Health Professions Review Board

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DECISION NO. 2016-HPA-024(a); 2016-HPA-025(a); 2016-HPA-026(a); 2016-HPA-027(a)
(Grouped File: 2016-HPA-G03)

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 1**
	A Physician	**REGISTRANT 2**
	A Physician	**REGISTRANT 3**
	A Physician	**REGISTRANT 4**
		Collectively the "Registrants"
BEFORE:	Brenda L. Edwards, Panel Chair	**REVIEW BOARD**
DATE:	Conducted by way of written submissions concluding on May 16, 2016	
APPEARING:	For the Complainant: Self-represented	

DECISION ON APPLICATION FOR REVIEW

I INTRODUCTION

[1] On February 16, 2016, the Complainant filed four applications with the Review Board seeking review of dispositions made by the Inquiry Committee of complaints made against four Registrants. On February 19, 2016, the Chair of the Review Board exercised his authority under s.35 of the *Administrative Tribunals Act* to combine the hearing of the applications and on April 15, 2016, after receiving the Record of the Investigation and Inquiry Committee's disposition (the "Record"), the Chair directed the matter to a Stage 1 hearing process under Rules 31(1)(c) and 43 of the Review Board's Rules of Practice and Procedure (the "Rules").

[2] On May 17, 2016, the review of these applications was assigned to me by the Chair of the Review Board for the Stage 1 hearing. At a Stage 1 hearing I may decide to:

(a) confirm the Inquiry Committee disposition under s.50.6(8)(a) of the Act if the application for review can be fairly, properly and finally adjudicated on the merits without the need for submissions from the College and Registrant; or

(b) determine that the application requires adjudication in a Stage 2 hearing, in which case no decision will be made until after requesting submissions from the College and Registrant, and further reply submissions from the Complainant.

[3] I am satisfied that this matter may appropriately be dealt with at Stage 1, that is to say based solely on the Record provided by the College and submissions from the Complainant.

II BACKGROUND

[4] The Complainant's mother (the "Mother") suffered from a number of complex medical conditions prior to her death, in hospital on March 22, 2015. At the time that the Complainant filed his first complaint against, Registrant 1, he noted that his mother weighed only 85 lbs. Her family physician described her as:

> a personable and lovely 80 year old lady with multiple significant medical issues. She was a bedridden double above knee amputee with severe peripheral vascular disease, chronic skin ulcers, laparascopic duodenal jejunostomy for gastric outlet obstruction and renal cell carcinoma...
>
> (She) required frequent dressing changes and eventually daily dressing changes. Specialized RN nurses did the dressing changes as instructed by a plastic surgeon who had followed her. She had several very large skin ulcerated areas and one of the more troubling was in the sacral region. This particular area was often contaminated with fecal matter and/or urine. The area gradually enlarged and became deeper until it invaded the peri-anal space towards the end of her life. At worst she was a pitiful human being with a massive burden of pathology.

[5] While not noted by the family physician in his brief summary provided to the Inquiry Committee, the Record establishes that the Mother also suffered from COPD (which I take to be cardiopulmonary obstructive disorder) and had a history of depression, anxiety and mental confusion (with dementia noted as likely).

[6] The Mother originally resided in a care facility in one city but was later transferred to a care facility in another town because the first facility was no longer able to provide the complex personal and medical care that she required. The family physician noted that the situation at the new care facility, like that at the previous one, had become quite polarized between staff and the Complainant. The staff would call the doctor, sometimes several times a day, seeking more effective pain relief for the Mother as they found the dressing changes very traumatic for her and for them. The Complainant

regularly expressed the view that his mother was not in pain or had a high pain threshold or that the staff was overmedicating her for other reasons.

[7] In 2013, the Mother signed a medical representation agreement (the "Representation Agreement") authorizing the Complainant, to make decisions regarding her medical care when she was unable to do so. The Mother had multiple hospital admissions from 2013 up to her death for new and chronic medical problems and the Complainant was very involved in her care.

[8] Throughout the fall of 2013, all of 2014 and into 2015, the nursing staff at the hospital and at the care facility repeatedly documented and voiced their concerns that the Mother was not receiving sufficient pain relief. The record is littered with references by staff to her screaming out in pain, going rigid and begging the caregivers to stop during many of her dressing changes. On a number of occasions, the Mother was transferred to the local hospital by ambulance because the staff at the care facility believed that they could not appropriately manage her pain.

