Registrant who was abrupt and rude by leaving and re-entering the examination room. The Complainant felt ignored and humiliated from complete dismissal by the College. For relief, the Complainant is “seeking the truth” behind this encounter with the Registrant.

[16] The application was accompanied by a second opinion from another orthopaedic surgeon and Registrant ratings of the Registrant from the RateMDs.com website.

[17] The second opinion included two reports. The first is a consultation report to the Complainant’s GP which stated X-ray and MRI findings show “some evidence of degenerative changes and/or spontaneous osteonecrosis of the knee. However, the onset of symptoms and severity of the symptoms certainly was aggravated by her fall”. Arthroscopy was recommended as the best way to progress…“seen as another imaging test to review the knee and potentially allow for some therapeutic improvement if, for example, there are findings such as meniscal tear or loose body, etc. which might lead to improvement if treated appropriately.” The Complainant was eager to proceed with surgery, the report stated.

[18] Arthroscopic surgery was performed by the second orthopaedic surgeon in June 2012. The meniscus did not have a specific tear but some waviness was evident and a small portion resected, followed by debridement. No new findings were noticed.

IV SUBMISSIONS OF THE PARTIES

A. Complainant

[19] The Complainant reiterates College bias and she regrets no face-to-face meeting was arranged. She notes that the College may say the Registrant is professional and competent but, not being present, they cannot state he acted in a professional and proper manner. She disagrees with the accusation of self-diagnosis. In sum, the Complainant believes the College investigation was not adequate and the reasonableness of its decision was flawed and biased.

B. College

[20] Counsel for the College maintains that steps were taken to obtain key information for the Inquiry Committee and that the College conducted an adequate investigation. The College acknowledges that no independent evidence is available to assess the interactions of Complainant/Registrant on May 12, 2011. The College submits it cannot criticize or discipline its members where, upon thorough review, it concludes the
physician had exercised appropriate clinical judgment including the decision to terminate a relationship that had deteriorated. Accordingly, the College decision to take no further action was reasonable.

[21] Counsel also argues that the second opinion reports submitted by the Complainant in February 2012 shortly after the letter of disposition are admissible only to support the disposition commentary that the Complainant may seek an opposing medical opinion. In addition, the College gives no weight to websites such as RateMDs.com and takes the position that this is not evidence and is inadmissible for this review.

C. Registrant

[22] The Registrant reiterates the chronology of the consultation meeting recounted above. He emphasizes that standard procedures were followed at the consultation meeting, no erratic behavior was shown, conservative management was recommended without surgery, the Complainant dissatisfaction with no treatment for cyst and, most importantly, the Complainant’s strong desire for medical support for her WCB claim. The disagreements and loss of rapport, despite attempts to mitigate, provoked discontinuation of the relationship by the Registrant.

[23] The Registrant did not respond to the accusations cited in paragraph [11] above, leaving it to the Inquiry Committee to judge whether the events were conjured. He says he was confounded by the points listed and absolutely did not fabricate or lie about any statements.

[24] The Registrant commented on his colleague’s reports. He has no disagreements with the consultation, recommendations and course of treatment. He views the arthroscopy as more exploratory than therapeutic. He does not see either report lending any support to the complaints against him. He says the findings do not conflict with his and predicts similar recommendations to those the Registrant had suggested will be made in post-operative follow-ups.

[25] The Registrant regards the 27 ratings (July 2007 to March 2012) cited in RateMD.com to be a tiny and unrepresentative sampling of the average 4500 per year assessments and surgeries he has performed from 2008 to 2010.

V ANALYSIS

[26] This complaint has clinical and inter-personal components. No evidence of clinical fault, oversight, deficiency, misjudgment, error or the like has been presented to challenge or criticize the diagnosis and treatment plan recommended by the Registrant. In fact, the second opinion consultation is essentially corroborative from a medical standpoint.

[27] The inter-personal component is more complex because only two people are privy to what took place during a consultation in a medical office over 18 months ago. No independent evidence or account is available. We do know that a medical consultation derailed way off track.
It is useful to speculate on what went wrong by exploring what was important to the parties and how those interests were served in the meeting of May 12, 2011.

The Registrant had a referral mandate to assess a painful osteoarthritic knee condition and advise on treatment. He was not asked to determine causality and refrained from doing so in his consultation report.

At the consultation meeting, the Complainant sought relief from her knee pain and her inability to work since the fall six months earlier.

The Registrant’s duty to make the proper medical assessment seemed to clash with the Complainant’s needs for physical and financial relief. The ultimate unraveling of a professional relationship ensued, an unsatisfactory outcome to an apparently frustrating encounter for both individuals.

How may the complaint have been avoided or resolved? Above all, courtesy and mutual respect could have prevailed between the parties on May 12, 2011.

In retrospect, the College might have granted the Complainant’s request for a supervised face-to-face meeting in order to exchange views, educate and air differences in a calm venue. Similarly, this case was amenable to resolution by mediation but the Registrant declined.

The issue of causality is critical. The Registrant says “I concluded that [the Complainant’s] pain was predominately secondary to osteoarthritis.” This diagnosis is confirmed by the second opinion of “knee pain secondary to degenerative changes and/or spontaneous osteonecrosis of the knee.” The Registrant has no disagreement with the second opinion that “the onset of symptoms and severity of the symptoms certainly was aggravated by her fall.”

Given the above, one wonders why the Registrant did not acknowledge the aggravation or contributory influence of the fall, in the summary of his consultation report. This would not have denied that osteoarthritis and a cyst were the root causes of knee pain and swelling. This is not to suggest the Registrant, an orthopaedic surgeon, should be expected to be an expert arbiter on WCB criteria for claim evaluation or processes. However, making a correct diagnosis does not seem to preclude reporting contributory factors that could affect an insurance claim.

The Complainant denies she was adamant that the Registrant support her WCB claim by attributing her arthritis to her injury. He refused and recommended legal advice. Temperatures rose with provocation and the relationship deteriorated.

The Complainant’s alleged pre-occupation with claim support and instant treatment for a condition not seen in its evolving context was perceived by the Registrant as an unrealistic challenge to the Registrant’s professional integrity.

No new evidence is advanced by the Complainant to support her concerns (noted in paragraph [15] above) seeking reconsideration of the disposition.

The scope for remedial action by the Review Board is prescribed and limited by s. 50.6(8) of the Act to:
(a) confirming the disposition of the Inquiry Committee;
(b) directing the Inquiry Committee to make a disposition within its jurisdiction; and
(c) sending the matter back to the Inquiry Committee with directions.

VI DECISION AND CONCLUSION

[40] I am required by s.50.6(5) to review the adequacy of the investigation conducted by the Inquiry Committee and consider whether its disposition was reasonable.

[41] Key factors that are relevant for assessing the adequacy of an investigation include:

(a) Seriousness of the harm alleged;
(b) Complexity of the investigation;
(c) Availability of evidence; and
(d) Resources available to the College.

[42] All parties have made sincere efforts to reconstruct the consultation meeting. The lack of independent support is acknowledged regarding events and claims made by the only two people who attended. Sensitivities and emotions were affected. Given the relevant factors above, I am satisfied that the College conducted an adequate investigation of the complaint. The review Board has established that an investigation need not be exhaustive or perfect to be adequate.

[43] I see no substantive reasons to vary the decision of the College to take no further action. The disposition falls clearly within the range of acceptable and rational alternatives.

[44] The Inquiry Committee decision is confirmed pursuant to section 50.6(8)(a) of the Act.

“Michael J.B. Alexandor”

Michael J.B. Alexandor, Panel Chair
Health Professions Review Board

January 23, 2013