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

CITATION: Complainant v. College of Physicians and Surgeons of British Columbia, 2019 BCHPRB 63

DECISION NO.: 2018-HPA-178(a), 2018-HPA-179(a); Grouped File No: 2019-HPA-G03

DATE: July 31, 2019

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 A**
	A Physician	**REGISTRANT B**
BEFORE:	Douglas Cochran, Panel Chair	**REVIEW BOARD**

HEARING DATE:	Conducted by way of written submissions closing on May 19, 2019	
APPEARING:	For the Complainant:	Self-Represented
	For the College:	Michelle Stimac, Counsel
	For Registrant A:	Mandeep K. Gill, Counsel
	For Registrant B:	Mandeep K. Gill, Counsel

Inquiry Committee Disposition Decision Review – Summary:

Stage 1 hearing of an application for review of a complaint Inquiry Committee disposition under s. 50.6 of the HPA – Disposition of IC confirmed. The Complainant wrote to the College that two Registrants, both physicians, did not properly care for his elderly mother who had been hospitalized with a number of ailments. The Complainant also wrote that the Registrants disregarded the family's religious beliefs by placing a Do Not Resuscitate order on the patient's medical file. In the Disposition, the Inquiry Committee of the College advised the Complainant that four large medical files from the hospital were considered for their investigation as well as the Registrants accounts of

the matter. The Inquiry Committee concluded that there was no basis for regulatory criticism of one of the Registrants; however, the Inquiry Committee was critical of the other Registrant for not documenting, at the time, a conversation that had taken place with the Complainant about not resuscitating the patient. The Review Board found the investigation adequate; noting that the Inquiry Committee obtained and reviewed the medical records and that the decision of the Inquiry Committee was made following a detailed investigation of the matter, concluding that their medical treatment by the Registrant met the appropriate standards. The Review Board found the Inquiry Committee's disposition to be reasonable in that it fell within the range of reasonable outcomes and was defensible on a review of the facts and law.

I INTRODUCTION AND BACKGROUND

[1] The Complainant applied under s.50.6 of the *Health Professions Act,* R.S.B.C. 1996, c. 183, (the "Act") for review of a November 8, 2018, disposition made by the Senior Deputy Registrar under s.32(3)(c), which was approved by the Inquiry Committee.

[2] The Complainant is the son of a 79 year-old-patient (the "Patient") who was treated in hospital after she was found lying on the ground in her bedroom after her daughter called for emergency assistance, as she could not contact her mother by telephone. Registrant A is an internal medicine specialist who treated the Patient in the intensive care unit (ICU) of a hospital. Registrant B is an internist and geriatrician working in the same hospital and who was responsible for the Patient's care in the last few days of her life.

[3] The Patient spent about three months in intensive care and her condition was described by Registrant A as follows:

> She developed septic shock and went into respiratory failure. She was intubated and brought to the ICU. While in ICU, she was diagnosed with influenza A, complicated by Staphylococcus aureus (MSSA) pneumonia and bacteremia. She later developed fungemia with Candida albicans. Other complications in the IU included a large right-sided pneumothorax resulting in a bronchopleural fistula and multiple pneumatoceles, right pulmonary embolism, demand ischemia gastrointestinal bleeding anuric renal failure requiring dialysis shock liver oral HSV, a new diagnosis of atrial fibrillation, critical illness encephalopathy critical illness myopathy and a sacral pressure ulcer.

[4] Registrant A also noted that the Patient developed hospital-acquired pneumonia after about two months in the ICU, but it was possible to wean her off the ventilator, and her tracheostomy tube was removed on March 17, 2017. He further notes that the Patient had renal recovery after prolonged dialysis.

[5] The Patient was moved from the ICU to a ward on March 20, 2017, and passed away on March 31, 2017, with the Complainant at her side. The decision to move the Patient from the ward and the care that she received on the ward, form the basis for the complaints to the College. The Complainant made additional complaints about other

treatment staff and of an institutional nature but the disposition letter correctly points out that the College does not have jurisdiction to deal with those matters.

[6] The Complainant's original complaint to the College lists the following concerns:

(a) Registrant A transferred the Patient from the ICU knowing that the care she would receive on the ward would be "lower than minimal;"

(b) Registrant A ordered the Patient transferred from the ICU despite her inability to "clear her throat or cough up sputum;"

(c) No antibiotics were given to the Patient when she was on the ward; and

(d) Registrant B did not render appropriate assistance to the Patient during the distress leading up to her death.

[7] The Statement of Points provided by the Complainant was in two parts. The concerns raised include:

(a) concern about the standard of care the Patient received on the ward, including the lack of "deep suctioning" of her lungs;

(b) concern that Registrant A "manipulated" the Complainant into agreeing that the Patient should be transferred to the ward; and

(c) concern that the Registrants did not respect the Patient and Complainant's faith and instituted a DNR protocol knowing that this was against their religious convictions.