[9] Over her many hospital admissions, the Mother was seen by a number of specialists including a plastic surgeon (regarding the open wounds on one of her stumps, both hips, her groin and an especially large wound on her coccyx); one or more vascular surgeons; wound care specialists; specialists in infectious disease, geriatric psychiatrists and a family physician who specialized in pain management and palliative care as well as a number of different hospitalists. In addition to her many medical care issues, the Mother was diagnosed with likely dementia (Alzheimer's or vascular in origin), depression and anxiety. She had also suffered a stroke. The wounds were stated to be "unhealable and unoperable" and at risk of sepsis. In June 2014, the vascular surgeon "had a frank discussion with (the Mother) again" (as he had in May). He advised her that these were "end of life issues" as the vascular network was failing. This had already led to a second amputation on one leg. There was no surgical option to repair the exposed bone in the leg or to close the large wound on her coccyx. He expressed the view that her situation was "palliative." A frequent theme in the consulting physicians and nurses notes is that the Mother needed better pain relief.

[10] In September and October 2014, other physicians at the hospital stated their view that the Mother was palliative and should be returned to the care facility. Her family physician agreed but in late October the Complainant, on learning that she had been discharged from hospital, threatened to call a lawyer if she was not admitted to the hospital as he directed. The hospital physician agreed to admit her but stressed that there needed to be a meeting between her caregivers and the Complainant to discuss her ongoing care.

[11] The Mother was admitted to hospital several more times over the winter months and into the spring of 2015.

[12] The Complainant believed that the caregivers tended to overmedicate his Mother. The Record and the Complainant's submissions document numerous incidences where the Complainant disagreed with the type, dosage or potency of the

analgesics prescribed for her by her treating physicians, frequently restricting her access to analgesics that her physicians had prescribed for her.

[13] I have listed the Registrants, below, in chronological order of their involvement in the care of the Mother. I note that the Inquiry Committee in its disposition of the Complaint listed the Registrants in different orders at different points in its disposition letter of February 2, 2016.

[14] Registrant 1 is a family physician with a special interest in pain management and palliative care who was contacted by a hospitalist at the regional hospital in November 2014 and asked to provide advice regarding analgesia options for the Mother and to see if he could help with managing issues of conflict between staff and the Complainant. Registrant 1 met with the Complainant a number of times and discussed the Mother's situation at length.

[15] Registrant 2 is the partner of the Mother's family physician and provided care to her, briefly, from November 3-4, 2014, while the Mother's family physician was out of town. When staff at the care facility first called Registrant 2 stating that the Mother was in serious pain he prescribed narcotics for her and, when staff called again reporting that the Mother had certain symptoms he ordered antibiotics for a suspected urinary tract infection. The Complainant insisted that the Mother be taken to hospital as he felt the analgesics were not appropriate.

[16] During her final admission in March 2015, Registrant 1 was asked, again, to see the Mother. Her condition had deteriorated and she now had a large open cavity encompassing the area where a wound, her anus and rectum had been. The nursing staff were distressed and told Registrant 1 that they found caring for the Mother to be very difficult as the Complainant was constantly interfering with their ability to provide analgesia. Registrant 1 discussed the issue with the Complainant and reduced the prescribed narcotics, on a trial basis, in response to the Complainant's concern that his Mother was too sedated to eat and thus, deteriorating and that she was confused.

[17] After Registrant 1 decreased her analgesic prescription, the Mother's condition continued to deteriorate and the developments of fever and increasing pain were charted. On March 6, 2015, Registrant 1 was in the room during one of the Mother's dressing changes. He observed the Mother to be "experiencing extremely severe pain" despite her analgesics. She was "yelling, crying and calling for help." This was very distressing to the nurses and to Registrant 1 despite his 24 years of palliative experience. Registrant 1 spoke with the Complainant and advised him that his mother was dying and that her care providers had an obligation to provide adequate pain control and that he was concerned that they were not acting in her best interest by restricting her access to the necessary analgesics. He advised the Complainant that the Mother's deterioration was related to the global burden of her diseases and not to the analgesics. The Complainant did not agree. Registrant 1 consulted with the Mother's other care providers and sought advice from Risk Management at the hospital and from the CMPA (which I understand to be Canadian Medical Protective Association) and then made the decision to remove the Complainant from his medical decision-making role on

behalf of the Mother and began prescribing different forms and strengths of analgesics to alleviate the Mother's pain.

