Health Professions Review Board
Suite 900, 747 Fort Street, Victoria, BC V8W 3E9

Complainant v. College of Physicians of British Columbia

DECISION NO. 2016-HPA-235(b)

August 9, 2018

In the matter of an application (the "Application") under section 50.6 of the *Health Professions Act,* R.S.B.C. 1996, c. 183, (the "Act") for review of a complaint disposition made by, or considered to be a disposition by, an inquiry committee

BETWEEN:	The Complainant		**COMPLAINANT**
AND:	The College of Physicians and Surgeons of British Columbia		**COLLEGE**
AND:	A Physician		**REGISTRANT**
BEFORE:	Doug Cochran, Panel Chair		**REVIEW BOARD**
DATE:	Conducted by way of written submissions closing on		
APPEARING:	For the Complainant:	Jennifer Metcalfe, Counsel	
	For the College:	Sarah Hellmann, and Michelle Stimac, Counsel	
	For the Registrant:	David W. Pilley, Counsel	

I INTRODUCTION

[1] This is an application for review under s.50.6 of the Act There are two issues on this review:

(a) Whether the investigation giving rise to the May 16, 2017, supplemental disposition of the Inquiry Committee (the May 2017 Disposition) was adequate within the meaning of s.50.6(5)(a) of the Act, and

(b) Whether the May 2017 Disposition was reasonable under s. 50.6(5)(b).[1]

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[1] The May 2017 Disposition, issued by the Inquiry Committee, was supplemental to a November 23, 2016, disposition issued by the Registrar under s.32(3)(c) of the Act (the November 2016 disposition). The procedural history giving rise to these dispositions is set out below.

II THE PARTIES

[2] The complaint was filed on April 25, 2016, at which time the Complainant was an inmate who resided in a Pretrial Centre (PC "A"). The complaint was filed on his behalf by Prisoners' Legal Services ("PLS") counsel.

[3] The Registrant is a psychiatrist. Her practice includes treatment of inmates in a correctional setting. The Complainant was treated by the Registrant in the PC "A" commencing on November 2, 2014, and ending on October 15, 2015.

[4] The College is the statutory body charged with processing complaints as part of its overarching duty to protect the public interest. The Inquiry Committee is a distinct and specialized statutory body within the College, charged with investigating complaints and issuing the dispositions set out in s.33(6) of the Act:

> 33(6) After considering any information provided by the registrant, the inquiry committee may
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> > (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,
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> > (b) in the case of an investigation respecting a complaint, take any action it considers appropriate to resolve the matter between the complainant and the registrant,
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> > (c) act under section 36, or
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> > (d) direct the registrar to issue a citation under section 37.

III THE COMPLAINT

[5] The Complaint, in essence, alleged that the Registrant, by her acts and omissions, violated professional standards in her care and treatment of the Complainant at times when he was subject to solitary confinement.

[6] It is common ground that the Complainant was in the Registrant's care between November 2, 2014, and October 15, 2015. The Complainant alleged that he was in solitary confinement during the following dates during this period:

- January 11 to 16, 2015 (5 consecutive days)

- January 30 to February 26, 2015 (27 consecutive days)[2]

- April 30 to October 15, 2015 (6.5 consecutive months, which does not include the additional time he remained in segregation after the Registrant's role concluded).

[2] The Complainant has since clarified that this period was 20 days, from January 30 to February 19, 2015.

[7] The Complaint alleged that on July 5, 2015, 67 days into the last referenced period of solitary confinement - the Registrant "canceled [the Complainant's] certification and request to transfer to the local forensic hospital, despite numerous notations in his medical Client Profile of psychotic behavior and other symptoms of prolonged solitary confinement…. [The Registrant] speculated that he was malingering, ignoring his other symptoms and the possibility of prison induced psychosis from prolonged isolation." Against that backdrop, the Complaint had three elements.

[8] First, the Complaint alleged that the Registrant's professional conduct reflected "a lack of current knowledge of international standards for the treatment of prisoners with mental disabilities" – specifically, a failure to properly consider the *United Nations Standard Minimum Rules for the Treatment of Prisoners* (the "*Mandela Rules*"). PLS argued on behalf of the Complainant that the *Mandela Rules* prohibit solitary confinement for more than 15 consecutive days (Rules 43 and 44), and prohibit solitary confinement outright for prisoners with mental or physical disabilities when their conditions would be exacerbated by its use (Rule 45). PLS placed particular emphasis on Rules 33, 34 and 46, which refer to the duties of health care professionals dealing with prisoners in solitary confinement:

> Rule 33
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> The physician shall report to the prison warden whenever he or she considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or any condition of imprisonment (including solitary confinement).
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> Rule 34
>
> If a health care professional becomes aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report it to the competent medical, administrative or judicial authority….
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> Rule 46
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> … Health Care personnel shall report to the director, without delay, any adverse effects of disciplinary sanctions or other restrictive measures on the physical or mental health of a prisoner subjected to such sanctions or measures and shall advise the director if they consider it necessary to terminate or alter them for physical or mental health reasons.

[9] The Complaint alleged that the *Mandela Rules*, the positions of other international organizations and the Canadian Medical Association all recognize that solitary confinement is harmful to health, and that the Complainant's case exemplified this:

> There are multiple notations in his medical Client Profile that he was exhibiting symptoms of prison psychoses, including anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia and psychosis. His psychosis appears to have been triggered by the stress of surgery, and was then exacerbated by his prolonged isolation.

[10] The Complaint alleged that, as matter of professional responsibility under the *Mandela Rules*, the Registrant was obliged "to refuse to engage actively or passively, in [the Complainant's] solitary confinement, which constitutes either torture or other cruel, inhuman or degrading treatment. By cancelling [his] certification, despite the fact that he obviously met the criteria for certification, and thereby preventing him from being admitted to [the forensic hospital], [the Registrant] passively allowed him to continue to be held in solitary confinement." The Complaint alleged that there is no evidence in the Complainant's medical records or otherwise that the Registrant reported the injurious effects of solitary confinement on anyone, and "does not indicate any awareness in her notes on the likely negative psychological effects that prolonged solitary confinement would have on [the Complainant]." The Complainant argued:

> [The Registrant] was aware that BC Corrections was maintaining [the Complainant's] solitary confinement status despite his mental health concerns and deterioration. As his psychiatrist in a correctional setting, she should be aware that his prolonged solitary confinement is exacerbating his mental illnesses. If she is not aware of the literature on the negative effects of solitary confinement on people with mental disabilities, and the negative effects of prolonged solitary confinement generally, she should have recognized her limitations and sought additional opinions and services.

[11] The second aspect of the Complaint alleged that the Registrant demonstrated professional misjudgment by speculating that the Complainant was malingering, and by "failing to consider a diagnosis of prison psychosis – she does not appear to consider that [the Complainant's] prolonged solitary confinement was the cause of his symptoms…. It is one thing to suspect malingering and proceed cautiously with appropriate treatment. It is another thing to dehumanize a patient to the extent that clear symptoms of prolonged isolation are ignored…." The Complaint alleged that the Complainant clearly satisfied the requirements for certification under the *Mental Health Act*, (the "MHA") and that by de-certifying him, the Registrant exhibited a lack of professional judgment.

[12] The final aspect of the Complaint was an allegation that the Registrant failed to provide the Complainant with access to medical information, as required by the College's Standards and Guidelines.

IV THE REGISTRANT'S FIRST RESPONSE

[13] By letter dated June 23, 2016, the Registrant responded to the Complaint. She provided an overview of her background and current practice, as well as the services she provides at PC "A" in general and specifically her treatment of the Complainant. The Registrant's response noted as follows:

(a) The population at the [PC "A"] includes approximately 600 people who have been charged in the region, mainly with serious personal injury offences. The length of stay can vary from a few days to two years.

