DECISION NO.  2012-HPA-087(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 COMPLAINANT

AND: The College of Physicians and Surgeons of BC COLLEGE

AND: A Physician REGISTRANT

BEFORE: Lorianna Bennett, Panel Chair REVIEW BOARD

DATE: Conducted by way of written submissions concluding on February 4, 2013

APPEARING: For the Complainant: Self-represented

For the College: Sarah Hellmann, Counsel

For the Registrant: Lindsay Johnston, Counsel

I DECISION

[1] This matter arises out of the Complainant’s elective cosmetic surgeries. The Complainant complained to the College that the surgery performed by the Registrant was painful and traumatic, that the Registrant did not provide informed consent with respect to the technique performed, and that he was displeased with the results of the procedure. After investigating, the College’s Inquiry Committee dismissed the complaints against the Registrant. The Complainant applies to the Review Board for a review of those dispositions.

II ISSUES

[2] The issues I must decide regarding this matter are:

(a) Did the Inquiry Committee adequately investigate the complaint against the Registrant?

(b) Was the Inquiry Committee’s decision to dismiss the complaint against the Registrant - its disposition - reasonable?
III BACKGROUND FACTS

[3] In 2010, the Registrant performed elective cosmetic procedure, namely abdominoplasty and gynecomastia on the Complainant. In October 2010 and January 2011, the Registrant performed two subsequent elective revision surgeries.

[4] The Complainant’s complaint to the College is dated March 8, 2011 and is in relation to the third elective surgery. The third surgery was performed under local anesthesia (“LA”). Further, the Registrant performed it free of charge as the previous two surgeries had not achieved the desired outcome of “a flat chest with no overhang”.

[5] The complaint includes a very detailed recollection of the Complainant’s surgical experience which he described as painful and traumatic. The Complainant says he did not feel he had a choice in terms of the LA, and he is upset that the Registrant went ahead with the surgery knowing that the Complainant was feeling a lot of pain and in much discomfort.

[6] By way of a letter dated May 13, 2011, the Complainant added two more complaints to his file. He alleges that his belly button is approximately 1 cm off centre to the left. The Complainant says that the Registrant had said that he would correct that in the third surgery but he did not do so.

[7] Additionally, the Complainant complains that he feels that he was not given choices throughout his surgical experience in so far as his desire to end up with a “flat chest” appearance.

[8] Despite these last two concerns, the major issue in this complaint is undoubtedly the allegation that, based on the Complainant’s description, the LA provided by the Registrant was not fully effective.

[9] In response, the Registrant says that the anesthetic was effective the majority of the time, and that the Complainant’s description of what occurred during the surgery is inconsistent with the Registrant’s medical OR information and what was described by his assisting nurses. The Registrant adds that had the Complainant actually exhibited the signs and symptoms that the Complainant described, he would have stopped the procedure.

[10] Further, the Registrant says that at no time during the procedure did the Complainant ask that the surgery be discontinued nor did he mention his discomfort.

[11] The Inquiry Committee investigated the complaint and concluded that no further action was necessary.

[12] In his application for review dated April 12, 2012, the Complainant explains that not only did he experience severe pain throughout the surgery, but that the Registrant continued the surgery knowing that the Complainant was in pain. Further, he says that he is dissatisfied with the results of his surgery.

[13] In his application, the Complainant challenges the adequacy of the Inquiry Committee’s investigation. More specifically, he says:
...Several facts were not pointed out in this review. First: there were two nurses present during the surgery; why wasn’t the second nurse spoken to? Second: I signed a consent form for videotaping; did anyone see that?...

[14] In terms of the College disposition, the Complainant alleges it was unreasonable. In terms of specific relief sought, he asks that the Registrant be held accountable. He says:

...I suffered, I was traumatized. [Registrant] should not have proceeded with the surgery. Also, as I am not satisfied with my surgery results, I would like that to be rectified. However, because of the last surgery, I am not comfortable with [Registrant].

[15] Both the College and the Registrant take the position that the College investigation was adequate and the disposition reasonable.

IV ROLE OF THE REVIEW BOARD

[16] The Review Board’s powers on a review are set out in s.50.6(8) of the Act which states that the Review Board may do one of the following on completion of a review of an Inquiry Committee disposition:

(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.

[17] 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.

[18] The scope of the Review Board’s jurisdiction is set out in s.50.6(5) of the Act which reads:

(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; and
(b) the reasonableness of the disposition.