[18] Registrant 3 is a hospitalist at the regional general hospital who treated the Mother during her final admission to hospital which began on March 6, 2015. He assumed care for her on March 9, 2015. At the time, her pain was not well controlled according to staff. The Mother was confused, had a recent fever and secondary infection in her ulcers. Registrant 3 continued the pain management that had been ordered by Registrant 1. On March 11, 2015, Registrant 3 called the Complainant to advise him that his mother had likely aspirated and that chest x-rays had been ordered and she had been placed on antibiotics. On March 12, 2015, she was diagnosed with pneumonia believed to have been caused by aspirating fluids into her lungs.

[19] Registrant 4 is a hospitalist at the same hospital as Registrant 3. He assumed care for the Mother between March 13 and 17, 2015. He reviewed her chart and noted that the risk management department of the hospital had ordered that the Mother was to receive appropriate narcotic pain relief despite the objections of the Complainant. He followed the narcotic pain management suggested by Registrant 1. In addition, he ordered IV fluids and potassium supplements and changed the method of pain medication administration to subcutaneous when the mother was no longer opening her mouth. On March 15, 2015, when the Mother was having difficulty breathing, he ordered another chest x-ray, EKG and medication and directed that she be given a specialized diet for those with difficulty swallowing and ordered a swallowing assessment. It was suspected that she had, again, aspirated fluid into her lungs. The assessment could not be completed as she was not sufficiently conscious. Registrant 4 met several times with the Complainant and discussed developments in the Mother's situation and the medical management plan that was in place.

[20] Registrant 3 saw the Mother, again, on March 18, 2015, and answered the Complainant's questions regarding her treatment. On March 20, 2015, Registrant 3 again saw the Mother and then participated in a family meeting at which Registrant 1, a medical student, the on-charge nurse, a social worker and a representative on behalf of the Patient Care Quality Office at the hospital also attended. After that meeting the Complainant agreed with the caregiver's advice that antibiotics should be stopped and that the intravenous lines would be removed as soon as they stopped functioning as she was dying. Registrant 3 spoke with the Complainant again on March 21, 2015, and advised him that the Mother had deteriorated further.

[21] The Mother died on March 22, 2015. Registrant 4 completed the death certificate after speaking with the Coroner and confirming that the Coroner was declining to order an autopsy as requested by the Complainant.

III DECISION

[22] In reaching my decision, I considered all the information that was before me whether specifically referenced in this decision or not, including:

(a) the Complainant's four separate applications for review of the Inquiry Committee Disposition dated February 2, 2016, involving the Registrants;

(b) the Complainant's 20 page Statement of Points, sent by email on May 13, 2016, and including a copy of Review Board Form 11 "Additional Documents" attaching:

(i) an April 15, 2016, decision of the Patient Care Quality Review Board decision regarding the Complainant's complaint about the care his mother received while in the care of a regional health authority;

(ii) Two pages of progress notes authored by two LPNs (which I take to mean "Licensed Practical Nurse") regarding the Complainant's mother's care on November 3, 2014 while at a nursing care facility; and

(iii) a six page "Monthly MAR Report - November 2014" which I take to be a record of the medications administered to the Complainant's mother while at a nursing care facility; and

(c) the 1,853 page Record.

[23] To be clear, while I have carefully reviewed all of the information set out in the preceding paragraph, including the "Additional Documents," I have focused my attention on those submissions in the Complainant's Statement of Points which raise issues regarding the adequacy of the investigation and reasonableness of the disposition by the Inquiry Committee as that is the limit of my mandate under the Act.

IV APPLICABLE LEGISLATION

[24] The Act governs the College's oversight of applications for registration and the supervision of registrants. It also provides for the investigation of complaints regarding the conduct or competence of registrants. In addition, the Act provides for the Review Board's authority to review dispositions made by Inquiry Committees of complaints.

[25] Counsel for the College provided the Record to the Review Board by letter dated April 12, 2016, and indicated that "the disposition of the complaint against the Registrants was concluded under s.33(6)(a) of the Act." This assertion by counsel merely confirms what was set out in the Minutes of a Panel of the Inquiry Committee meeting of January 18, 2016.