(b) In her role as psychiatrist at [PC "A"], where she attends twice a week, the Registrant is a member of the mental health team, not the most responsible physician. She writes consultation notes to the [General Practitioner] in respect of cases referred to her by the team. The mental health team operates separately from the Corrections function of the centre: she has no

access to the corrections file, she has no role in placing or removing inmates from segregation, and she is not acting as a forensic psychiatrist or advocate in relation to the charges.

(c) The Registrant generally sees inmates in the institution's Health Care Centre, except in cases of severe behavioural disturbances, where she will see them in segregation. "Most are double bunked. Approximately 4% of inmates will have a psychotic mental disorder and these would usually be the inmates pre-selected for me to see. I assess them and offer recommendation for appropriate voluntary medication treatment…. If the inmate agrees with the medication recommendation, I write this as a recommendation to the most responsible physician."

(d) If an inmate requires certification and hospitalization for involuntary treatment under the MHA, they are placed on a waitlist until a bed becomes available at [a forensic hospital].

(e) The Registrant's involvement with the Complainant was as follows:

- On November 2, 2014, the Registrant first assessed the Complainant. After obtaining a social and psychiatric history, and conducting a mental state evaluation, "my impression was that he had no major mental disorder and I made no psychiatric recommendations."

- On January 11, 2015, the Registrant saw the Complainant again, after a collapse with no loss of consciousness the previous day. "He was not in segregation." On that day, based on his presentation – reporting "a sudden onset of agitation with religious and grandiose delusions but in the absence of loose associations" – she certified him with a provisional diagnosis of "unspecific psychosis" though the symptoms were atypical as he was well groomed and well nourished and avoided answering many of her mental state questions. It was her "hope that a hospital would provide closer observation and contribute to a clearer diagnosis.

- From January 16 to 28, 2015, the Registrant was admitted to a forensic hospital. Dr. A., his psychiatrist there, saw him six times. Dr. A obtained a history from Alberta which "outlined a lengthy history of polysubstance abuse (with crystal meth being the drug of choice) and extensive legal problems since the age of 15." Dr. A wrote "while [the Complainant] may have some mild psychotic symptoms, I opine that he was feigning or exaggerating many of his symptoms in order to avoid returning to [PC "A"]."

- On February 1, 2015, the Registrant saw the Complainant again in segregation. "My impression was that his need for feedback and his lack of bizarre ideation or classic psychotic symptoms argued against psychosis." She stated that "He asked me to have him placed in another area of [PC "A"] and I explained to him that I was not involved in these decisions."

- By May 7, 2015, the Complainant had been moved to another Pre-trial Centre [PC "B"] where he was certified by other physicians "who wrote of verbal aggression and threatening with a history of responding to auditory

hallucinations."

- On June 28, 2015, the Registrant saw him again at [PC "A"], and her impression was that "it was possible he had a drug-induced state or that he was malingering." She stated that Bipolar disorder was also a possibility, though it "would be very unusual to have … a first episode at age 33, particularly since his genetic history was of Antisocial Personality Disorder and Substance Use Disorder. I recommended treating him with Risperidone again."

- The Registrant described the events of July 5, 2015 as follows:

> He had been on the transfer list to [a forensic hospital] since May 10. He was refusing Risperidone. He again showed atypical presentation compared to other patients who were psychotic. The psychotic thoughts did not seem to interfere with his normal interactions. He did not have flat or blunt affect which would have been consistent with mental illness. He was quite angry when I saw him with many "F… words." He was now refusing Risperidone. I considered that the likely presentation was that of malingering and cancelled the certificate. I considered that he had already been at [a forensic hospital] where the opinion was that of malingering. My own conclusion, having seen him for several months, was consistent with this.

- On October 15, 2015, the Registrant saw the Complainant for the last time. "At this time, there was a sudden onset of psychotic-like symptoms in the context of court the next day. He said his trial was set for December. He stated he was firing his lawyer and pointed out that the judge is "pissed at me." He was asking why he had been decertified and stated that he wanted to go to [a forensic hospital]…"

[14] With regard to the complaint that the Registrant should have recognized "prison psychosis" and the negative effect of segregation on the Complainant's health, the Registrant stated that "there is no diagnosis of 'prison psychosis' in the DSM V.[3] She advised the College as follows:

> The complainant's lawyer indicates a preference for the diagnosis of "prison psychosis". The concept is one which is in the press, with the view that the prison creates the psychosis and that prolonged sensory deprivation impairs an inmate's mental state. This has in fact been seen in torture victims with severe deprivation such as lack of any light, lack of sound, lack of sleep or lack of social contact of any kind (torture). This degree of deprivation does not exist in [PC "A"].
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> Most press releases fail to lay out the extremely challenging behaviors and violent histories seen in prison and stress instead the psychological disorders. Typically the press fails to suggest methods of dealing with extreme behaviors except to put inmates

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[3] The DSM refers to the Diagnostic and Statistical Manual produced by the American Psychiatric Association. The Registrant stated that "Psychiatrists are required to make a psychiatric diagnosis using the criteria from the DSM V."

> in general populations or move them to mental hospitals. They do not address the responsibility to keep other inmates and staff safe from the violence which is usually the reason for the segregation in the first place.
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> Corrections administration in [PC "A"] are, in my opinion, scrupulously aware of the need for the least restrictive alternative in managing inmates. Most inmates in segregation are double bunked and they all have personal contact with staff several times per day. There is certainly no torture…. The challenge is to find methods of dealing with extreme behaviors such as self mutilation, smearing of feces, and head banging on the steel doors or brick walls which frequently is associated with the inmate's drug withdrawal, reaction to incarceration or mental disorders….
>
> …If "prison psychosis" existed as a distinct entity based on clinical research it would have symptom descriptions. In the absence of this, psychiatrists will not diagnose it.

[15] With regard to the malingering issue, the Registrant outlined her qualifications, the reality that "malingering presents more commonly in correctional populations," and the factors to consider. She stated that:

> This person had atypical symptoms, symptoms presenting at a late age for first-break psychosis and an intense request to be sent to hospital. He also showed severe behavioral disturbances. This was in the context of facing serious legal charges. The psychiatrist is obliged to suggest the treatment that is clinically indicated. This may or may not be the type of care that the inmate requests…

[16] The Registrant stated that she arrived at her conclusion with benefit of the file history, including the opinions of the other professionals, but noted that "their observations are, by definition, cross sectional… The more valid assessments are done having seen the inmate several times…." Further, "Behavioral disturbances in corrections do not always mean there is a mental illness. There are extremes of aberrant behavior in corrections which are not associated with psychosis. This is because the population has a high proportion of persons with personality disorders who are experiencing high levels of stress due to uncertain court outcomes." The Registrant stated that she is very conversant with the MHA criteria for involuntary admission and stated that "It is extremely atypical for a patient to want to be certified which involves involuntary treatment with medications." After reiterating that she is not involved in segregation decisions, she stated:

> When I cancelled the certificates on July 5, 2015 it was based on my evaluation of [the Complainant's] presentation. He was claiming a psychotic disorder but refusing medications which would have been the treatment for this. At the same time he was demanding hospital care where the main treatment would be medications.

[17] With regard to the allegation that she did not advocate for the Complainant, the Registrant stated that while "this inmate told me that he is facing a "Dangerous Offender hearing in court," her role "does not involve legal advocacy" and that "it would be completely inappropriate for me insert myself into this process (assuming this is what the term "advocacy" means in the context of this complaint):"

> Along with the other mental health team, I would of course advocate within my role for clinical services if needed, such as advocating for dental care or psychological therapy

or hepatitis testing. This would usually be done by chart communication but could be in verbal exchanges with the team.

V COMPLAINANT'S REPLY TO THE COLLEGE

[18] On August 24, 2016, the College provided the Registrant's response to the Complainant. On September 16, 2016, the PLS, on behalf of the Complainant, responded as follows:

(a) The Complainant never alleged that the Registrant should involve herself in his criminal charges. His allegation was that in cancelling his certification, the Registrant "speculated that he was malingering, ignoring his other symptoms that appear to have been triggered by the stress of surgery, and exacerbated by his prolonged isolation." The Complainant submitted that the Registrant's emphasis that some prisoners fake mental health symptoms shows evidence of bias against her patients who are prisoners, and was shown to be unfounded here as the Complainant pled guilty to his charges.

