DECISION NO. 2012-HPA-246(a); 2012-HPA-247(a)  
(Grouped File: 2013-HPA-G05)

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 and Surgeon REGISTRANT A

AND: A Physician and Surgeon REGISTRANT B

(Collectively, “Registrants A/B”)

BEFORE: Michael J.B. Alexandor, Panel Chair REVIEW BOARD

DATE: Conducted by way of written submissions concluding on September 13, 2013

APPEARING: For the Complainant: Self-represented

For the College: Sarah Hellmann, Counsel

For Registrant A: Lindsay R. Johnston, Counsel

For Registrant B: Lindsay R. Johnston, Counsel

I INTRODUCTION

[1] This complaint arises in the context of a seven month period to test for, diagnose and treat a patient’s breast cancer. Once the cancer was identified, it spread extensively and rapidly, ultimately causing the patient’s death at age 47. The patient’s husband, as Complainant, views the Registrants as responsible for delays in diagnosis and treatment during those seven months, and made his concerns known to the College by way of a formal complaint. The Inquiry Committee adjudicating his complaint concluded the Registrants acted appropriately throughout, met the expected medical standard and were not responsible for a two month delay in diagnosis caused by “system issues” beyond their control. The Complainant continues to feel earlier detection and treatment would have saved his wife.
II  ISSUES

[2] The two issues before the Review Board are whether the Inquiry Committee (a) conducted an adequate investigation of the complaint and (b) rendered a reasonable decision, or “disposition” in the language of the Act.

III  BACKGROUND

[3] Following is the chronology of events over seven months beginning in February 2009.


[5] February 26, Patient visit to office of family doctor, Registrant A. Some calcification noted from test. Physical examination did not identify any palpable mass or lump in either breast, or lymph node enlargement. No family history of cancer. Diagnostic mammogram recommended and completed March 19, showing calcification in the right breast that appeared benign.

[6] April 8, Second office visit. Repeat examination demonstrated no breast lump or enlarged lymph nodes. Repeat mammogram recommended in 6 months, as advised by the radiologist.

[7] In May, Registrant A obliged written request to transfer patient records to Dr. C who had seen the patient at a walk-in clinic a few days after screening mammogram back in February. Patient was concerned because the mammogram technician felt that one breast was denser than the other. Dr. C confirmed this finding at the time but did not detect a lump and recommended waiting for the report and then following up with family doctor.

[8] May 7, Patient visit to Dr. C who noted concern about denseness of the right breast and made referral to surgeon, Registrant B.

[9] May 21, Registrant B examined patient and identified a mass in right breast. A fine needle aspiration was completed on May 28. At a follow-up visit on June 11, Registrant B explained that aspiration had not provided a diagnosis.


[12] September 9, Patient and husband informed of above findings by locum of Registrant B during office visit. The recommendation was for right mastectomy and lymph node biopsy.

[13] October 3, Despite the change in care noted in paragraph [7], the patient returned to Registrant A for a pre-operative examination. Subsequent visits occurred on October 23 following surgery and November 9 during chemotherapy. The family doctor provided support and stated he was baffled by the unusual character of the malignancy, its cause and outcome.
[14] October 6, Patient underwent mastectomy and reconstruction. An axillary lymph node dissection was done as the cancer had spread beyond the breast.

[15] October 14, patient referred to Cancer Agency and seen there on November 5 to determine what further treatment was indicated.

[16] Paragraphs [4] through [14], from initial test to surgery, consumed seven months. This is the focal period for the complaint discussed in paragraph [18].

[17] Following surgery, the patient endured cancer therapy and suffered multiple setbacks from aggressive and pervasive spread of the disease ultimately affecting her brain. She passed away in June 2011.

[18] On July 26, 2011, a letter of complaint was received by the College. The Complainant, in his distress, stated that the February 2009 evidence of calcification was not taken seriously by the family doctor and MRI /CT scans were not proposed. He is critical of the lack of medical information about the dangers of cancer and sees the delay in diagnosis allowing the disease more time to spread. He questioned how this medical negligence happened, amounting to systematic murder in his view. He seeks an investigation by the College to help ease the family suffering.

[19] The College received full written reports from Registrants A/B and Dr. C. All replies were forwarded to the Complainant.