[26] The Act provides in s.33 for investigations of complaints by the Inquiry Committee and requires that the Inquiry Committee request information from registrants who are the subject of a complaint. Staff on behalf of the Inquiry Committee requested and received responses from each of the Registrants and sought and received a summary of care from the Mother's family physician.

[27] Section 33(6) of the Act authorizes the Inquiry Committee to take certain steps after considering any information provided by the registrants.

33 (6) After considering any information provided by the registrant, the inquiry committee may

(a) take no further action if the inquiry committee is of the view that the matter is trivial, frivolous, vexatious or made in bad faith or

> that the conduct or competence to which the matter relates is satisfactory.

[28] In this instance, the Inquiry Committee decided to take no further action against any of the Registrants as it concluded that each had provided the Complainant's mother with "reasonable and appropriate care." Under s.50.6(1) of the Act, a person may apply to the Review Board for a review of the disposition of the Inquiry Committee made under s.33(6) of the Act.

[29] Section 50.6(5) sets out the responsibility of the Review Board when conducting a review and s.50.6(8) identifies the powers of the Review Board after conducting the review:

> **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:
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> (b) the adequacy of the investigation conducted respecting the complaint;
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> (c) the reasonableness of the disposition.

[30] Section 50.6(8) sets out the powers of the Review Board after completing the review.

> **50.6** (8) On completion of its review under this section, the review board may make an order
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> (a) confirming the disposition of the inquiry committee,
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> (b) directing the inquiry committee to make a disposition that could have been made by the inquiry committee in the matter, or
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> (c) sending the matter back to the inquiry committee for reconsideration with directions.

[31] My task, on behalf of the Review Board, as described in s.50.6 (5) of the Act, is to review the College's disposition of the complaints and to consider one or both of the adequacy of the investigation and the reasonableness of the disposition. In this case, I have considered both. Having said that, it is not within my mandate to conduct a fresh examination of the complaints nor is it my role to substitute my decision for that of the Inquiry Committee.

V THE INVESTIGATION PROCESS

The Complaints:

[32] On March 12, 2015, while the Complainant's mother (referred to after this as "the Mother" or "his Mother") was hospitalized, the Complainant filed a complaint with the College regarding the conduct of Registrant 1 in caring for the Mother. He alleged that Registrant 1 had the Complainant removed as the designated health care

representative for his Mother, was over-medicating her and had initiated end-of-life care without proper consent.

[33] On April 9, 2015, the Clinical Manager, Complaints and Investigation department of the College (the "Clinical Manager") wrote to Registrant 1 providing him with a copy of the Complaint and seeking his response. On June 1, 2015, the Complainant wrote to the College advising that his Mother had died in hospital on March 22nd (which I take to be March 22, 2015). At this time he stated that his original complaint "related to events up to and including March 6th." He now wished to expand on his complaint to allege events that occurred throughout his Mother's final admission to hospital and immediately after her death and involved physicians other than Registrant 1.

[34] On June 5, 2015, counsel for Registrant 1 wrote the Clinical Manager and provided Registrant 1's response to the complaint dated June 3, 2015, and enclosed an email from the regional health authority to Registrant 1 dated March 6, 2015.

[35] On June 8, 2015, the Clinical Manager, wrote to the Complainant noting that his June 1, 2015, letter mentioned several physicians and asked him to confirm which, if any of the others he wished to have the College review as subjects of complaint. By letter dated June 11, 2015, the Complainant confirmed that he wished the College to also review the care provided to his Mother by Registrants 2, 3 and 4 and expanded on his concerns regarding the care provided to his Mother by each of the Registrants.

[36] With respect to Registrant 2, the Complainant alleged that Registrant 2 inappropriately prescribed morphine and fentanyl to the Mother, without first examining her.

[37] With respect to Registrants 1, 3 and 4, the Complainant alleged that each was aware that the Complainant had decision-making power over the Mother's health care decisions under a valid Health Care Representation Agreement and that each ignored the agreement and appointed themselves as substitute decision-makers. He further alleges that these three Registrants treated his Mother as palliative, without consent, and over-medicated her such that she was unable to eat or drink and thereby hastened her death. Finally, the Complainant alleges that Registrant 4 blocked his attempts to have an autopsy completed on his Mother.