(b) A 2010 article published in the *Journal of the American Academy of Psychiatry and the Law* recommends that "In addition to providing whatever services they can to segregated patients, [psychiatrists] should advocate within the prison system for changed segregation policies and, if that fails, they should undertake public advocacy … Their professional organizations should help them."

(c) Prison psychosis is not a creation of the "press." PLS submitted:

> Prison psychosis is the topic of medical journal articles by qualified mental health professionals, and described as a "phenomenon"…. Although prison psychosis is not a "diagnosis" under the DSM-5, it may manifest in other disorders that are diagnosable under the DSM-5 such as delusional disorder … depression, anxiety … or psychotic disorder due to another medical condition. Medical research is the basis for the limits contained in the May 22, 2015 [*Mandela Rules*] that prohibit the use of solitary confinement for over 15 days and its use for any time on prisoners with mental disabilities. Prison psychosis not a creation of "the press" [cited articles omitted]
> It seems that [the Complainant] may meet the criteria for a diagnosis of delusional disorder or psychotic disorder due to another medical condition, under the DSM-5.
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> Regardless of [the Complainant's] diagnosis, according to the *Mandela Rules*, [the Registrant] had a responsibility to alert authorities to the torture or cruel treatment of [the Complainant] who had spent far in excess of the maximum number of days as a prisoner (without a mental disability) should stay in solitary confinement under the *Mandela Rules*.
>
> It is at least accepted that [the Complainant] had FASD or depression (both noted in his medical file), he should not have spent any time in solitary confinement under the *Mandela Rules*, and [the Registrant] had an obligation to

advocate for his removal from solitary confinement.

(d) *Bacon v. Surrey Pretrial Service Centre*, 2010 BCSC 805 addressed the solitary confinement conditions at Surrey Pretrial which "are virtually identical" to those at PC "A." The Court in *Bacon* held that those conditions "have been condemned internationally" and "would be deplorable in any civilized society." Whether or not this constitutes torture, it is clearly "solitary confinement" that would be captured by the *Mandela Rules*:

> [The Registrant] ignores [the Complainant's] submissions regarding her obligations under the *Mandela Rules* to refuse to engage actively or passively in torture or other cruel, inhuman or degrading treatment and to report the injurious effects of [the Complainant's] solitary confinement. She merely states that the psychiatrist is not involved with placing persons in segregation or removing them from segregation.

(e) *Bacon* also rejects the position that segregation is the only option to protect the safety of others.

VI THE NOVEMBER 23, 2016 DISPOSITION

[19] On November 23, 2016, the Deputy Registrar of the College dismissed the complaint under s.32(3)(c) of the Act. He framed the issue as being whether "the *medical care* provided *by [the Registrant] to [the Complainant] was consistent with the standard expected of a psychiatrist practicing in a correctional setting.*" [emphasis added] In this regard, he focused on the process the College expected the Registrant to follow in making a diagnosis (which he held was reflected in her clinical records), affirmed the Registrant's qualifications to make certification decisions under the MHA and noted that it was not uncommon for qualified physicians to differ on the application of the criteria. The Deputy Registrar cited the file information where malingering was postulated and stated:

> The above documentation of [the Registrant] is consistent with an appropriately detailed history of presenting events, and a well reasoned clinical decision. We note that, at this point, [the Registrant] had assessed [the Complainant] on several occasions, and had the benefit of a previous assessment by the [forensic hospital] team. It was appropriate for [the Registrant] to consider this information in making her diagnosis. We acknowledge you disagree with the diagnosis of [the Registrant].
>
> The College must respect the processes specified in the *MHA*. Our role in reviewing complaints regarding certification under the *MHA* is limited to ensuring that the physicians involved have documented appropriate assessments. It would be inappropriate for this College to second-guess a well-founded decision of this nature, made by an appropriately qualified psychiatrist at the bedside. [The Registrant's] assessments of [the Complainant] were consistent with requirements set out in the *MHA* and standard medical practice.

[20] The Deputy Registrar also rejected the suggestion that the Registrant failed to consider a diagnosis of prison psychosis:

> [The Registrant] has noted that this diagnosis, while present in the mainstream media, is not an accepted psychiatric diagnosis. You have presented evidence to dispute [the Registrant's] statements in this regard. The College is unable to resolve issues of scientific controversy. However, the College expects psychiatrists to practice consistent with the community standard as set by the DSM-V. As noted by [the Registrant], prison psychosis is not a diagnosis recognized in the DSM-V.

[21] With regard to the allegation that the Registrant failed to meet with PLS, the Deputy Registrar held that the Registrant appropriately declined to meet given her role and given other available processes for advocacy.

[22] The November 2016 disposition did not expressly address the allegation that the Registrant failed in her *ethical* duty to take appropriate action in accordance with the *Mandela Rules* in response to the impacts of prolonged solitary confinement. The closest the disposition came to addressing this issue was to accept the Registrant's statement: that "the nature of correctional practice is such that she has no ability to influence the placement of a patient in segregation."

VII THE DECEMBER 20, 2016 APPLICATION FOR REVIEW

[23] On December 20, 2016, PLS filed an application for review on behalf of the Complainant. A key allegation made in that application was that the November 2016 Disposition failed to fully consider or investigate the allegation that the Registrant violated both the *Mandela Rules* and the *CMA Code of Ethics* by:

> [F]ailing to address the psychological harm done to [the Complainant] by prolonged solitary confinement. The College failed to consider, address or investigate the fundamental ethical concerns and evidence raised by [the] complaint, which was the substance of [the] Complaint.

[24] The application for review also alleged that the Deputy Registrar improperly assumed jurisdiction over this complaint which was a serious matter, and that the disposition "disproportionately, and therefore unreasonably, limited [the Complainant's] *Charter* value rights and it is not within a range of possible outcomes that is consistent with the College's statutory objectives and *Charter* values in the context of this case."

VIII APPLICATION FOR REVIEW HELD IN ABEYANCE

[25] On February 2, 2017, counsel for the College wrote to the Review Board acknowledging that "the November 23, 2016 disposition letter does not specifically address the allegation that there has been a failure to comply with international standards." As a result the College proposed that this review:

> …be held in abeyance to afford the College an opportunity to take his matter back to the Inquiry Committee for consideration:
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> - Of the issues raised in the Application for Review and the material cited therein; and
> - A further response from [the Registrant] in respect of the issues raised in the Application for Review.

The College will then be in a position to issue a supplemental disposition letter.

[26] PLS opposed the application on the basis that it would unnecessarily delay matters as the College had in 2015 already declined to engage on the duties of physicians under the *Mandela Rules* and on the basis that the College "would simply take this opportunity to provide additional reasons for dismissing [the] complaint."

[27] On March 17, 2017, I issued Review Board Decision No. 2016-HPA-235(a), granting the College's request for an abeyance. After summarizing the competing positions, I held that:

> …it is preferable to have the Inquiry Committee address the application of the *Mandela Rules* specifically and for the Complainant to have an opportunity to respond to the amended disposition prior to the Review Board dealing with the application for review.

[28] I make two points in relation to the supplementary disposition process.

[29] First, while Decision No. 2016-HPA-235(a) focused on the application of the *Mandela Rules*, the Inquiry Committee cannot in my view be faulted for considering all the issues raised by the Complainant on the application for review. The Inquiry Committee, which has primary authority to dispose of complaints, was not bound by the Registrar's earlier decision,[4] and was entitled to undertake a supplementary look at the complaint file as augmented by the Application for Review, the materials cited therein, and the Registrant's further response. That subsequent Inquiry Committee consideration renders academic the objection raised by the Complainant concerning whether the Deputy Registrar had jurisdiction to make the November 2016 disposition. As a result, it is not necessary in this case to address that issue. Nor do I see any evidence that the 13 Inquiry Committee members who issued the May 2017 disposition considered themselves bound or fettered by the earlier disposition by a staff member, though they clearly agreed with the decision (the substance of which informs this Application for Review).

