DECISION NO.  2012-HPA-205(b)

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: Colleen Cattell, Q.C., Panel Chair

DATE: Conducted by way of written submissions concluding on April 30, 2014

APPEARING: For the Complainant: Harkamal Rai, Counsel

I STAGE 1 HEARING

[1] This review of the Inquiry Committee’s disposition was based solely on the record of investigation provided by the College and submissions received from the Complainant.

II INTRODUCTION

[2] The complaint in this matter arises out of neurosurgery performed on the Complainant’s neck. The complaint concerns surgical care and conduct, and includes allegations of financial exploitation, breach of pre-operative standard of care, non-disclosure and lack of consent, failure to manage patient care, and not conducting appropriate tests.

III BACKGROUND

[3] The history to this matter is somewhat lengthy. The neck surgery which is the subject of this complaint took place on May 31, 2010. The Complainant was then 56 years old. Prior to that he had suffered from progressive neck and upper limb pain for a number of years. Conservative treatment had not resolved his symptoms.

[4] The Complainant has had a number of surgical interventions on his neck. The first disc surgery took place on April 28, 2010 at a different facility and with a different surgeon
It was followed a month later by the May 31st surgery performed by the Registrant. Two further surgeries took place afterwards, on September 8, 2010 (another surgery by Surgeon No. 1) and on April 30, 2013 (in Germany). The three British Columbia surgeries took place in private medical facilities, including the surgery giving rise to the complaint.

The Complainant’s path through these surgeries started with an MRI scan of his cervical spine in February 2010. It showed cervical spondylosis. According to Surgeon No. 1’s reports, the scan revealed a disc osteophyte complex at the C3-4 level but no cord compression or definite nerve root impingement at that level. There was a large osteophyte complex at the C5-6 level, with marked compression of the thecal sac, spinal stenosis and left nerve root impingement.

Surgeon No. 1 did not think that the C3-4 level was symptomatic, and advised the Complainant that surgery at C3-4 was not indicated or recommended. He suggested an anterior discectomy at C5-6, removal of osteophytes and fusion using vertical spacers. That surgery was carried out on April 28, 2010.

Surgeon No. 1 says that the Complainant asked him to perform surgery at the C3-4 level when he first saw him on April 14, 2010. He relates that the Complainant was fixated on the point that the C3-4 osteophyte was not good for him and he wanted to have it removed. He asked Surgeon No. 1 to do so a few times before and after the surgery, and was turned down on multiple occasions. Surgeon No. 1 told the Complainant that it was technically difficult to remove the osteophytes high up at the C3-4 level; the gain would be minimal and the risk was too high.

In the result, some two weeks after the C5-6 surgery the Complainant turned to a medical broker he found on the internet to locate a surgeon who would carry out a C3-4 cervical discectomy/fusion (“ACDF”) with osteophyte removal. He was told that could be facilitated immediately, with a neurosurgeon who is “amazingly talented” and the statement that “if anyone can fix your spinal problem, he can”. A number of email communications with the broker followed and the surgery was scheduled for May 31, 2010. Key to the complaint is that the Complainant felt he had communicated clearly that the osteophyte removal was an integral part of what he was seeking.

There were also discussions about price. The fee quoted was $13,800, some $5,100 more than what the Complainant had paid for the C5-6 ACDF with osteophyte clean-up with Surgeon No. 1.

All of the communications prior to the surgery date were with the broker. The Complainant did not actually meet or communicate directly with the Registrant until a consultation on the morning of May 31st immediately before the surgery. The Complainant says that he discussed the osteophyte clean up with the Registrant at that time.

The Registrant did not remove the osteophytes. The post-operative report made no mention of osteophyte clean up. On July 30, 2010 the Complainant had a CT scan which confirmed that the osteophytes were not removed.
When the Complainant followed up with the Registrant by phone and email, he was told that the Registrant does not take osteophytes off with the fusions he performs, and had not said that he would do so in this case. In the Registrant’s view osteophytes themselves are not a problem, particularly in a fused setting, and in the Complainant’s case removing them was completely unnecessary.