[19] The Review Board’s limitations as set out in s.50.6(5), together with the limited remedies available by the Review Board, are clearly set out for all parties in the Review Board’s letter dated November 19, 2012.

V ADEQUACY OF THE INVESTIGATION

[20] 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 assess the particular complaint. (Review Board Decision No. 2011-HPA-0036(b)).

[21] It is not the role of the Review Board to reinvestigate the complaint or to substitute its decision for that of the Inquiry Committee.

[22] 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.

[23] 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. In other words, I will consider:

(a) Has the College conducted an investigation with an appropriate degree of due diligence whereby the College has considered and attempted to obtain evidence from the Registrant that is the subject of the complaint?

(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 Registrant and the particular complaint?

VI ADEQUACY OF THE INVESTIGATION

[24] In addition to his letter of complaint dated March 8, 2011, the Complainant provided the College with the following information:

(a) Letter from his mother dated March 8, 2011;
(b) Copy of his email to the Registrant dated February 22, 2011;
(c) Copy of Registrant’s emailed response dated February 23, 2011;
(d) Copy of email to the Registrant dated March 3, 2011.

[25] The Complainant’s letter of complaint dated March 8, 2011 contains several comments which suggest avenues of possible investigation:

...I sign several consent forms: one for pictures and video for medical purposes, another for allowing medical students to come and watch and a third about the operation...

...They put the curtain up to my face...

...The doctor said to one of the nurses that it is too bad the anaesthesiologist had already left. He said that he had used all the freezing that he could use and so he asked the nurse to rub my chest vigorously...
...Once he started to work on me, I tried to focus on my breathing as much as possible, since there were parts of my chest that were not numb. I started cringing and taking deep breaths as I could feel the knife cutting me. The pain would increase and my entire body would clench, clenching hands, raising my legs and I kept trying to focus on breathing. Soon after they started asking me if it hurt and I said yes. I was just to tell them as I kept saying it hurt and so then he said to say if its sharp and so I said “its sharp” in one word answers. They knew I was feeling pain as the doctor started to cut me. They told me if I felt dizzy to tell them and then they would give me a cold cloth for my forehead.

...Then he did a long cut – at least it felt like that. The nurse and doctor both went completely silent and he muttered something to the nurse under his breath. They both walked away towards the counters and supplies. At that point I felt some liqueate (blood)... Then they came back and put stuff and pressure on it. They became serious on the surgery. They didn’t talk much afterwards...

...There was so much pain and discomfort...

...Around the half way point, my body was getting very stressed. My body was making dramatic movements throughout the surgery. Even my chest was moving up and down, jerking from all the pain, which also concerned me. I can’t imagine how they could cut me while my chest was jerking so much. Around midway through the surgery my entire body started to shake uncontrollably due to the pain. The nurse was to watch my face. She was literally staring at my face during the surgery for 5 to 10 minutes during the surgery.

...After I was all sewn up, the nurses had me sit up, so they could wipe down my back. They commented that there isn’t as much as they thought...

[26] I note that the Registrant’s medical OR notes confirm the Complainant’s recollection that two nurses were present during the surgery.

[27] Additionally, the record (page 26) consists of the Registrant’s handwritten notes which again confirm there were three witnesses in the OR.

[28] With respect to the presence of the two nurses, the Registrant’s emailed response of February 23, 2011 contains additional noteworthy comments:

...Our operating room staff reviewed our records from the surgical revision we did that day, in light of your concerns! Indeed, we all remember “testing you” with the forceps (which is my technique) to make sure you were “frozen”, and then asked you to communicate with us. The following was determined from your OR review:

...we certainly were trying to “hear” your concerns throughout...

...through most of the procedure you said “fine” when asked if you were OK!...

...the nurses present in the room with me do not recall you expressing that you were in the kind of pain your description would suggest, nor do I...

...FYI: the standard of having two OR nurses...and a fully manned OR is NOT typical for smaller procedures done under LA. It is well above College Standards, but it is the way we choose to do things!
...I can assure you that the staff are disappointed your experience was as you describe it, and are surprised with the description of it...

[29] I indicate these comments are “noteworthy” because they suggest an obvious avenue of investigation: the OR nurses.

[30] According to the Complainant, one of the nurses stood at his head above the curtain and appeared to be tasked with watching the Complainant’s facial expressions. The second nurse, presumably, was on the other side of the curtain and/or assisting the Registrant.