[30] Second, nowhere in the process just described did the College propose, did the Complainant request, or did the Review Board rule, that the Complainant must have an opportunity to make a further submission to the Inquiry Committee before it issued its new disposition. I cannot fault the Inquiry Committee for proceeding according to my ruling that the Complainant would have an opportunity to respond to the amended disposition prior to the Review Board dealing with the Application for Review. The Complainant was given that opportunity in his Statement of Points and in his reply submissions, discussed below.

IX REGISTRANT'S FURTHER RESPONSE TO THE COLLEGE

[31] On March 22, 2017, the College wrote to the Registrant's counsel requesting that she review the Complainant's December 20, 2016, application for review "and provide the College with a response to the points raised therein. In providing a response, we

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[4] *Ferrari v. College of Physicians and Surgeons of Alberta* 2008 ABQB 158 at para. [9]

ask that [the Registrant] address her understanding of the *Mandela Rules* and its applicability to the work she does in the prison setting."

[32] On April 24, 2017, the Registrant responded. She stated that she first read the *Mandela Rules* in June 2015. She expressed the view that they are not clinical rules or guidelines, and "do not speak to the specific role of psychiatric practice in Corrections." She stated that while Rules 30(c), 42 and 27 could "in theory, involve psychiatry," they "do not do so in [PC "A"]" because "the psychiatrist is not contracted to Corrections and is an independent body." The Registrant further stated that rules 24 through 35 of the *Mandela Rules* "are principles I consider fundamental to the practice of medicine and psychiatry, both in the prison and in the larger community." She advised the College that:

> Had the Mandela Rules never come to the attention of my medical and psychiatric colleagues, I think my colleagues in Correctional psychiatry would nevertheless have considered these principles fundamental.

[33] With specific regard to the Complainant's contention that "segregation in British Columbia in Pre-Trial is torture and cruel and unusual punishment" such as to trigger Mandela Rules 32(d),[5] 33[6] and 34[7] which were violated by the Registrant, she stated:

- "I do not know of any correctional facility or even a designated mental health inpatient facility which does not have some form of segregation. I do not control or influence the placement of the 600 or so inmates in this centre."

- "Frankly, I do not agree that segregation as implemented at [PC "A"] constitutes either torture or cruel or unusual treatment or punishment. Maintaining safety is important in the management of dangerous individuals who cannot control their own behavior or are self-harming."

- "I have not seen an inmate who suffered from a new mental disorder or suffered from an exacerbation of an existing mental disorder because he had been placed in segregation."

- "Segregation almost always involves two inmates being housed together in corrections and cannot be described as solitary confinement. The rules

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[5] Rule 32(d) states: "The relationship between the physician or other health-care professionals and the prisoners shall be governed by the same ethical and professional standards as those applicable to patients in the community, in particular … (d) An absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment…."

[6] Rule 33 states: "The physician shall report to the prison warden whenever he or she considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or any condition of imprisonment (including solitary confinement)."

[7] Rule 34 states: "If a health care professional becomes aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report it to the competent medical, administrative or judicial authority. Proper procedural safeguards shall be followed in order not to expose the prisoner to foreseeable risk of harm."

governing time out of the room for exercise and hygiene are handled in the BC Correction regulations."

- "… I did not form the view that [the Complainant] was experiencing a mental disorder or an exacerbation of a mental disorder due to his placement in segregation. I never saw any signs which suggested he was being subjected either to torture or to cruel and unusual punishment."

- "…my opinion was that [the Complainant] suffered an adjustment disorder associated with his incarceration, and antisocial personality traits…. I could not identify … any disorder which would need to be a focus of transfer to hospital for acute psychiatric treatment"…. "It was my opinion that he was not suffering from psychosis. I was not alone in holding this view…"

[34] The Registrant further stated:

> Although the situation has never risen in my practice, if hypothetically, one of my patients at the [PC "A"] showed signs of developing a mental disorder or of suffering an exacerbation of an existing mental disorder, and if I were of the opinion that this was because of segregation, I would likely discuss the matter with the [PC "A"] MD and one of the team psychologists, mental health coordinator and nursing staff and we would collectively recommend to Corrections staff that the patient be removed from segregation assuming he was not imminently violent or self-harming. This has not happened to me at [PC "A"].
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> Although the situation has also never arisen, if hypothetically, one of my patients at the [PC "A"] showed signs suggestive of torture or of cruel and unusual punishment or if I witnessed this behavior from staff, I would likely bring this to the attention of the [PC "A"] MD, one of the team psychologists, mental health coordinator and nursing and we would report this to Corrections. I cannot be absolutely sure what I would do, because it has never happened.

[35] The Registrant also reiterated her opinion that she discontinued the certification because she did not believe the Complainant satisfied the criteria for certification under the MHA: "He did not have a mental disorder under the definition of the Act. He did not require treatment. He was not in need of prevention of deterioration and could accept treatment in the Pre-Trial Centre if it were offered to him."

[36] Finally, the Registrant reiterated that she did not speak to PLS because she does not meet with counsel for prisoners and PLS was not involved in the clinical process.

X THE REVIEWER'S SUMMARY

[37] On April 28, 2017, a College Medical Reviewer prepared a memorandum and background documents for Inquiry Committee Panel "B."[8] The Reviewer posed the

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[8] Panel B is a 13 member inquiry committee panel, consisting of 8 physicians and 5 public representatives.

following “Issues for Committee Consideration,” with bullets which appeared to provide the Reviewer’s assessment of the issues:

> How does the Committee consider the issue of Mandela Rules?
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> - these are not evidence-based medical standards for psychiatric practice.
> - a psychiatrist has no role in placement of an inmate in correctional facility.
> - No evidence that [the Registrant] witnessed torture that would require a physician to act.
>
> How does the Committee consider [the Registrant’s] statement that [the Complainant’s] diagnosis was that of an adjustment disorder with antisocial personality traits?
>
> - Based on her psychiatric opinion and consistent with standard psychiatric practice.
> - The decision to de-certify was reasonable and appropriate, consistent with the diagnosis and standard psychiatric practice.
> - Prison psychosis is not a recognized psychiatric diagnosis.
> - [The Registrant] stated she saw no evidence to support diagnosis of ADD, or the pediatric diagnosis of fetal alcohol spectrum disorder.

XI INQUIRY COMMITTEE MINUTES (MAY 16, 2017)

[38] The Minutes of the Inquiry Committee’s May 16, 2017, meeting record its assessment that the Registrant’s conduct and competence were satisfactory under s.33(6)(a) of the Act, and did not warrant regulatory intervention. The Minutes stated:

> The Committee was informed that the Mandela Rules have been acknowledged in Canada, but have not yet been adopted as legally binding by official enactment. Thus, they are not determinative in legal proceedings but they remain an important encapsulation of human rights norms that are largely consistent with the CMA *Code of Ethics* and therefore properly assist and inform physicians who practice in the correctional setting.
>
> The Committee acknowledged that [the Complainant] had an acknowledged history of polysubstance abuse and violence toward other inmates. He had been transferred back and forth between institutions due to peer conflicts and violence. In British Columbia, solitary confinement is permitted and the prisoner must be reviewed by a physician every 30 days. Regardless of the physician’s opinion, the prisoner does not necessarily have to be moved out of solitary confinement. The Committee reviewed the occasions on which [the Registrant] assessed [the Complainant]; at times he displayed no psychotic symptoms and at other occasions she certified him for admission to a forensic facility. A subsequent certification was later cancelled as [the Complainant] was refusing medical and [the Registrant] believed him to be malingering. Other mental health professionals, including a physician at the forensic facility and a psychologist who saw [the Complainant] subsequent to [the Registrant], agreed that his history was complex and that a definitive diagnosis was difficult to ascertain.
>
> The Committee agreed that [the Registrant] used her clinical judgment in July 2015 when she cancelled [the Registrant’s] certification. She did not believe he was experiencing aggravation of his mental disorder due to segregation. She saw no signs he was being subject to torture or to cruel, unusual punishment. Based on the totality of

information available to her, her opinion was that he was experiencing adjustment disorder due to incarceration and antisocial traits. The Committee noted that a physician should not certify someone solely to keep them out of solitary confinement. The Committee believed [the Registrant] to have demonstrated a good understanding of the Mandela Rules and their role in her particular professional context. She also demonstrated a good understanding of prison health and behavioral disturbances versus mental health disorders, and stated that had she believed [the Complainant] to be decompensating as a result of his solitary confinement, she would have alerted appropriate authorities.