The scan also disclosed an issue with the placement of one of the screws of the anterior fusion at the C3 level. It was positioned lateral to the vertebral body and not through it. The Registrant noted that the Complainant’s surgery was very difficult given the scarring from the previous surgeries on his neck and scar tissue. At an earlier stage he had both left and right parotidectomy surgeries for chronic infections and a tonsillectomy. With respect to the screw placement, the Registrant did not believe that the screw placement was a problem, as the screw was up against the plate. The surgery was effective in the view of the Registrant in that the Complainant’s pain had been relieved.

Another aspect of the complaint is that immediately after the operation the Complainant had felt that something was not right and requested an x-ray. No x-ray was taken.

At the same time he was following up with the Registrant, the Complainant consulted Surgeon No. 1 again, complaining of right neck and shoulder pain. Surgeon No. 1’s report of September 29, 2010 was attached to the complaint. He was of the view that the Registrant should have ordered a CT or MRI scan before the May 31, 2010 surgery, and that it would have shown that the pain originated from a residual osteophyte on the right at the C5-6 level, not C3-4. In his opinion the May 31st surgery should have been performed at C5-6 and not C3-4. He was also very critical of the plate and screw positioning, referring repeatedly to the upper left screw being “in thin air”. Although it was a locking screw he saw a potentially life threatening risk, though small, of a nick to the vertebral or carotid artery if the Complainant were to be involved in any kind of injury like a motor vehicle accident.

On September 8, 2010 the Complainant underwent an ACDF at C5-6 with Surgeon No. 1 which included resection of the osteophyte on the right.

The Complainant also sought a referral from the Registrant to another neurosurgeon who could provide an opinion on the stability of the plate and the screw. That examination took place on October 26, 2010. According to that report, the Complainant complained of neck discomfort and insisted on having the plate removed because he had been told there was significant risk of arterial injury. The neurosurgeon suspected the pain was primarily myofascial, and reassured the Complainant that the screw did not contact an artery, and that current plating systems prevent the screw backing out. He recommended against further surgery as it would not improve his neck discomfort and carried significant risk to either the esophagus or the pharynx. He asked one of his colleagues to also look at the scan, and the colleague agreed that the C3-4 plate would be best left alone.
[18] In his complaint to the College made on March 21, 2011 the Complainant says he would not have proceeded with the surgery on May 31st if he had known that the osteophytes would not be removed. He alleged breach of trust arising from this non-disclosure, and exploitation for personal financial advantage, describing what happened as a “bait and switch”. He also alleged a breach in the post-operative standard of care as no follow up visits were scheduled. Further to his consultation with Surgeon No. 1 he was of the view that the Registrant should have ordered a CT or MRI scan before the surgery. He also complained of a breach by the attending anesthesiologist for not conducting a post-surgery x-ray when requested by the Complainant.

[19] In his review application the Complainant has submitted as additional evidence a medical report and a surgery report from his surgery in Europe which took place on April 30, 2013. They show that he underwent a discectomy at level C4-5 and C6-7 with artificial disc replacement, and also a reposition and refusion at C3-4 including a “discectomy and osteophyte complex removal affecting spinal canal and impinging neural structures in the central canal and both foramina”.

IV   JURISDICTION

[20] Section 50.6(5) of the Act sets out the scope of review by the Review Board:

(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 complainant;

(b) the reasonableness of the disposition.

[21] Section 50.6 (6) sets out that the review is a review on the record. The Review Board may, however, consider additional evidence under s. 50.6 (7):

(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.

[22] The Complainant has submitted additional evidence, including an affidavit from his friend who was present for the consultation with the Registrant on the day of the surgery, two reports from his subsequent surgery in Germany, and a further letter from Surgeon No 1. I have reviewed the additional evidence submitted for the purpose of determining whether the Inquiry Committee’s investigation was adequate.

[23] The Review Board’s powers on a review are limited. Pursuant to s. 50.6(8) of the Act the Review Board may do one of the following on completion of a review of an Inquiry Committee disposition:

(a) confirm the disposition of the inquiry committee;

(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 for reconsideration with directions.

V THE INVESTIGATION AND DISPOSITION

[24] The investigation in this matter took some time. The College received the complaint on March 23, 2011. The disposition is dated August 20, 2012. In early December 2011 the College and the Complainant communicated regarding timing as the Act permits the College a maximum of 255 days to conclude the investigation. At that point the Inquiry Committee was in the process of retaining an independent expert, and the Complainant provided his verbal consent to continue with the investigation. On October 11, 2012 the Complainant filed an Application for Review of an Inquiry Committee Disposition. The Review Board also accepted an Application for Review of a Delayed Investigation. Where there is a delayed investigation, the Review Board may under s. 50.58 (1) direct that the Inquiry Committee complete the investigation. As the disposition had already been made prior to the Complainant’s Application for Review of a Delayed Investigation that order is not necessary and the Complainant’s application for review in that regard is dismissed.

