DECISION NO. 2012-HPA-250(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

COMPtAINANT

AND: The College of Physicians and Surgeons of BC

COLLEGE

AND: A Physician

nEGISTANT

BEFORE: John H. O’Fee, Panel Chair

REVw BOARD

DATE: Conducted by way of written submissions concluding on August 6, 2013

APPEARING: For the Complainant: Self-represented

For the College: Sarah Hellmann, Counsel

For the Registrant: Lindsay R. Johnston, Counsel

I INTRODUCTION AND BACKGROUND

[1] The Complainant applied under s. 50.6 of the Act to review a November 13, 2012 disposition of the Registrar concluded under s. 32(3)(c) of the Act and communicated to her by a letter signed by a physician on behalf of the Inquiry Committee (the “Committee”).

[2] The Complainant asserts that the Registrant failed to meet a proper standard of care in performing gall bladder surgery on the Complainant and that this failure to provide adequate care continued through the post-operative period and the subsequent complications that arose after the surgery was performed. The specifics of the initial complaint can be summarized as follows:

(a) The Registrant performed surgery on the Complainant in a fatigued state;
(b) The procedure used treat the Complainant’s ailment was ill advised in the circumstances;

(c) The decision of the Registrant to discharge the Complainant two days after her surgery was inappropriate;

(d) The surgery performed by the Registrant on the Complainant was not completed to a suitable standard;

(e) The Registrant failed to meet a professional standard in terms of communicating with the Complainant and keeping her advised of her medical condition; and

(f) The Registrant failed to meet a professional standard in that he left on vacation and passed responsibility for the care of the Registrant to a third party physician without appropriately briefing that physician on the Complainant’s medical condition. The Complainant asserts that this conduct resulted in her suffering in a hospital without being seen by a surgeon for a period of two days.

[3] After the surgery but while she was still suffering from post-surgical complications, the Complainant chose to end her relationship with the Registrant and had a different physician manage her care for the balance of her recovery.

[4] As a result of the post-surgical complications suffered by the Complainant, she has experienced pain, scarring, stress and mental anguish. She states she suffered a nervous breakdown and post-traumatic stress disorder. She found it impossible to care for her newly adopted son or to be able to work to support her family. The situation caused her to be forced to sell her home and put her career plans on hold. In turn, she holds the Registrant responsible for these struggles due to what she perceives as his failure to properly provide for her care.

[5] The Complainant raised other issues with the College concerning the nursing staff and the patient care environment at the hospital where she was treated.

[6] In its response to the Complainant the Committee canvassed each of the Complainant’s issues as they relate to the Registrant. They also advised the Complainant that they lacked authority to comment on or address the concerns she raised respecting the condition of the hospital facilities or the conduct of medical professionals who were not members of the College.

[7] In terms of the issues raised by the Complainant, the College indicated the Committee reviewed the indications for surgery and the conduct of the operation as well as the post-operative care. As a result, the Committee responded as follows:

(a) While they were unable to determine if the Registrant was suffering from stress or fatigue when he operated on the Complainant, the Committee determined that the surgery appeared to have been performed competently.

(b) The type of surgery conducted on the Complainant was appropriate in the medical circumstances.
(c) The decision to discharge the Complainant two days after the surgery was appropriate as the medical record indicated that the Complainant was recovering uneventfully at that point.

(d) The subsequent issues suffered by the Complainant were recognized as a possible outcome of a competently performed surgery and were not an indication of a failure by the Registrant to meet an acceptable standard of care. The diagnosis and treatment of the post-surgery complications were also recognized by the Committee as appropriate in the circumstances.

(e) The Committee found that the Registrant met an acceptable standard of patient care in his communications with the Complainant but did acknowledge that there was an atmosphere of tension between the Registrant and the Complainant. The Committee determined that the development of post-surgical complications caused the Complainant to question the Registrant’s surgical technique. She and her family then sought input from other physicians so as to decide on a path forward in dealing with her complications. The Committee determined that the breakdown in mutual trust resulted in both the Complainant and the Registrant preferring that a different physician provide care to the Complainant. In the circumstances, the Committee determined it was appropriate that responsibility for the Complainant’s care be passed to a different physician.

(f) Regarding the specific complaint that the Complainant was in the hospital for two days without being seen by a surgeon, the Committee noted the medical record indicated a visit by the Registrant on July 29, 2012 and the replacement physician on July 31. The standard of care indicated by the Committee is that a patient be seen by a surgeon or their designate on a daily basis but found that there were no indications of any problems resulting from the Complainant not being seen by a surgeon on July 30, 2012. The Committee indicated that it was satisfied that there was a competent surgeon designated in the record for each day the Complainant spent in the hospital.

[8] The Committee concluded that the Complainant suffered a recognized post-surgical complication. While it did not find this complication was the result of the Registrant’s level of skill or diligence, the Committee also recognized the suffering of the Complainant arising from this complication caused her to express limited confidence in the surgical care and professional behaviour of the Registrant. As such, it was the Committee’s view that the choice of a different surgeon for the Complainant was in the best interests of all concerned. This change in physicians did not detract from the larger Committee determination that the Registrant “provided appropriate surgical care and behaved in a professional manner” during the Complainant’s hospitalization.