The Committee did not have any criticisms of [the Registrant] for adhering to her practice of not meeting with a prisoner's legal representative or advocate, and noted that the matter of releasing medical records is not within [the Registrant's] control.

XII FINAL SUPPLEMENTAL DISPOSITION REPORT (MAY 16, 2017)

[39] In addition to the Minutes, the Record also includes the May 2017 disposition letter, mailed to the parties on June 5, 2017.

[40] The May 2017 letter elaborates on the points made in the Minutes. After concluding that the *Mandela Rules* "are largely consistent with the principles reflected in the *Code of Ethics,*" the letter:

- Quoted from the Registrant's response to the allegation that she violated the *Mandela Rules*.

- Referred to the clinical records, noting that "while [the Complainant] was certified on a number of occasions there were also chart entries made by various health care professionals indicating suspicion of malingering and difficulty in reaching a definitive diagnosis given the challenge in parsing out genuine symptoms from feigned or exaggerated ones."

- Stated as follows with regard to the Registrant's decision not to continue the Complainant's involuntary certification:

> The Committee agreed that it is appropriate for medical regulators to afford a degree of deference to physicians in the exercise of clinical judgment generally and specifically in relation to making diagnoses: the physician is in the best position to evaluate the symptoms and potential treatment options based on his or her direct observation of the patient at the time of the clinical encounter in question. As long as the care provided falls within the range of acceptable standards expected of physicians and is supported by the clinical record, regulatory intervention may not be necessary or justified.
>
> Finally, the Committee did not have any criticisms of [the Registrant] for adhering to her practice of not meeting with a prisoner's legal representative or advocate.

[41] The May 2017 letter concluded as follows:

Following a lengthy discussion of the issues raised in this matter, the Committee did not identify grounds for criticism of [the Registrant's] care and conduct. Rather, the additional input of [the Registrant] and the Committee's consideration of all of the

available information suggested to the Committee that [the Registrant's] care and conduct was satisfactory; she exercised her clinical judgment in a reasonable manner, she provided a rationale for her clinical decisions supported by the clinical documentation; and, demonstrated an awareness of international standards for the treatment of prisoners and how they impact the work she performs in the correctional setting. The Committee determined that the available information was not supportive of a finding that [the Registrant's] conduct constituted a marked departure of the conduct expected of a physician in analogous circumstances, and as such, the Committee did not view remedial or disciplinary action to be warranted in this instance. Accordingly, the Committee directed that the matter be concluded under section 33(6)(a) of the HPA.

XIII REVIEW BOARD PROCESS RESUMES

A. Complainant's Statement of Points

[42] On July 27, 2017, PLS filed a Statement of Points on behalf of the Complainant.

[43] In addition to reiterating the position that the Deputy Registrar did not have jurisdiction to issue the November 2016 disposition (an issue I have concluded is now academic in view of the Inquiry Committee's May 2017 disposition), the Complainant submits that:

(1) The Inquiry Committee failed to consider the Complainant's submission that the Registrant violated her ethical obligations by participating in a practice that violated his basic human rights as defined by Mandela Rules 43, 44 and 45[9]. The IC simply relied on the Registrant's position that she has no authority over placement decisions. The Complainant submits that this assertion is itself factually incorrect as a matter of BC Corrections Policy, and also fails to recognize the options that would have allowed the Registrant to comply with her ethical obligations, including advocate for additional human contact for the Complainant, report his deterioration to correctional or outside authorities or advocate for his transfer to a forensic facility. The Registrant was "required … to do what was within her power to ensure that [the Complainant] was not held in solitary confinement."

(2) The Mandela Rules 32, 33, 34 and 46, as well as para. [9] of the CMA Code of Ethics, require physicians to "refuse to participate in or support practices that violate basic human rights." Insofar as the Disposition is based on the finding that the Complainant's basic human rights were not violated in solitary confinement, the Disposition was unreasonable, a conclusion reinforced in Bacon, supra. In support, the Complainant seeks to tender an affidavit, as well as PLS report advocating for the abolition of solitary confinement, which report sets out the experience of provincial prisoners in solitary confinement.

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[9] Rules 43 and 44 define "prolonged solitary confinement" (solitary confinement of 22 hours per day, without meaningful human contact, for a period exceeding 15 consecutive days) as a prohibited practice under the heading of torture or other cruel, inhuman or degrading treatment or punishment. Rule 45 prohibits solitary confinement altogether in the case of prisoners "with mental or physical disabilities when their conditions would be exacerbated by such measures."

(3) The Inquiry Committee failed to consider or give proper weight to overwhelming evidence that the Complainant suffered from a mental disorder that was exacerbated by this solitary confinement. The Registrant's opinion "flies in the face of multiple reports in [his] medical and correctional records," is "unreasonable" given the options of many other medical professionals regarding his psychosis, many of whom saw [the Complainant] more often than [the Registrant] did," and fails to recognize that there are other mental disabilities apart from psychosis that would have justified continued certification, including adjustment disorder. The Complainant argues as well that the Complainant's medical chart corresponds with the results of international research regarding the effects of solitary confinement. PLS submits:

> To the extent that the further evidence provided in this submission is relied upon in confirming that [PC "A"]'s use of solitary confinement treats people without dignity, respect, violates basis human rights or constitutes torture or cruel treatment, this is an indication that the College's investigation was not sufficient to reasonably conclude otherwise.

(4) The Inquiry Committee also failed to recognize that the Registrant had a duty to ensure the Complainant could access his medical records, and continued to mischaracterize PLS's request to speak with the Registrant. The Disposition failed to address the complaint that the Registrant "has an obligation to ensure BC Corrections has addressed issues of access to medical records when she agrees to contract with it," for example contacting BC Corrections to ensure they release the records without delay, or speaking with her patient via his counsel.

[44] The additional evidence the Complainant has sought to tender include his own affidavit sworn in July 2017, the affidavit of a PLS advocate, the PLS Report headed "Solitary, the case for Abolition," and five journal articles dealing with psychiatric diagnosis and treatment issues.

B. College's Statement of Points (October 11, 2017)

[45] Citing Review Board Decision No. 2010-HPA-0073(a), the College submits that an application for review is not properly used to address an advocacy group's systemic concerns regarding the operation of (in this case) the correctional system. It submits that the Review Board's focus must remain on "the specific facts and circumstances regarding the care and conduct of [the Registrant] in relation to [the Complainant]." The College contrasts the Review Board's "application for review" role from its "guidelines and recommendations" role, emphasizes the other legal mechanisms for the review of corrections and mental health decisions, and points out that by virtue of s.44 of the *Administrative Tribunals Act* (which applies to the Review Board by virtue of s.50.64 and the Schedule to the Act) the Review Board is not the proper forum for the consideration of the *Charter* issues raised by the Complainant.