[25] The complaint is 110 pages long with attachments, and includes a number of medical records and an article on fraud. On May 12, 2011 the Inquiry Committee wrote to the Registrant as well as the anesthesiologist who were the subjects of the complaint, and also sought records from the medical facility where the surgery was performed, Surgeon No. 1, and the provider of a MRI report dated October 25, 2010.

[26] By mid-July 2011 the Inquiry Committee had received all of the requested records and responses, and on July 27, 2011 those responses were provided to the Complainant.

[27] The Registrant’s response was detailed and lengthy. He set out his position that osteophyte removal, in the opinion of many experts, is not indicated unless it can be shown that the osteophyte is pressing on the nerve root. The removal itself can cause problems and complications, and in this case he saw no reason to remove them. He had no recollection of any discussion about osteophyte removal.

[28] The Registrant was not aware until seeing the scan of July 30, 2010 that the plate was off centre and one of the screws was misplaced. He maintained that while it was not ideal there was sufficient stabilization, and further surgery should be avoided. He noted that the Complainant had received the second opinion in October 2010 to the same effect.

[29] The complaint attached the September 29, 2010 report of Surgeon No. 1. In response the Registrant obtained an expert report from a neurosurgeon who had not been involved in the Complainant’s treatment. The Inquiry Committee received that report on August 5, 2011.

[30] The Inquiry Committee then took steps to locate an independent expert medical reviewer. He was provided with the report from Surgeon No. 1 attached to the complaint, Surgeon No. 1’s response to the Inquiry Committee, and the report of the expert retained
by the Registrant. The reviewer delivered his independent expert opinion on December 26, 2011.

[31] The reviewer found that the Registrant’s management did just meet expected standards. The reviewer believed that the procedure was the appropriate one in the circumstances, the position of the errant screw did not affect the clinical outcome, and that removal of the osteophytes was not indicated. In his opinion updated imaging should have been done before the operation, and the surgery should not have been done on the same day as the consultation. He was also critical that the operative report was not sufficiently detailed, and stated that an x-ray should have been taken during the operation after the plate was secured.

[32] The Inquiry Committee reviewed the expert opinion at its meeting of January 16, 2012 and identified a number of preliminary concerns. It directed that the Registrant be advised of the concerns and given the opportunity to respond to the expert opinion. The report (with the identity of the reviewer removed) and the Committee’s concerns were provided to the Registrant on April 5, 2012, together with a request that he attend for an interview.

[33] The Inquiry Committee’s concerns were:

(a) It did not appear that conservative measures had been adequately considered or offered as an alternative to surgery;

(b) The consultation and surgery took place on the same day;

(c) There were serious communication issues. The Complainant appeared to harbor important misperceptions about spinal surgery and apparently gave consent based on unrealistic expectations, which should have been managed more effectively;

(d) Imaging was not updated prior to the decision to proceed with surgery;

(e) Whether the surgery offered any realistic prospect of relieving the Complainant’s symptoms; and

(f) The Complainant appeared to be directing his own care, which raised concerns about the Registrant’s professional judgment.

[34] The interview took place on May 24, 2012. In his interview the Registrant:

(a) confirmed that since this surgery on the Complainant he no longer does any surgery the same day as the consultation, and will not in the future. In the past this had been done primarily to accommodate out of town patients.

(b) agreed that the standard of care is to do x-rays at the end of the procedure. Although he had reviewed images using a C-arm in this instance none were recorded and retained. In the future he will always record x-rays at the conclusion of these procedures.
(c) agreed that in hindsight an argument might be made to do updated imaging prior to surgery as it is possible that anatomy may have changed, though there was no history or clinical findings indicating that was the case here.

(d) with respect to the statements made to the Complainant by the broker, confirmed that he had written to the private surgical facilities where he has privileges directing that any communication on his behalf conform with College policies.