[38] On June 15, 2015, the Clinical Manager wrote to Registrants 2, 3 and 4 notifying each of the complaint(s) and seeking a response. In addition, the Clinical Manager wrote the family physician who had provided care to the Mother and provided him with a copy of the Complainant's June 11, 2015, letter and requested that he provide a summary of his care of the Mother.

[39] The family physician wrote a two page letter to the Clinical Manager on June 17, 2015, briefly summarizing his care of the Mother and enclosing over 300 pages of chart notes and medical records about her care.

[40] On July 13, 2015, Registrant 2 provided the Clinical Manager with his written response to the complaint.

[41] After being granted an extension of time to reply, on August 12, 2015, counsel for Registrants 3 and 4 provided the Clinical Manager with each of the Registrants' written responses to the complaint. The Clinical Manager provided all of the Registrants' responses to the Complainant on September 11, 2015.

[42] On September 21, 2015, the Complainant made a brief supplemental submission and included 2 of 5 pages of a geriatric consult prepared by another physician in 2013.

[43] On October 21, 2015, the Clinical Manager provided each of the Registrants with the September 21, 2015, supplemental submission and, additionally, provided Registrant 1 with the Complainant's June 1 and June 11 letters.

[44] On January 18, 2016, an Inquiry Committee Panel was assigned to consider the complaints. This was a 12-person panel consisting of seven medical doctors with expertise in emergency medicine, family medicine, internal medicine and respirology, orthopedics, general surgery and obstetrics/gynecology plus five representatives of the general public who have been appointed by the College and the provincial government.

[45] The Minutes and supporting documents indicate that the Inquiry Committee had before it the entirety of the Complainant's submissions to the College together with all of the Registrants' responses and the summaries of care provided by the Family Physician. In addition, the Inquiry Committee had a "Summary and Points for Consideration" report prepared by the Medical Reviewer for the College who had reviewed the complaint, the written responses to the complaint, hospital and medical records for the Mother and other documentation.

VI ADEQUACY OF THE INVESTIGATION

[46] As a member of the Review Board, I am aware of the fact that the College has limited resources and many complaints that require investigating every year. The College has the authority to manage those limited resources in a manner that is consistent with its duty to protect the public interest: *Moore v. College of Physicians and Surgeons of BC and the Health Professions Review Board*, 2013 BCSC 20181 at para. [119].

[47] As a result, the degree of diligence that the Inquiry Committee must exercise in order to ensure that an investigation is adequate will differ from one case to the next and will depend, in large part, on the seriousness of the issues raised in the complaint and the findings of the investigation as it progresses.

[48] What constitutes an adequate investigation was well defined in Review Board Decision No. 2009-HPA-001(a) to 0004(a) at paras. [97-98]:

> [97] A complainant is not entitled to a perfect investigation, but he or she is entitled to an 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.

[49] I accept that definition and have applied it to this review.

[50] In *Moore*, *supra* the Court found that the question of whether an investigation is adequate is contextual:

> [104] The HPA requires the Board to determine whether or not the investigation conducted by the College was adequate and whether the disposition was reasonable.
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> [105] The adequacy of any investigation must be considered relative to the matter being investigated. What might be inadequate in one case might be adequate in another. By way of a simple example a serious complaint about a physician might result in an admission by the physician of misconduct after very little investigation. Even though the investigation amounted to nothing more than drawing the complaint to the physician's attention and requesting a response, that is all that was required for an adequate investigation in that context. Conversely, an extensive investigation into a complaint might be considered inadequate where one line of inquiry was ignored or not properly pursued.
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> [106] Thus, the nature of the complaint will inform the extent of the investigation required. Where the complaint is of a minor or trivial nature it may not be necessary in each case to conduct an extensive investigation.

[51] I do not read *Moore*, *supra* as requiring that an Inquiry Committee take every step by way of investigation that a Complainant wishes.

[52] I have already set out the steps that the Inquiry Committee took in investigating the complaints. My task is to assess whether those steps resulted in an investigation that was "adequate" in all of the circumstances.

[53] In this case, the Inquiry Committee had before it submissions from the Complainant. The Inquiry Committee also had detailed responses from all four Registrants together with medical records for the Mother. Further, the Inquiry Committee sought and obtained hospital records from two facilities regarding care provided to the Mother. Still further, the Inquiry Committee had a summary of care provided to the Mother by a physician who was not the subject of the complaints.