[46] With respect to the adequacy of the investigation, the College submits that the investigation was adequate. The College points to the extensive material that was considered by its decision-makers in both in November 2016 and May 2017, and

submits that this information "was sufficient to allow the Committee to assess [the Registrant's] care of [the Complainant]." The College submits the expectations of complainants must be balanced against the demands of administrative efficiency in light of the College's resources, and submits that "a review of BC Corrections policy and the conditions at [PC "A"] were not necessary for the Committee's review" given its role.

[47] With respect to the reasonableness of the disposition, the College emphasizes the deference that it is due, and submits that "the question for the College is whether the Registrant's actions are consistent with the expected standard of care" - a "threshold of competency" which is best addressed by the Inquiry Committee, given its expertise. The College submits that the Inquiry Committee's disposition was reasonable because it set out a clear line of analysis setting out the scope of review, the expected standard, the evidence and a conclusion on the specific facts. The College refers to previous Review Board decisions arising from complaints on *MHA* certification decisions, and notes that the Review Board process is not designed to re-hear complaints.

[48] With respect to the remedy sought by the Complainant, the College notes that the Review Board does not have authority to direct any of the outcomes requested.

[49] With respect to the fresh evidence the Complainant has sought to introduce, the College takes no position on the receipt of the Complainant's affidavit, but objects to the remaining material on the basis that they introduce irrelevant material (for example, corrections policies, systemic advocacy material and articles of a general nature not related to the Registrant's specific care of the Complainant).

C. Registrant's Statement of Points (October 11, 2017)

[50] The Registrant, like the College, submits that the investigation was adequate and the disposition was reasonable. She submits the College collected and considered all relevant evidence, exercised its specialized medical expertise and provided cogent reasons supporting its conclusion. The Registrant submits that while the Complainant appears to be bringing this application for review in pursuit of changes to corrections policy, "these Review Board proceedings are not the appropriate forum for these concerns."

[51] With regard to the adequacy of the investigation, the Registrant submits that the College collected all relevant evidence. She argues that it does not lie well for the Complainant to argue that the College should have investigated BC Corrections Policy which the Complainant himself could easily have tendered. Further, that Policy, which speaks to a psychiatrist's ability to report an inmate's deterioration, is not relevant to this Complaint because the Registrant's clinical view was that the Complainant was not deteriorating.

[52] With regard to the reasonableness of the disposition, the Registrant submits that this case involves a heightened degree of deference because the Inquiry Committee was assessing clinical care. The Registrant submits that:

(a) Submissions by the Complainant's lawyer about clinical records and medical literature are not sufficient to show that the Inquiry Committee was unreasonable in assessing the Registrant's clinical conduct or diagnosis.

(b) The submission that the Inquiry Committee failed to consider the argument that the Registrant "violated her ethical obligations by participating in a practice that violated his basic human rights" (i) presupposes that the Registrant was aware of and shared the view that his human rights were being violated, and (ii) assumes her diagnosis (that the Complainant was not deteriorating) was incorrect.

(c) With regard to the submission that solitary confinement is a violation of human rights, the only relevant issue for the Inquiry Committee was:

> …what [the Registrant] knew and understood about segregation at the time she was treating [the Complainant]. [The Registrant] advised … that to the best of her knowledge she did not understand that [the Complainant] was being treated in a manner that constituted torture or cruel or unusual punishment. It was reasonable for the College to accept her evidence on this point. [emphasis added]

(d) With regard to the *Bacon* decision, the Registrant submits that that case "involves a different correctional centre than[PC "A"], and does not necessarily reflect the experience of [the Registrant] at [PC "A"]."

(e) Finally, with regard to the allegation that the Registrant did not do enough to assist the Complainant in seeking his medical records, the Registrant submits that the allegation that the Registrant should have insisted on contract terms pertaining to medical records is a new issue, and is one that applies to every corrections physician, and is thus not unique to the Registrant. As a result, the Inquiry Committee would not have been critical on this issue.

[53] With regard to the new information the Complainant seeks to tender, the Registrant takes issue with the admissibility of all the information, as it was either all available and could have been tendered to the College, or it is irrelevant. While the Complainant has sought to justify the admission of this material on the grounds of providing "rebuttal" to the Registrant's second response, the Registrant points out that she made many of the same points in her first response to the College (e.g., not involved in placing inmates in segregation), that the Complainant appears to be seeking to bolster or split his case by adding information to positions he had already raised and that all this information has been available to the Complainant from the start.

D. Complainant's Reply (November 1, 2017)

[54] In reply, the Complainant submits first that the fact that an ethical issue with systemic consequences arises from a specific complaint does not take the issue outside the Review Board's jurisdiction, particularly given the public interest purpose of the Act. Nor is the Review Board prohibited from considering *Charter values*, or remitting matters to the College to consider constitutional rights. The Complainant submits that his complaint:

> …relates squarely to [the Registrant's] failure to comply with the Canadian Medical Association Code of Ethics by not refusing to participate in or support practices that violate basic human rights and failing to take all reasonable steps to prevent harm to patients, and by failing to provide access to his medical information. He is not

> challenging a certification under the *Mental Health Act*. Neither is he challenging BC Corrections' policy on the role of medical professionals. In fact, he relies on BC Corrections' policy to demonstrate that [the Registrant] had obligations under those policies to protect [the Complainant] from harm, and failed to comply with them….

[55] With respect to the adequacy of the investigation, the Complainant submits that the November 2016 disposition noted that the relevant standard was "the standard expected of a psychiatrist in the correctional setting," but did not examine what those standards entailed, relying instead on the statement of the Registrant that she has no influence over the placement of inmates. He further states that this concern was compounded when the College did not share the Registrant's second response before issuing its disposition, at which point the Complainant would have provided the information.

[56] With respect to the reasonableness of the disposition, the Complainant submits that it unreasonable for the Inquiry Committee to accept the Registrant's position in the face of what the United Nations considers to be either torture or cruel treatment, and what can be described as human rights abuses. With respect to the issue of deference, the Complainant submits that the Inquiry Committee does not include anyone with expertise in international law standards and human rights in the prison context. The Review Board has the right to interfere if the College applies these standards "in a way that falls outside the range of acceptability."

[57] In reply to the position that the Complainant presupposes that the Registrant was aware of human rights violations, and did not share this view, the Complainant submits:

> …that it is not necessary that [the Registrant] be aware that his conditions violated basic human rights for a reasonable finding that she participated in the violation of his human rights. His complaint assumed that she was not aware of the *Mandela Rules…* The College's decision was unreasonable because it accepted [the Registrant's] unfounded assertion that she did not agree that his conditions amounted to a violation of human rights, torture or cruel treatment, despite the *Mandela Rules,* which are based on research of the negative effects of solitary confinement (which included many symptoms [the Complainant] suffered as documented by numerous medical professionals), and despite [the Complainant's] evidence and the *Bacon* decision that corroborated [his] evidence.

[58] With regard to the issue of medical records, the Complainant reiterates that upon being told that BC Corrections was denying him access to his own medical records, the Registrant was under "a duty to share with him information about her care plan for him, though his counsel."

[59] Finally, the Complainant in reply clarifies that the relief he is seeking is that the Review Board direct the Inquiry Committee to make a disposition that it could have made under s.33(6), of the Act or in the alternative to remit the matter back to the Inquiry Committee for reconsideration with directions.

E. FURTHER SUBMISSIONS

[60] On February 7, 2018, counsel for the Complainant wrote to the Review Board drawing my attention to the British Columbia Supreme Court's judgment in *British*

Columbia Civil Liberties Association v. Canada (Attorney General), 2018 BCSC 62, in which the Court referenced evidence regarding the psychological harms associated with solitary confinement.