[35] He also responded to the findings of the expert retained by the Inquiry Committee and to the issues of particular concern to the Committee. He maintained that the surgery was not patient driven. Conservative measures had been exhausted, and surgery was indicated.

[36] With respect to the broker’s statements recommending the Registrant, in his response he had indicated his intention to communicate with the broker that those types of statements are contrary to College policies. He confirmed that he had done so by telephone and would consider providing the broker with written direction.

[37] The matter came before the Inquiry Committee again on June 29, 2012. The complaint against the anesthesiologist was dismissed. There was nothing to suggest that the anesthesiologist had failed to meet accepted standards, as ordering a post-operative x-ray is up to the surgeon. It appears that no review is sought with respect to that disposition, and the Complainant notes in his annotation to the disposition letter that he included the anesthesiologist in his complaint because he would have been aware of the x-ray request to the Registrant.

[38] The Inquiry Committee’s disposition letter is 23 pages long. It also attached the independent expert opinion and a summary of the interview with the Registrant. It summarizes the complaint and the Registrant’s response, and reviews the Consultation and Operative Report, the independent expert opinion, the concerns it identified in its January 16, 2012 discussion, and the Registrant’s interview. It then sets out its analysis of the standard of care and addresses each of the Complainant’s specific allegations.

[39] In its discussion and analysis of care the Inquiry Committee, based on its review, agreed with the independent expert that the Registrant met expected standards. It was very critical, however, of a number of aspects of the communication preceding the surgery. It concluded that these resulted in large measure from what it described as “high stakes, entirely elective” surgery being performed on the same day as the assessment. The Inquiry Committee was not critical that the Registrant performed the wrong operation; its expert found that it was appropriate to the Complainant’s circumstances. Its concern was that mechanical pain is often not improved by surgery, and there was no time for the Complainant to reflect on whether surgery was the best option.

[40] The Inquiry Committee was unable to determine what was said about osteophyte clean up. There was nothing reflected in the history, the consent discussion or the consent form. It noted that the communications seemed to have been adversely affected
by the involvement of the broker. One particular letter from the Complainant dated May 13th apparently never made its way to the Registrant until long after the surgery. The Complainant takes issue with the point of time after the surgery when the Registrant did see it, but the College’s concern was that the Registrant address patient misconceptions prior to the surgery.

[41] In addressing how it was that the Registrant did not identify the Complainant’s desire for an “osteophyte clean-up” the Inquiry Committee suggested to the Registrant that that is the primary lesson to be learned, and that there is no value in having performed the right elective procedure aimed at relief of symptoms if the patient is left feeling dissatisfied.

[42] Key to the disposition of the complaint, however, is that the Inquiry Committee agreed with its expert that the removal of osteophytes was not necessary. It noted that this had been the opinion of Surgeon No. 1 as well. It was therefore specifically not critical of the Registrant for not removing the osteophytes, finding that “osteophyte clean-up” is not an accepted surgical concept and is potentially hazardous. It would be critical of a surgeon who acceded to a patient request to clean up osteophytes where there was no evidence they were causing harm. The Inquiry Committee found no evidence that the Complainant was exploited by the Registrant. The Complainant had not addressed his cost concerns with the Registrant.

[43] The Inquiry Committee was also critical of the Registrant for his decision not to update the imaging prior to the surgery and his failure to meet the standard of care when he did not obtain an x-ray post-operatively. That would have revealed the screw placement and afforded the Registrant an opportunity to explain it himself to the Complainant. But the Inquiry Committee found that the operation was successful, even with the errant screw.

[44] The Inquiry Committee specifically set out that its criticisms go to what constitutes best practice, and do not constitute failure to meet the expected standard of care from a regulatory perspective. The Inquiry Committee found nothing in its review to suggest that the Registrant is not competent or that he was negligent in the care provided. The Inquiry Committee explained that in its view the circumstances dictated a remedial solution, not disciplinary action.

[45] The Complainant’s application for review reiterates many of the points made in his original complaint and includes a copy of the disposition letter with many extensive annotations.