[54] In my view, the Inquiry Committee's investigation was thorough and provided it with the key information it required to understand the nature of the complaint, the conduct complained of, the harm alleged and the Registrants' explanation for their conduct.

[55] I have summarized what I take to be the Complainant's concerns with the adequacy of the Inquiry Committee's investigation as set out in his Statement of Points. He alleges that the Inquiry Committee

- failed to consider whether the Registrants' actions were in keeping with the *Health Care (Consent) and Facilities (Admissions) Act* and the *Representation Agreement Act*;

- failed to address the fact that a no-swallow order was posted by the Mother's bed when no swallowing assessment had been completed;

- failed to address the fact that the Mother's intravenous site was not moved for week and became compromised;

- relied on Registrant 2's response to the complaint without seeking the MAR (which I take to mean medication administration record) from the care facility.

[56] In conducting its investigation, an Inquiry Committee should consider the suggested lines of inquiry posed by a Complainant and take all reasonable steps to ensure that any line of inquiry which is likely to lead to relevant information that is readily available and which might inform the Inquiry Committee about the complaint is obtained. I am satisfied that the Inquiry Committee, in this case, did just that.

[57] As I have noted, the Inquiry Committee conducted a thorough investigation. By taking the reasonable steps that I have described, the Inquiry Committee ensured that it had the key information that it needed to understand the nature of the allegations against each registrant, the circumstances under which care was provided to the Mother and the extent of the care that was provided by each registrant - both in isolation and in the context of care provided by other registrants and other health care providers during the relevant time period.

[58] Given the above, I find that the Inquiry Committee's investigation of the complaint was adequate, I must next turn my mind to whether the Inquiry Committee's disposition was reasonable given the information that it had at the end of the investigatory process.

VII REASONABLENESS OF THE DISPOSITION:

[59] The language of the Act is clear; it is not for me to substitute my decision for that of the Inquiry Committee simply because I might have reached a different conclusion. Rather, I am mandated to determine whether the disposition that the Inquiry Committee arrived at was "reasonable" in the circumstances and, if it was, I am to confirm that disposition. That said, as a member of a specialized administrative tribunal, I am entitled to determine the degree of deference that it is appropriate for me to afford the Inquiry Committee’s disposition in the circumstances bringing to bear my own expertise as an administrative decision-maker.

[60] In this case, I have afforded a high degree of deference to the Inquiry Committee with respect to those aspects of its disposition that require the exercise of medical expertise and judgment.

[61] The law is settled that the test for "reasonableness" requires that the reviewing body ask itself whether the decision falls within the range of acceptable outcomes that

are defensible having regard to the facts and the law: *Dunsmuir v. New Brunswick* 2008 SCC 9 at para. [47].

[62] The Supreme Court of Canada in *Dunsmuir* provided further guidance to reviewing courts (and bodies such as the Review Board) when it held that:

> (R)easonableness is concerned mostly with the existence of justification, transparency and intelligibility within the decision-making process: at para. [47]

[63] The Review Board in Review Board Decision 2015-HPA-088(a) at para. [12], noted some of the key factors that should be present in a "reasonable" disposition:

> A reasonable disposition should be transparent (clear as to how the Inquiry Committee arrived at its conclusion), intelligible (clearly expressed, easy to understand) and justified (the reader should be able to understand the factual and legal foundation for the Inquiry Committee's conclusion).

[64] As noted above, the Panel of the Inquiry Committee that considered the complaints was a 12-person panel with seven physicians representing a wide range of specialties and including five lay members. In my view, the Panel was well qualified to assess whether the Registrants' conduct met the standards expected of physicians who are called upon to provide care to a patient with the complex medical conditions that plagued the Mother at and near the end of her life.

[65] I am mindful that the Review Board has previously determined that the Inquiry Committee's function is not to adjudicate the level of satisfaction in respect of the Registrants' service, but rather whether its members have met appropriate standards of practice; Review Board Decision No. 2011-HPRA-151(a). I agree.

[66] That said, the Inquiry Committee must make a disposition that reflects an appropriate level of investigation and, more importantly, the disposition has to be supported by the evidence before it: Review Board Decision No. 2012-HPA-056(a).