[61] On March 1, 2018, the College and the Registrant each responded. The College noted among other things that the Court's judgment was rendered seven months after the Committee's disposition. The College notes that "while context is useful, arguments about systemic problems and *Charter* rights are for the courts, and in the Review Board process, these issues have the potential to distract from the appropriate focus of the proceeding. The Registrant objected to the admissibility of the decision, on the basis that it does not form part of the college's investigative record (the "Record"), and it is not relevant because "the College cannot reasonably be expected to render a disposition that takes into accord evidence that has not yet been heard, let alone evidence that was only presented in an entirely different forum." The Registrant also submits as follows in the event the Review Board finds the decision to be relevant:

> …[The Registrant] submits that the decision reflects the deep divide in the professional community with respect to opinions on the effects of segregation in a corrections setting. Mr. Justice Leask considered the expert evidence submitted on behalf of the plaintiff and defendant, and aptly referred to this as the "debate" between the experts… [The Registrant] submits that it is not within the College's legislated duties and objects to resolve differences in professional opinions.

[62] The Complainant's reply submits that the Court's judgment is case law, not "new evidence," and that the case reinforces its position that it was unreasonable for the Inquiry Committee to conclude that the Registrant met the standard of care expected of a psychiatrist in a corrections setting.

XIV DISCUSSION

[63] After carefully considering the comprehensive arguments advanced before me in light of the Record, it is my view that this application for review turns on a single important issue. That issue is whether the Inquiry Committee reasonably addressed the Complainant's objection that the Registrant violated her duty to "refuse to participate in or support practices that violate basic human rights" (*CMA Code of Ethics,* para. [9]) which, in this context, finds expression in the *Mandela Rules* which include various obligations on physicians and health care professionals (see Rules 33, 34 and 46).

[64] Before turning to this issue, two preliminary points are in order.

[65] First, I find the Inquiry Committee's investigation to be adequate. In my view, the Committee had sufficient information before it in May 2017, in the form of clinical records and submissions, to enable it to assess the complaint. The Complainant submitted that the investigation was inadequate because Inquiry Committee did not request records from Corrections about what ability a psychiatrist has to influence placement decisions. However, I cannot fault the Inquiry Committee for not taking that step when the Registrant asserted to the contrary in her first submission, and the Complainant chose not to tender the relevant policies in the opportunity for reply that was provided. In the unique circumstances of this case, where the Complainant was represented by an able advocacy organization, the Inquiry Committee was entitled to

assume that key allegations would be met in the submissions process it established. Furthermore, the evidence was already clear from the Registrant that *if* she believed that segregation caused or exacerbated a mental disorder, she would take action through the mental health team. Thus, the actual policy was not necessary in order to address the point. The real issue was whether, as a matter of professional standards, the Registrant was required to take that step in this case, based on what she knew or ought to have known.

[66] Second, I take no issue with the reasonableness of the Inquiry Committee's disposition insofar as it pertains to the Registrant's clinical decision-making under the MHA. While the Complainant has strongly challenged the Registrant's impression that he did not suffer from a mental illness, both the Deputy Registrar and later the Inquiry Committee, which included eight physicians, reviewed the entire clinical file and determined that the Registrant's clinical assessment did not breach the professional standard that it expected. The issue was addressed directly by the Inquiry Committee, and it is not my role in this review to disagree with that assessment.

[67] As noted above, the remaining issue here is whether the Inquiry Committee reasonably addressed the allegation that, separate and apart from her clinical assessment – and, for that matter, separate and apart from her stated view that "I have never seen an inmate who suffered from a new mental disorder or suffered from an exacerbation of an existing mental disorder because he had been placed in segregation" – the Registrant breached professional standards because she did not take action when the *Mandela Rules* prohibit the prolonged solitary confinement the Complainant was experiencing.

[68] To reasonably confront this question, the Inquiry Committee was required to answer at least these subsidiary questions:

> A. Is para. [9] of the *CMA Code of Ethics* applicable as a professional standard in British Columbia?
>
> > 9. Refuse to participate in or support practices that violate basic human rights.
>
> B. Does the Inquiry Committee accept, as professional standards in British Columbia, paras. [33, 34 and 46] of the *Mandela Rules*?
>
> > Rule 33
> >
> > The physician shall report to the prison director whenever he or she considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.
> >
> > Rule 34
> >
> > If, in the course of examining a prisoner upon admission or providing medical care to the prisoner thereafter, health-care professionals become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment,

> they shall document and report such cases to the competent medical, administrative or judicial authority…
>
> Rule 46
>
> 1. Health-care personnel shall not have any role in the imposition of disciplinary sanctions or other restrictive measures. They shall, however, pay particular attention to the health of prisoners held under any form of involuntary separation, including by visiting such prisoners on a daily basis and providing prompt medical assistance and treatment at the request of such prisoners or prison staff.
>
> 2. Health-care personnel shall report to the prison director, without delay, any adverse effect of disciplinary sanctions or other restrictive measures on the physical or mental health of a prisoner subjected to such sanctions or measures and shall advise the director if they consider it necessary to terminate or alter them for physical or mental health reasons.
>
> 3. Health-care personnel shall have the authority to review and recommend changes to the involuntary separation of a prisoner in order to ensure that such separation does not exacerbate the medical condition or mental or physical disability of the prisoner.

C. As a matter of professional standards, does the Inquiry Committee accept the *Mandela Rules'* statement that "prolonged solitary confinement" – defined in Rule 44 as solitary confinement for 22 hours or more a day without meaningful human contact for a time period in excess of 15 consecutive days – is a form of "torture or other cruel, inhuman or degrading treatment or punishment" within the meaning of Rule 33?

D. Does the Committee reject the Registrant's position that the *Mandela Rules* have no application to her because she is not contracted to Corrections?

E. Did the Registrant know or should she have known that the Complainant was in prolonged solitary confinement during the period when she was treating him?

F. As a matter of professional standards in relation to human rights protection, do the *Mandela Rules* apply to registrants whether or not a particular registrant agrees with the *Mandela Rules* as a matter of policy, and despite the registrant's conclusion about the impact of solitary confinement on the particular patient's mental health?

G. How did the Inquiry Committee assess the Registrant's conduct in relation to *Mandela Rules* 33, 34 and 46?

[69] As I read the Inquiry Committee's May 16, 2017, minutes and disposition letter, the Committee provisionally answered questions A - D "yes," but then failed to confront the key issues set out in questions E- G. I say "provisionally" in respect of A-D because the Inquiry Committee described the *Mandela Rules*, in the Minutes, as "an important encapsulation of human rights norms that are largely consistent with the *CMA Code of*

Ethics and therefore properly assist and inform physicians who practice in the correctional setting." That said, the Inquiry Committee did not expressly speak to question D above, and it is also not clear what the Inquiry Committee made of the statement in the Reviewer's Summary that the *Mandela Rules* "are not evidence based medical standards for psychiatric practice." Such a statement could be read as rejecting the underlying validity of the *Mandela Rules*, a view which does not appear to be shared by the experts whose evidence has been accepted in court proceedings addressing this issue: see *Bacon*, *supra,* and *British Columbia Civil Liberties Assn. v. Canada (Attorney General)*, 2018 BCSC 62 at paras. [227-254].

[70] I have carefully considered the Registrant's argument that no adverse finding could have been made by the Inquiry Committee unless she "was aware of and shared the view that his human rights were being violated."

[71] Is this the test for compliance with professional standards? This proposed test raises the fundamental issue as to whether the professional standards associated with upholding basic human rights depend on the knowledge and agreement of a professional regarding such rights. For a health-profession college, grappling with this issue requires decision-makers to confront important questions, including how professional standards are properly understood and defined given the objective status of basic human rights, having regard to the College's mandate to protect the public interest. In order for the Inquiry Committee to accept the position of the Registrant as referenced in para. [71] above, it would have to accept that the *Mandela Rules*, and torture as defined therein, are only applicable where a treating physician agrees with them.

[72] I refrain from commenting on the merits of that issue here, because the more fundamental problem is that, in my opinion, the disposition failed to confront the key issue. Instead, the disposition letter merely makes the general statement that "the Committee believed [the Registrant] to have demonstrated a good understanding of the *Mandela Rules* and their role in her particular professional context" (Minutes) and "demonstrated an awareness of international standards for the treatment of prisoners and how they impact the work she performs in the correctional setting" (Disposition Letter). The Committee's quotations from the Registrant's response which "refuted certain assertions made by [the Complainant's legal counsel]" are not expressed as being those of the Inquiry Committee, and they do not in any event answer the key questions.