[46] In his Statement of Points filed subsequently in this review the Complainant identifies six issues that he requests be reviewed, summarized as follows:

a. The Surgical Procedure and Pre-Operative Imaging

The Registrant’s position on this issue was that he accepted the argument for performing updating imaging but maintained that it is a matter of clinical judgment that will vary from case to case. The Complainant submits that in finding this satisfactory the Inquiry
Committee’s disposition was unreasonable because it fails to take into serious consideration the views of the independent expert and Surgeon No. 1. The Inquiry Committee also failed to follow up with Surgeon No.1 for an explanation or an oral interview.

b. Misplacement of the Stabilization Screw

The Complainant submits that the investigation discounts Surgeon No. 1’s opinion completely. He cites the medical and surgical reports from the April 2013 operation in Germany as suggesting that the surgery performed by the Registrant was not done properly and was incomplete. He submits that the disposition was unreasonable, and that the Registrant must be held accountable for the errant screw.

c. The Consultation and Consent

The Complainant says that he was not given an opportunity to consider the surgery that would take place as the consultation was hurried and broken up. The affidavit filed in this review supports the Complainant’s evidence on this point. The Complainant’s friend who was there for the consultation, but not for the signing of the consent forms, deposes that a nurse gave the Complainant some medication and administered a blood test during the consultation while the Respondent was out of the room, and that the Complainant’s demeanor changed as he showed signs of the medication taking effect. The Complainant submits that the Inquiry Committee failed to conduct an adequate investigation into whether the Registrant was allocating sufficient time to each of his patients, and taking on too many patients, resulting in hurried consultations. He says that there was not informed consent and the Inquiry Committee failed to address this with disciplinary action and concrete remedial measures.

d. Communication between the Complainant and the Registrant

On this point the Complainant argues that the Registrant failed to identify and address an issue that was clearly raised by the Complainant. On the divergent accounts of what was discussed about the osteophytes he submits that the Inquiry Committee should have favoured the views of the Complainant. The additional affidavit evidence filed supports the Complainant’s contention that he raised the issue of osteophyte removal at the consultation, and that this issue was not addressed by the Registrant. On the Inquiry Committee’s finding that osteophytes did not play a significant role in his suffering, the Complainant asks that the Inquiry Committee consider the views of the German surgeon.

e. Post-Operative Care

The Complainant reiterates his concern that the Registrant failed to address the Complainant’s post-operative request for an x-ray. He submits that the Registrant’s commitment to do and retain x-rays at the conclusion of surgery fails to reasonably address the various criticisms of the imaging that were raised in the investigation. The independent medical expert stated that an x-ray should have been taken during the surgery after the plate was secured.

f. General Shortcomings in the Committee’s Review
The Complainant maintains that an adequate investigation required an oral interview of him to fully understand his concerns.

[47] The Complainant seeks a direction to the Inquiry Committee from this review that the Inquiry Committee: find that the Registrant has not met the standard of care, criticize his performance, and request that he commit to further remedial activities and implement further changes to his practice. In particular the Complainant asks that formal disciplinary charges be issued against the Registrant. He acknowledges that the Inquiry Committee made several criticisms of the Registrant, and that the Registrant committed to addressing them, but he argues that those commitments are not sufficient and that the disposition is therefore unreasonable.

VI ANALYSIS AND DISCUSSION

[48] As noted above, the scope of review by the Review Board is limited to reviewing the adequacy of the investigation and the reasonableness of the disposition. It is not the role of the Review Board to reinvestigate the complaint or to substitute its decision for that of the Inquiry Committee.

[49] What is considered to be an “adequate” investigation may differ from case to case and depends, among other relevant considerations, on the seriousness of the complaint. Review Board Decision No. 2009-HPA-0001(a)-0004(a) at paragraph [97] describes it this way:

A complainant is not entitled to a perfect investigation, but he or she is entitled to 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.

[50] On the approach to be taken in reviewing the reasonableness of an inquiry committee’s decision, Review Board Decision No. 2009-HPA-0001(a)-0004(a) (at paragraph [92]) draws from the direction provided by the Supreme Court of Canada in Canada (Citizenship and Immigration) v. Khosa, 2009 SCC 12 and Dunsmuir v. New Brunswick, 2008 SCC 9:

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.

[51] It follows that the Review Board cannot make findings of negligence or misconduct, nor does it have the power to sanction or discipline (Review Board Decision No. 2009-HPA-0034(a)).
As acknowledged by the Inquiry Committee, the Complainant’s disappointment with the surgery carried out by the Registrant is very clear. He was frustrated with the communication around the osteophyte removal and the fact that the osteophytes were not removed in this procedure. He reported ongoing neck pain. He has since travelled overseas for a fourth ACDF and appears from those records to have obtained a replacement of the previous spacer and screws and the osteophyte removal he was seeking.