[8] Registrant A notes that after the Patient had been in the ICU for about two months an extraordinary critical care meeting was held in which all 10 physicians who had provided care for the Patient agreed that should the Patient be able to be taken off of life support measures that "the appropriate level of care/intervention was medical care focusing upon comfort and dignity without re-referral to ICU for CPR, re-intubation, ventilation or defibrillation." The treating physicians agreed that "aggressive, painful and difficult life support measures in the event of a relapse were universally viewed as having no therapeutic utility while subjecting the patient to serious discomfort."

[9] The conclusions of the care team were communicated to the Complainant in meetings on March 16 and 17, 2017. In an earlier ICU meeting on December 30, 2016, the following note was made:

> Family meeting was held today with pt's son and his partner, pt's dtr and ICU Attending-Dr. W, Spiritual Care, bedside RN and SW. ICU Attending provided the news that pt's condition has deteriorated significantly, due to the complications from the staph infection in her lungs. She also remains in multi-system organ failure and has not made any meaningful recovery since she has been in ICU.

[10] Notes of the same meeting state that the Complainant had requested a second opinion and that report was provided to the Complainant at the meeting. It contained the same findings that the Patient was not expected to survive this admission.

> ICU Dr. said he is going to consult with Respiratory to see if there are any other options for treatment for pt's failed lungs. In the event there are no other viable options, than (sic) comfort care measures will be further discussed with family and medical team in the upcoming days.

[11] The Complainant acknowledges that he agreed that CPR would be harmful to his mother given her condition: "I agreed that CPR would be harmful, but didn't understand why this precluded her from any other treatments." In his initial complaint to the Review Board, the Complainant confirms a more optimistic point of view about his mother's recovery in ICU.

> [The Patient] was a patient in the ICU for approximately three months with pneumonia and related complications. Her condition was starting to improve by the end of three months of being in ICU. By this, I mean she was no longer on any breathing machines, she was cognizant, she no longer needed any medications other than pain killers. She was also starting to be able to speak again and the possibility of starting to eat again.

[12] Registrant B was involved in the Patient's care from March 27, 2017, until her passing on March 31, 2017. On March 27, 2017, Registrant B documented a conversation with the Complainant in the context of him inquiring about rehabilitation options. She informed the Complainant that his mother was not showing signs of improvement and it was unrealistic to think she could undergo rehabilitation.

[13] Registrant B indicated that the Patient was started on antibiotics on March 30, 2017, and had received several doses prior to her passing. Regarding the contentious period just prior to the Patient's death, Registrant B notes that there was a do not resuscitate (DNR) notation on the Patient's chart and that the Complainant had not spoken with her about re-discussing his mother's code status. She states:

> I did not call a Code Blue. It was documented in the ICU notes that (the Patient) would not survive CPR or intubation due to her multiple underlying lung insults and myopathy, and therefore such invasive treatments would be futile.

[14] Referring to the Complaint's concern that his mother's lungs were not deep suctioned, Registrant B states:

> [The Complainant] says "I can't understand why they wouldn't use a tool that would have cleared her air passages and allowed her to breathe." There was no such treatment that could be offered, as deep suctioning would have not been indicated with (the Patient's) unconscious state. Additionally, (the Patient's) primary medical issue at that time was septic shock, which would not have been reversed simply by suctioning.

[15] There are also a number of nursing notes in the days prior to the Patient's passing which confirm the Complainant's repeated requests for deep suctioning of his mother's lungs. The notes indicate that the oxygen absorption at those times was good (94-95%) and that the Complainant was informed that given the concern that deep suctioning would cause trauma, this would not be employed while there is good oxygen uptake. A March 30, 2017, note states:

> Unnecessary to suction at this time may also be dangerous since pt ↓ LOC. Pt's son agreeable (with symbol) this.

[16] Notably, on March 31, 2017, when the Patient was in distress, the Respiratory Therapist was called to set up a machine which would provide a higher flow of oxygen but the Patient died as this was being set up.

II NOVEMBER 8, 2018, DISPOSITION LETTER

[17] The disposition letter was critical of Registrant A for "his failure to document a contemporaneous note outlining the details of the DNR discussion." In the conclusion, the letter states:

> We are also hopeful that our review will reassure you that your mother's care was medically appropriate, she was not abandoned due to age, and there is no evidence to suggest that any physician withheld any medical therapy which would have been appropriate for her evolving, and worsening medical situation.

[18] The Inquiry Committee did not have any regulatory criticism of Registrant B; however the disposition letter does note that this should be an important reminder to doctors to be "mindful of the emotional needs of family members when they are coping with a very ill family member. In times of stress misunderstandings can occur."

III STATUTORY MANDATE

[19] This application is brought pursuant to s.50.6(1) of the Act, thus my role is to review the adequacy of the investigation and the reasonableness of the disposition by the Inquiry Committee. This is set out s.50.6(5) of the Act:

> **50.6 (5)** On receipt of an application under subsection (1), the review board must conduct a review of the disposition and must consider one or both of the following:
>
> (a) the adequacy of the investigation conducted respecting the complaint;
>
> (b) the reasonableness of the disposition.