[20] On November 22, 2011, the Complainant wrote back to the College challenging the physicians' reports. In summary, he emphasized negligence and delay in reaching a cancer diagnosis, including two months for a repeat mammogram and biopsy following suspicion of DCIS (see paragraph [11]) and another month before surgery. He felt his faith in the medical system had been betrayed, yet expressed appreciation to several other doctors who, post-operatively and belatedly, tried to save his wife.

[21] On December 2, 2011 the two Registrants were sent the Complainant’s rebuttal and invited to comment. Both replied and included patient medical records. The family doctor, Registrant A, confirmed physical examination of the patient on February 26 as documented in his clinical notes, contrary to the Complainant’s assertion of no examination on that date. The surgeon, Registrant B, pointed out that multiple investigations and image guided biopsy were required for definitive diagnosis. She stated that at no time was this investigation halted or ignored until final cytology was obtained.

[22] The Inquiry Committee met on May 28, 2012 to consider the complaint with supporting evidence from correspondence with the Complainant, Registrants A/B & Dr. C, plus patient medical records from these sources and the BC Cancer Agency. The Committee minutes commented on a) the extraordinarily aggressive nature of this cancer, b) the clinical and mammographic abnormalities evident initially did not suggest the need for urgent action and c) wait times for tests and surgery are part of our health system. The Committee was unable to conclude that these wait times impacted the outcome for the patient. In conclusion, the Committee acknowledged the Complainant’s grief and difficulty in the loss of his wife but was not critical of care provided by Registrants A/B, and directed no further action.
[23] A letter of disposition was sent to the Complainant on October 29, five months after the Committee met and 15 months after the complaint was lodged. No explanation for either delay was given.

[24] The College letter of disposition concluded that the patient’s death was attributable to her aggressive cancer and not to any diagnostic delay or mismanagement by Registrants A/B. Both physicians were judged to have met the expected medical standard, scans were not medically indicated and that the multiple steps required to arrive at a diagnosis were necessary, timely and not avoidable.

[25] The Inquiry Committee also agreed that the two-month delay at hospital for a repeat mammography and biopsy “was not ideal” in the circumstances. The disposition noted that “such diagnostic delays are intrinsic in our publicly funded health care system and largely outside the control of individual physicians, in this case Registrants A/B.” It was also observed “that had the test been completed in a few weeks instead of two months, it was almost certain that the patient result would have been the same”. The Committee did not feel this diagnostic delay worsened the prognosis and offered no criticism of Registrant B in this regard.

[26] An amended application for review of the disposition decision was received on December 4. The Complainant felt his concerns mainly about the 7-month diagnostic delay were ignored and that the Registrants were negligent in not acting properly or with urgency. He believes that these doctors are accountable for their delays and mistakes. He seeks review by the Review Board to produce a brighter future for other patients.

IV SUBMISSIONS OF THE PARTIES

[27] The Complainant reiterates strong disagreement with the decision based on a reprise of reasons stated before: case treated lightly, no physical examination in February, inattention to signs of calcification, no scans, slow seven-month process of detection, no sense of urgency, lack of professionalism. Above all, he disagrees that proper and fair treatment was given to his wife by the Registrants in a timely manner. His embittered rebuttal to the statements of points (below) presents no new evidence, alleges that the Inquiry Committee disposition “did not address an iota of my concerns” and expresses strong disagreement with College adequacy of investigation and reasonableness of decision.

[28] Counsel for the College argues that the investigation of the complaint was adequate and the disposition reasonable, relying on reasons cited in the disposition letter. These include complete patient records from three treating physicians, their written reports and a transparent process of correspondence exchange. All this data was discussed and evaluated by a committee of seven doctors and three public representatives. After due consideration, the Inquiry Committee dismissed the complaint pursuant to section 33(6)(a) of the Act.

[29] Counsel for Registrants A/B holds similar views and sheds more light on the June/August 2009 period. The fine needle aspiration ordered by Registrant B was not definitive, per the pathology report. “The slides are hypocellular and are considered technically nondiagnostic. There is a small amount of proteinaceous fluid present. If this mass remains a clinical concern, a surgically directed biopsy is recommended”. As a result, Registrant B requisitioned on June 17 a second opinion from the hospital if an image guided biopsy would be indicated. Due to hospital concern about calcification and
possible “widespread DCIS” on July 3, this led to a repeat mammography with a stereotactic core biopsy at the hospital on September 2 which showed infiltrating carcinoma with mixed lobular and ductal features.