It is also evident that the Complainant is also dissatisfied with the Inquiry Committee’s disposition of his complaint, as he believes that more should have been done to discipline the Registrant.

I will address the six specific issues that the Complainant asks be reviewed in his Statement of Points.

The Complainant submits that on pre-operative imaging the Inquiry Committee failed to take into serious consideration the views of the independent expert and Surgeon No. 1, and failed to follow up with Surgeon No. 1 for an explanation or an oral interview. He makes the same point with respect to the misplaced screw, arguing that it discounts Surgeon No. 1’s opinion completely.

It is clear from the record that the Inquiry Committee viewed the Complainant’s case as complex. It advised the Complainant of this when corresponding with him regarding the delay in the investigation. The Inquiry Committee had before it numerous expert opinions, including Surgeon No. 1’s and the expert retained by the Registrant. It then took the step of retaining its own independent expert. It interviewed the Registrant. It is clear from the disposition letter that it took Surgeon No. 1’s opinion into account.

Regarding pre-operative imaging, the Registrant in his interview accepted the argument for updating imaging, but pointed out that decisions to repeat imaging should be based on well-established clinical indications. In this case there were no such indications, and the imaging would not have affected the Registrant’s recommendation. The Inquiry Committee agreed with its expert that ideally imaging would be updated prior to the surgery, but regarded this as a matter of clinical judgment on which different surgeons might legitimately disagree. Having made that determination it was not necessary to follow up with Surgeon No. 1 for a further explanation of his opinion or an oral interview considering his views.

On the misplaced screw the Inquiry Committee concluded that it agreed with its expert and the two other surgeons the Complainant was referred to in October 2010, and that the screw and plate pose no risk and should be left alone. Here it specifically addressed the views of Surgeon No. 1. It regarded his statement that the screw was “in thin air” as misleading and found no reasonable basis for Surgeon No. 1 to be giving the Complainant such a frightening perspective.

On consultation and consent the Complainant submits that the Inquiry Committee failed to conduct an adequate investigation into whether the Registrant was allocating time
to each of his patients, and taking on too many patients, resulting in hurried consultations. In the interview report, however, it is clear that the interviewer had a detailed discussion with the Registrant regarding his approach to consultations. The Registrant explained that the same day consultation that had been done in the past was virtually always to accommodate out of town patients. The Inquiry Committee was critical of the Registrant for performing the procedure on the same day as the assessment. The outcome of the complaint is that the Registrant committed to amending his practice so surgical procedures are no longer performed on the same day as the consultation.

[60] On the communication issue regarding the Complainant’s desire to have the osteophytes removed the Inquiry Committee noted that this is yet another argument for not performing surgery on the same day as the consultation. The Registrant agreed to amend his practice in future as one of the outcomes of this complaint. The Inquiry Committee noted that it was unable to resolve the divergent accounts of what was discussed, and the Complainant has provided additional affidavit evidence supporting his contention that he specifically asked the Registrant twice about the removal of the osteophytes at the C3-4 level.

[61] The Inquiry Committee was concerned about how it was that the Registrant did not identify the Complainant’s significant desire to have an osteophyte clean-up, and noted the adverse effect of the broker involvement. But it also agreed with its expert that the surgery was appropriate to the Complainant’s circumstances, and that the removal of osteophytes was not necessary. It was specifically not critical of the Registrant for not removing the osteophytes, citing that “osteophyte clean-up” is not an accepted surgical concept and is potentially hazardous. Furthermore, it would be critical of a surgeon who acceded to a patient request to clean up osteophytes where there was no evidence they were causing harm.

[62] In the context of those conclusions it was not necessary for the Inquiry Committee to resolve the divergent accounts of what was discussed at the consultation. Decisions of this Review Board have established the inquiry Committee is not required to carry on an exhaustive fact-finding process to assess the truthfulness of one version events over another.

[63] Based on its investigation the Inquiry Committee determined that while regrettable, the risk of the communication issues which transpired here occurring again was addressed by the Registrant’s commitment to not perform surgery on the same day as the initial consultation. It was satisfied with this remedial outcome.