[31] According to the Registrant, it is his standard practice although not required, to have two OR nurses present for smaller procedures done under LA. Although he does not state his reasons for doing this, one can infer that it is done for the purpose of additional OR assistance which would be extremely beneficial particularly if problems arise.

[32] It stands to reason then that both of the OR nurses would be interviewed as part of the investigative process, given the gravity of the Complainant’s description of the pain and trauma he allegedly endured, and given the Registrant’s own description of what “the nurses” do or do not recall. Yet, the College Inquiry Committee interviewed only one of the two nurses.

[33] It further stands to reason that if the Complainant signed a consent to videotape form, and such a video does exist, that the video would also be requested and viewed by the College as part of its investigative process.

[34] The College, in its submissions, acknowledges these potential avenues of investigation and says:

It is further submitted that it would be unreasonable for the Review Board to require the College to pursue lines of investigation where there is no basis for thinking those liens [sic] will bear fruit. The complainant has raised questions as to why a second nurse was not interviewed and whether anyone has reviewed a video of the procedure. It is respectfully submitted that this was not necessary for the College to fulfill its obligation to perform an adequate investigation, particularly where the operative report, Registrant, and the nurse he identified as his assistant, were consistent in demonstrating that the local anaesthesia was effective, and that the patient did not experience involuntary symptoms of severe distress. As noted, an investigation need not be exhaustive in order to be adequate.

[35] While the College is not required to conduct a perfect investigation, it is required to conduct an adequate investigation that is sensible in the circumstances. Reasonable steps must be taken to obtain key information that may affect the Inquiry Committee’s assessment of the complaint, and the degree of the investigation that is considered adequate is commensurate with the nature of the complaint. As stated in Review Board Decision No. 2009-HPA-0001(a)-0004(a) (supra) at para [98]:

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

[36] In Review Board Decision No. 2010-HPA-G06, the Review Board again emphasized the importance of considering relevant collateral sources.

[37] In this case, the College appears to have made no efforts whatsoever to investigate the second OR nurse or to request and review the video of the surgery. In consideration of the seriousness of the harm alleged, the availability of the evidence and the resources available to the College to obtain this evidence, the College should have investigated these two relevant sources.

[38] The video alone, if one exists, will speak volumes as to whether the Complainant in fact demonstrated the behavioural symptoms he describes.

[39] The evidence of the second OR nurse is also key, particularly as she appeared to have been on the other (body) side of the curtain assisting the Registrant. Again, I reiterate the Registrant’s own words that, although not required, it is his practice to have a second OR nurse in the surgery room. Presumably he has good reasons for doing this, one of which may be so that he has an additional witness who can verify events should difficulties occur or be alleged to occur in his OR.

[40] Yet, counsel for the College suggests that it would be unreasonable for the College to be required to pursue these lines of investigation where there is no basis for thinking those lines will “bear fruit”. I could not disagree more. If the surgery proceeded as the Registrant says it did, these additional lines of investigation will undoubtedly reflect that. Likewise, if there is merit to the Complainant’s complaints, the additional lines of investigation will reflect that also.

[41] The College disposition letter dated March 16, 2012 summarizes the complaint and the Registrant’s response, and provides a conclusion. It does not, however, outline the various steps taken by the College during its investigative process.

[42] Nonetheless, the record shows that the information obtained by the College Inquiry Committee consisted of various correspondence between the Registrant and Complainant, medical OR notes, and an interview with one of the two nurses present. The College and the Registrant confirm these steps in their written submissions.

[43] While it was certainly reasonable for the College to investigate all of the identified sources, the College’s investigation fell short of considering two additional key sources of information that appear to be readily available. Accordingly, I find the investigation into the complaint was inadequate.

[44] In the circumstances, there is no need to consider whether the disposition of the complaint was reasonable. I direct the matter back to the Inquiry Committee for further investigation with respect to the allegations.
VII ORDER

[45] For the reasons given above, I remit the complaint back to the Inquiry Committee to adequately investigate the complaint against the Registrant, and in particular to expeditiously request and consider any video evidence from the surgery together with the evidence from the second OR nurse.

[46] I further direct that upon completion of the investigation set out in paragraph [37], and if applicable, paragraph [38], any supplementary information obtained be sent to the Complainant and the Registrant for consideration.

[47] 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

May 1, 2013