V ANALYSIS

[30] Medical diagnosis is clearly a demanding discipline built on expertise and evidence-based science. Proof and accuracy are pre-requisites to be confident in the right next steps. The correct identification of malignant cells, cytology, is a complex, time-consuming process intolerant of mistakes. Lay people not trained in medical science can become frustrated by the changing dynamics of cell development/manifestation and impatient with the necessary steps leading to proof. The metastases of this aggressive cancer became all too apparent following the period of this complaint.

[31] The time necessary to follow diagnostic protocols and reach an irrefutable conclusion is the essence of this complaint. It took seven months from screening mammography to surgery. The Inquiry Committee reviewed the time period and the delays, and they identified those medical practices controlled directly by the target of the complaint, the Registrants, and those practices not controlled by them.

[32] Based on careful review of a copious Record of 250 pages, I conclude the investigation of the Inquiry Committee was complete and adequate. It is also evident that the College had an adequate foundation for concluding that Registrants A/B met the appropriate medical standard during their five months of direct responsibility. No contrary medical evidence was presented to the Inquiry Committee.

[33] Many of the Complainant’s arguments are not supported by the evidence, yet his frustration and grief are clear. Given the investigation and resulting findings about these Registrants, the decision by the Inquiry Committee to take no further action against them is reasonable.

VI A NON-JURISDICTIONAL OBSERVATION

[34] As I read the Record, I am struck by the goodwill, trust and positive attitude shown by the deceased toward all her care givers, despite major afflictions - and the heartbreak, indeed anger, her loss brings to her husband and family. As noted earlier in this decision, the Complainant is motivated at least in part by a desire to produce a brighter future for other patients; this is a concern frequently expressed by persons seeking reviews before the Review Board.

[35] The Review Board has specific and limited remedial jurisdiction that is defined in Part 4.2 of the Act. As a member of the Review Board I am not at liberty to impose my views on matters beyond assessment of the adequacy of a College complaint investigation, and the reasonableness of the resulting disposition. The Act also provides authority to the Review Board to develop and publish guidelines for the purpose of assisting Colleges to establish and employ registration, inquiry and discipline procedures that are transparent, objective, impartial and fair. The Review Board possesses no authority, nor does it possess the expertise, to provide direction in matters of medical administration.
The College in turn possesses a limited jurisdiction focused upon the competency and conduct of its members; its primary duty under section 16(1) of the Act is to serve and protect the public, and to exercise its powers and discharge its responsibilities under all enactments in the public interest. Section 16(2)(k) also provides that Colleges are to promote and enhance collaborative relations with other colleges, with regional health boards, and with “other entities in the Provincial health system.” I take this as providing at least tangential authority for the College to make its voice heard where in the course of its investigative work it comes upon circumstances suggestive of systemic deficiencies. The College, made up of knowledgeable practitioners in the medical community, possesses the collective expertise to provide commentary and guidance in matters of both clinical practice and medical administration.

The so-called “system issues” flagged by the Inquiry Committee are an important and troubling matter left unresolved. This refers to the two month period during July/August 2009 when the hospital controlled the patient treatment agenda with a mammography image review and repeat mammogram, followed by a biopsy in another month. No investigation was undertaken by the Committee about this admitted delay in cancer diagnosis, characterized as intrinsic to the system. The disposition asserts the delay did not worsen the prognosis and was not determinative of the ultimate patient result. Assuming this assessment is true, it is a statement made in hindsight about the characteristics of this particular patient’s disease, and does nothing to answer the important public policy question of who takes responsibility to address such issues with the hospital. Merely noting that such deficiencies are beyond Registrant control does nothing to promote examination of possible systemic failures in the public health system.

I make this observation as a courtesy to the parties in the public interest that I believe is shared by all persons and organizations that make up our health care system. I am aware that I am doing nothing more than reminding the College of the scope of its mandate and its potential to be a force for good by identifying potentially lethal gaps in this system, and making informed proposals to remedy those deficiencies.

**VII CONCLUSION AND DECISION**

I am satisfied that the College obtained and assessed sufficient information to conduct an adequate investigation of the complaint against Registrants A/B. Similarly, I agree with the College decision to take no further action against these physicians. Based on the Record, this decision is justified, transparent, and intelligible.

I confirm the disposition made by the Inquiry Committee pursuant to 50.6(8)(a).

“Michael J.B. Alexandor”
Michael J.B. Alexandor, Panel Chair
Health Professions Review Board
December 9, 2013