[64] The Complainant has provided copies of the medical and surgical reports documenting his surgery in Germany on April 13, 2013, and an additional letter from Surgeon No. 1 dated April 26, 2014. The letter describes Surgeon No. 1’s review of the Complainant’s cervical spine x-ray, which shows the resection of the posterior osteophyte at the C3-4 level, replacement of the previous spacer with 4 screws anchored between the vertebral bodies, and an artificial disc between C4-5 and C6-7. The spacer he put in C5-6 is still in place. He says that the alignment is satisfactory and there is no instability of flexion or extension.
The Complainant requests that the Inquiry Committee consider the views of the German surgeon in this matter, but the fact that subsequently another surgeon was prepared to carry out further surgery and the osteophyte removal requested by the Complainant does not bear on the adequacy of the investigation or the reasonableness of the outcome of the complaint before the Inquiry Committee. It already had contradictory opinions before it. The Inquiry Committee investigated those further by retaining its own independent expert. It concluded that osteophyte removal was not an accepted surgical concept and potentially hazardous.

The Inquiry Committee also accepted the opinion of its independent expert, the Registrant, and the specialists consulted by the Complainant in October 2010 that the C3-4 plate would be best left alone. I note that in Surgeon No. 1’s May 23, 2011 response to the Inquiry Committee he refers to the Registrant obtaining yet another opinion to try and get the screw and plate removed and that this was turned down. Surgeon No. 1 was also not sure what the best solution was for the Registrant’s situation. The information that the Complainant subsequently chose to undergo further surgery indicates that another surgeon was prepared to carry out a further procedure, but does not resolve the conflict in the opinions.

The Inquiry Committee acknowledged that while it does not share or agree with it, it respects the Complainant’s conviction that specific surgical interventions will help. The Inquiry Committee concluded on the basis of its comprehensive review that the Registrant offered the only operation justified in the circumstances. He documented having informed the Complainant that benefit could not be guaranteed, and notwithstanding the screw and failure to obtain x-rays after the surgery, was found to have performed the surgery to acceptable standards. The acceptable standards are those in effect at the time of the Inquiry Committee’s investigation and in this jurisdiction.

On the issue of post-operative care the Complainant notes that both the anesthesiologist and the witness in her affidavit confirm that he requested an x-ray. In hindsight it would have revealed the misplaced screw. While the Registrant committed to performing and retaining x-rays at the conclusion of this kind of surgery, the Complainant submits that the Registrant did not address the independent expert’s opinion regarding taking x-rays during surgery. The expert commented that a lateral x-ray is typically performed during the operation to confirm appropriate plate positioning, but this is usually only a lateral view which in this situation would not have identified improper plate positioning. Furthermore, performance of an x-ray would not have affected the eventual clinical outcome of the procedure which in the Inquiry Committee’s view was unrelated to the positioning of the plate.

Lastly, the Complainant maintains that an adequate investigation required an oral interview of him to fully understand his concerns. I do not agree. The Complainant set out his concerns in a lengthy and detailed complaint. He was provided with all of the responses and invited to provide any new information.

The question before me on review is whether there was sufficient, relevant information available to the Inquiry Committee on which it could reasonably base its
decision. It is not necessary that the investigation be exhaustive. In my view the investigation steps carried out by the Inquiry Committee were adequate. Those steps and the results of its investigations were clearly explained in the letter disposing of the complaint. The Inquiry Committee was focused on a complex analysis of whether the Registrant met the basic standard of expected care in his assessment and treatment of the Complainant. It cogently set out its analysis of the standard of care and its rationale in accepting the remedial commitments made by the Registrant.

[71] As discussed in Review Board Decision No. 2009-HPA-0001(a)-0004(a) (at paragraph [90]), citing Canada (Citizenship and Immigration) v. Khosa, 2009 SCC 12, the reasonableness standard requires deference. It is not for reviewing bodies to substitute their own appreciation of the appropriate solution, but to determine if the outcome falls within a range of possible acceptable outcomes which are defensible in respect of the facts and the law.

[72] The Inquiry Committee’s disposition was not sufficient to satisfy the Complainant. It was, however, a reasonable and defensible outcome given all of the evidence before the Inquiry Committee.

VII ORDER

[73] 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 this Registrant.

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

“Colleen Cattell”

Colleen Cattell, Q.C., Panel Chair
Health Professions Review Board

September 17, 2014