[67] I am satisfied that the Inquiry Committee's eight page disposition letter reasonably responded to the key issues raised in the complaints.

[68] I think it only fair to note that the Inquiry Committee had the difficult task of determining exactly what conduct of the Registrants was the subject of complaint. The Complainant's various submissions do not clearly articulate his concerns apart from his clear concern that the Registrants did not obtain his consent to all of the treatment that was afforded his Mother, especially when that treatment involved narcotic analgesia to alleviate her pain.

[69] The Complainant's letters are written in a third party narrative style with extensive detail and attention paid to some aspects of the Mother's condition and her care on an almost daily basis and with little or no attention given to other aspects of her complex medical situation. He set out lengthy quotes of conversations that he alleges occurred between himself and the Registrants and others as if he had actually recorded those conversations. At times the Complainant speculated about what might have occurred or made inferences from comments that other health care providers allegedly made to him.

At other times the Complainant mused about what other treatment might have been provided. The Inquiry Committee did its best to identify the Complainant's concerns by setting out what it saw as "themes" in his complaint letters.

[70] Interestingly, the Complainant noted in his Statement of Points that it was "reasonable for the College investigator (i.e. the Inquiry Committee) to conclude that the most serious allegations were (as set out)." I agree.

[71] The Inquiry Committee's disposition letter is detailed and transparent as to the investigatory process and decision-making. The Inquiry Committee identified the steps it took in the investigation of the complaint, summarized the "primary themes" that it was able to identify in the complaints and the responses received from the Registrants and the family physician. The Inquiry Committee then set out its key findings with respect to each of the Registrants. In my view, this was a reasonable approach to the complaints in the circumstances. The Inquiry Committee was not obliged to provide a protracted response to every nuanced issue raised by the Complainant's narrative or investigate and respond to every possible avenue that he suggested.

[72] I am satisfied that the disposition was intelligible in that it is clear, flows logically and is written in language a layperson could understand. Where medical terms or procedures are included they are explained, for the most part. (I note that the Complainant demonstrated that he was very familiar with medical terminology given his role in his Mother's medical care). When the Inquiry Committee was not critical of a registrant it indicated why it was not.

[73] Finally, I am satisfied that the disposition of the Inquiry Committee was justified in that it is defensible with respect to the law and the facts. To be clear, when I say that the disposition was defensible with respect to the law, I mean that the Inquiry Committee had the legal authority to make the decision that it did. While the disposition letter does not indicate the legal basis for the disposition, i.e. s.33(6)(a) of the Act, the Minutes of the Committee record that the Inquiry Committee acted under that authority. In my opinion, there is a clear factual basis in the Record to support the Inquiry Committee's lack of criticism of the Registrants and the Inquiry Committee was entitled to find, based on the Record, that the conduct of the Registrants was "satisfactory" within the meaning of s.33(6)(a) of the Act.

[74] For all of these reasons, I am satisfied that the Inquiry Committee's disposition was transparent, intelligible and justified. In other words, it was reasonable.

VIII CONCLUSION

[75] I have concluded that the investigation of this complaint was adequate and the disposition was reasonable and I am ordering that the Inquiry Committee's disposition is confirmed under s.50.6(8)(a) of the Act.

[76] I want to say in closing that, it is clear to me from his submissions and from the Record that the Complainant remains dissatisfied with the medical care provided by the Registrants, other health care providers, the Patient Care Quality Office at the hospital

in which his mother died and is now also dissatisfied with the Inquiry Committee's disposition.

[77] It is understandable that the Complainant would seek answers to his many unanswered questions. That said, in my view, his anger, frustration and accusations in regard to the conduct of the Registrants was not justifiable and was not borne out by the Record. It is clear to me, based on all of the information before me, that the Registrants acted in the best interests of the Mother and acted to alleviate her pain and suffering even when that meant that they must make the difficult decision to contravene the wishes of her son.

[78] I note that the Complainant began the complaint process while his Mother was still alive and in hospital but gravely ill. For anyone who has experienced the prospect and then eventuality of losing a loved one, it is trite to say that it is a difficult time in that person's life. To the Complainant I wish to say that I am very sorry for your loss.

“Brenda L. Edwards”

Brenda L. Edwards, Panel Chair
Health Professions Review Board

June 6, 2016