[73] The point of this review process being held in abeyance was to "address the application of the *Mandela Rules* specifically." Regrettably, I am unable to find that this was done. The Inquiry Committee failed to confront the key issues.

[74] In Decision No. 2016-HPA-146(a), the Review Board held as follows:

> [61] … there is no doubt that the Inquiry Committee expressed a conclusion – that the Registrant's opinion was "reasoned" and "within the range of medical judgments"; that his "method appeared appropriately comprehensive," that he "described the interpretation of highly sensitive laboratory tests" and that it was reasonable for him to "consider the patient's dishonest answers to questions about drug use."

> [62] The problem is that these conclusions fail to disclose any meaningful explanation that was responsive to the key criticisms the Complainant advanced in detail.
>
> [63] It is recognized that inquiry committees are "screening" bodies, that their panels include medical professionals, that their time is limited, that they issue numerous decisions every year (sometimes numerous decisions per day), and that it would be too much to require them to deliver lengthy and detailed reasons as if they were the discipline committee. At the same time, these committees, which are supported by College staff, exercise an important part of the College's public interest mandate. The legislature's decision to make their dispositions subject to reasonableness review means that these panels are not to be seen as infallible or entitled to blind deference. While reasonableness review does not allow the Review Board to simply second guess inquiry committee medical judgments, reasonableness review would be meaningless if it did not at least require Inquiry Committees to reasonably explain themselves in a fashion commensurate with the realities of the complaint they are dealing with…

[75] I refer also to Review Board Decision No. 2016-HPA-111(a):

> [123] I accept that Inquiry Committees should not be put to an unreasonable burden in explaining themselves. However, a reasonable disposition requires a reasonable degree of transparency. Where, as here, the Complainants raised specific and carefully researched questions alleging substandard care by a specialist in respect of a clinical decision of such importance, it is unreasonable for the Inquiry Committee to fail to meaningfully speak to how it assessed the key points raised in the complaint. To return again to the turn of phrase used in one of the decisions referred to above, this decision "cries out" for explanation on the key issues raised by the Complainants.
>
> [124] There are cases where the failure to address a complaint issue is of little consequence because it is apparent from the Record that the conclusion arrived at by the Inquiry Committee was the only reasonable outcome, or the reasons were obvious and implicit from the disposition viewed in light of the Record. However, I am not prepared, for several reasons, to regard the Committee's failure to provide transparent reasons in this case as being inconsequential.
>
> [125] This is not a case where the Review Board can speculate as to how the Inquiry Committee would have answered one or both of the questions posed at para. [121] above had it answered them expressly. A reasonable disposition, given the public interest purposes of the College, required both questions to be addressed on this complaint.
>
> [126] Nor am I satisfied that the College's contested submissions on this review regarding the merits of the complaint should be taken to represent the views of the Inquiry Committee. As noted in Review Board Decision No. 2015-HPA-G23 at para. [110]: "…the College and the [Inquiry Committee] are not simply interchangeable, and I am not prepared to receive the College's submissions as simply being 'supplementary reasons' of the [Inquiry Committee]…." That caution is particularly powerful where, as here, the College's submission refers to material in the Record that was not even seen by the Inquiry Committee, where the College takes positions not reflected in the Inquiry Committee's Minutes and Disposition Letter, and where the Complainants are arguing that the College's submission mischaracterizes and misunderstands some of the key medical and research material on which it relies.

> [127] The dangers of the Review Board finding that the lack of responsive reasons is inconsequential to the outcome is especially pronounced where, as here, there was no apparent specialized expertise on the Inquiry Committee in relation to oncology or allergies, and no report from a specialist….

[76] I am alive to the Inquiry Committee's statement that it considered all of the materials and undertook a "lengthy discussion." However, after my own lengthy review of the file and of its work, I am nonetheless left without any meaningful guidance as to the basis on which the Inquiry Committee decided the very important issue on which the College sought and was granted an abeyance so the matter could be remitted to it for further consideration. To use the language of the cases, its disposition cries out for explanation on a central objection of the Complaint. If it is the Inquiry Committee's view that the *Mandela Rules* were not breached or not even in play, it should explain itself. If its view is that that one or more of the *Mandela Rules* was breached but that, despite this, no professional standards issues arose, the Committee should say so and explain itself. If on the other hand it is of the view that a professional standards issue does arise from the *Mandela Rules* on the facts of this case, the Committee is obliged to say so and fashion a remedial outcome accordingly.

[77] The final issue raised on this application concerns the reasonableness of the disposition insofar as it dismissed the complaint about access to medical records. The Inquiry Committee expressly considered this complaint, and held that it could not criticize the Registrant for adhering to her practice of not meeting with a prisoner's legal representative, and that the release of records was beyond her control. While the Inquiry Committee might reasonably have taken a broader approach, I do not think it was unreasonable for it to read the College's published professional standard as being applicable only to records that a registrant controls. Nor do I think that the only reasonable outcome for the Inquiry Committee was to find professional misconduct because the Registrant did not require a term in her contract which gave her control over medical records. Nor do I think that the only reasonable outcome for the Inquiry Committee was to find that the Registrant, who has a specialized role within the prison and was not the most responsible physician, was specifically obliged to meet with PLS to assist PLS in its advocacy efforts.

XV ORDER SOUGHT

[78] Section 50.6(8) of the Act sets out the Review Board's remedial authority:

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

[79] I have considered the Complainant's request that the Review Board direct the Inquiry Committee to make a particular disposition in this case. However, it is my view that the Inquiry Committee is the appropriate body to directly confront the professional

standards issues raised by this case in the first instance: see, recently, *Groia v. Law Society of Upper Canada*, 2018 SCC 27 at para. [51].

[80] I am aware that the Inquiry Committee finds itself in a somewhat novel position in this case. At least as reflected in the experience of this Review Board, the Inquiry Committee does not often have to confront the issues of professional responsibility concerning the protection of "basic human rights." While a traditional clinical lens is obviously more familiar and comfortable territory for the Inquiry Committee, assessing that was only part of its task in this case. Its duty required it to confront the ethical issues raised by the Complainant's reliance on the *Mandela Rules*. The fact that the Inquiry Committee's findings might have wider systemic implications did not diminish that duty. It had to confront the issues directly.

[81] It would obviously have been easier for the Inquiry Committee if the College Board had issued a standard or guideline addressing this subject matter – something the Board may wish to revisit in light of the judgment in *British Columbia Civil Liberties Assn. v. Canada (Attorney General)*, 2018 BCSC 62. However, in the absence of guidance from the College Board, the Inquiry Committee must address the issue.

[82] Taking all the circumstances into account, it is my view that the most appropriate disposition in this matter is to remit this matter to the Inquiry Committee, with the direction that the Committee issue a new disposition that specifically addresses the issues identified in para. [69] of this Decision, without prejudice to its ability to rely on whatever additional factors or reasons it considers should properly inform its decision.

[83] The only information I will direct the Inquiry Committee to consider as part of this decision, is the Complainant's affidavit of July 26, 2017, on the issue of his time in solitary confinement, in case there is any doubt whatsoever that the Complainant was in solitary confinement. While I will not direct the Committee to consider any further information, my order does not prevent the Inquiry Committee conducting whatever further investigations or consultations it requires, including considering some or all of the evidence the Complainant sought to tender in this proceeding, the Supreme Court's decision in *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2018 BCSC 62, and any further information it requires from the Registrant and the Complainant.

[84] Finally, and for completeness, it will be apparent that, given my ruling, I have not found it necessary to rule on the Complainant's application to adduce new evidence. Even if I had admitted all of that evidence, it would not have changed the outcome.

"Doug Cochran"

Doug Cochran, Panel Chair
Health Professions Review Board