[9] The Complainant takes issue with the findings of the Committee and states in her application for review “I wish to have the adequacy of the College’s investigation and the reasonableness of the Committee’s decision assessed”
II JURISDICTIONAL ISSUES

[10] This application is brought pursuant to s. 50.6(1) of the Act which provides for the Review Board to review the disposition of a matter by a college. Upon receipt of such application for review the Review Board is bound by s. 50.6(5) which reads as follows:

50.6 (5) On receipt of an application under subsection (1), the review board must conduct a review of the disposition and must consider one or both of the following:

   (a) the adequacy of the investigation conducted respecting the complaint;

   (b) the reasonableness of the disposition.

[11] In her initial complaint, the Complainant indicates that she in no way wishes to compromise any legal remedy she may choose to pursue. I can assure her that my role is not to adjudicate the relationship between the Registrant and the Complainant in terms of whether or not it gives rise to a claim of negligence. That is a matter strictly for a court of competent jurisdiction.

[12] The Complainant expresses a somewhat cynical view of the process to this point. She sees herself as one layperson up against many professionals who are knowledgeable and experienced in what she asserts is an opaque process. As such, I want to assure her that as panel chair, I have no vested interest in the outcome of this review. I do not know any of the parties to these proceedings and I operate independently from the College. However, this is not a forum for a re-hearing of the complaint. My role is clearly defined above and my decision will reflect that statutory mandate.

III THE ADEQUACY OF THE INVESTIGATION

[13] Review Board Decision No. 2009-HPA-0001(a) to 0004 (a) is a common starting point for outlining the test for the adequacy of an investigation respecting a complaint. At paras. [97] and [98] it states:

[97] 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.

[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.
The Committee panel in this instance was comprised of ten people. Seven members of the panel were medical doctors with a broad range of experience. The panel included expertise in surgery, internal medicine and other disciplines. Three panel members were non-medical public representatives. The Committee reviewed hundreds of pages of medical records including reports provided by all of the surgeons who treated the Complainant with respect to this matter.

Counsel for the Registrant directs me to Review Board Decision No. 2010-HPA-0115(a) which states that the degree of due diligence is met when a college “considers and attempts to obtain evidence from those Registrants that are the subject of the complaint as well as from relevant collateral sources”. It is clear that the Committee canvassed responses and opinions from its own experts, the Registrant and other medical professionals providing the Complainant’s care.

The medical record and the responses of the Respondent and the other surgeons responsible for the Complainant’s care are reasonably thorough. The depth of the panel and the thoroughness of the review of this complaint indicate to me that the College treated this matter seriously and devoted considerable resources towards a reasonably careful review of relevant materials. I am satisfied that the investigation was adequate.

IV THE REASONABLENESS OF THE DISPOSITION

Decision No. 2009-HPA-0001(a) to 0004 (a) at para. [92] also outlines how a panel chair should consider the concept of reasonableness:

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.

The Complainant makes particular note of the day she spent in the hospital without being seen by a surgeon. She asserts that this gap in her medical care was trivialized by the College. While there is no doubt that the Complainant suffered from her complications and should have been seen by a surgeon each day, the Committee determined that this incident did not hinder or delay her recovery from some very difficult post-surgery complications. The Committee made it clear that the usual expectation was that a patient would be seen by his or her surgeon each day.

There is no doubt that the Complainant suffered through severe and prolonged complications resulting from her ailments and the surgeries she underwent to address them. I have no doubt that her suffering and stress is very real and her path to recovery has been difficult.

At the same time, my role is not to second guess the expertise of the Committee as to what constitutes an acceptable standard of care. In Decision No. 2010-HPA-G02(b) at
paras. [44] and [45] the Review Board reached a similar conclusion and noted “The Review Board cannot provide treatment advice to physicians”.

[21] In a prior decision I stated that a reasonable standard of care can be characterized as a threshold of competency that all practitioners within a given field are expected to meet. That threshold is best determined by the college through an expert inquiry committee (Decision No. 2011-HPA-145(a) para. [25]).

[22] The Complainant’s submissions and the Committee’s findings both point to a breakdown of the relationship between the Complainant and the Registrant. The Complainant states her view quite clearly that the Registrant failed to competently perform her initial surgery and blames him for the subsequent complications she suffered. While the Committee found that the surgery in question was competently performed, in such circumstances the Committee found it reasonable for the care of the Complainant to be passed onto another physician.

[23] Like medical standards, standards of conduct for non-medical matters such as decisions to change physicians are also set by colleges and their experts. It is reasonable for a College to conclude that a change in physicians is best for a patient in the event they lose confidence in their existing doctor, regardless of whether or not that doctor is performing to an acceptable professional standard.

[24] While I am independent of the College, my role is to consider, on a reasonableness standard, whether the disposition of the Committee falls within the range of acceptable outcomes that are defensible in respect of the facts obtained through an adequate investigation and the applicable law. I find that the disposition of the Committee in this matter is reasonable.

V DECISION

[25] My review of the Record causes me to conclude that the requirements of the Act have been met. I find that there was an adequate investigation of the facts concerning the complaint and that the disposition of the complaint was reasonable. Pursuant to s. 50.6 (8)(a) of the Act I confirm the disposition of the Inquiry Committee of the College.

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


“John H. O’Fee”

John H. O’Fee, Panel Chair
Health Professions Review Board

November 29, 2013