[20] Making college investigations subject to review ensures transparency and accountability in the exercise of the college's screening role mandated by ss.32 and 33 of the Act. This has been described as follows;

> …An inquiry committee pays a critical role in the exercise of a professional health college's larger public interest mandate. "Screening" is not simply about whether to send the matter to a discipline hearing – a rare event. Screening also involves inquiry committees making provisional findings and assessments whether evidence supports a determination that a registrant's conduct had fallen below the regulatory standard….Screening is also about whether, in order to protect the public interest, the inquiry committee should seek to exercise one of the several other remedial options reflected in ss.33(6)(b), 33(6)(c) and 36(1) of the Act, which remedies are no less

important just because they depend on a registrant's consent: Review Board Decision No. 2018-HPA-039(a); 2018-HPA-040(a), (2018 BCHPRB 52), at para. [18])

IV ADEQUACY OF THE INVESTIGATION

[21] The Review Board has consistently determined that a Complainant's right to an adequate investigation does not equal a requirement for a perfect investigation. In determining adequacy, a proportionality test is utilized, thus what is adequate in one case may not be adequate in another and what falls short of adequacy in one case satisfies the test in another. Adequacy depends on the circumstances, which include 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: Review Board Decision No. 2009-HPA-0001(a); 2009-HPA-0002(a); 2009-HPA-0003(a); 2009-HPA-0004(a), (2010 BCHPRB 6).

[22] In *The College of Physicians and Surgeons v. The Health Professions Review Board*, 2018 BCSC 2021 (Dawson), the Court stated that "the adequacy of an investigation conducted by the College must be assessed by the Review Board on a reasonableness standard." (para.[179]) Applying this approach, the question before the Review Board is whether the College exercised its investigative discretion reasonably, having regard to all the circumstances of the complaint. (Dawson, para.[181])

[23] In conducting the investigation in this matter the Inquiry Committee submitted the complaint to Registrant A and Registrant B for their response. In addition, the Record in this matter contains over four thousand pages of documents primarily relating to the care that the Patient received while in hospital from December 19, 2016 to March 31, 2017. The Complainant was provided an opportunity to respond to the replies from Registrant A and Registrant B and the Complainant did provide a response received by the Inquiry Committee on March 23, 2018.

[24] Taking into account the nature of this complaint, the seriousness of the harm alleged and the information in the Record, I find that the investigation by the Inquiry Committee was adequate. I find that the Deputy Registrar and Inquiry Committee exercised their investigative discretion reasonably, having regard to all the circumstances of the complaint. The investigation satisfies the requirements of adequacy.

V REASONABLENESS OF THE DISPOSITION

[25] In assessing whether the Registrar's disposition is reasonable, I consider that a "reasonable decision," based on the current state of the law, is a decision that falls within a range of possible, acceptable outcomes, which are defensible, in respect of the facts and the law. A reasonable disposition should be transparent, intelligible and justified.

[26] In his Statement of Points (two documents) responding to the disposition letter, the Complainant expressed a number of concerns. These include a concern that the Inquiry Committee's statement, that it was appropriate for [Registrant A] to transfer the

Patient to the ward once she was discharged from ICU, failed to address the concern that it was not appropriate to transfer her from the ICU at her stage of recovery. While the Inquiry Committee might have more directly addressed this concern, read as a whole, the disposition letter does respond to it. There is reference to the extraordinary meeting of the ten physicians who had treated the Patient in the ICU and their agreement that discharging her from the ICU was "the appropriate level of care/intervention". In addition, the Patient survived eleven days on the ward and ultimately died as a result of septic shock. The disposition letter indicates that the Inquiry Committee considered the Complainant's concern about the timing of the Patient's transfer to the ward and they had a reasonable basis to conclude that they have no regulatory criticism in relation to that decision.

[27] The Complainant also stated that the Inquiry Committee failed to address the "professional ineptitude and manipulative nature" of Registrant A. This relates to the discussions surrounding the DNR notation on the Patient's chart. In essence, the Complainant feels that he was duped into agreeing that his mother should be moved from the ICU to the ward. The evidence before me is consistent that a discussion took place where the Complainant acknowledged that CPR would be harmful to his mother, in her condition. Registrant A refers to social worker notes that document the nature of the conversations with the Complainant March 16 and 17, 2017, which are consistent with the Patient's status being noted as DNR.

[28] The disposition letter makes references to misunderstandings between the Complainant and medical staff. The misunderstandings relate to conversations between the Complainant and both Registrant A and B, as well as others. The disposition letter notes:

> It appears that [Registrant A] believed you understood the details of the discussion and given the documentation found in the medical record, it would also indicate to us that your mother's ICU medical team was attempting to offer you realistic ongoing updated information regarding your mother's illness and progress.

[29] Based on a number of references in the material before me, it is likely that the Complainant was undergoing tremendous stress due to his mother's deteriorating condition and did not process the negative information about her declining health.

[30] The Complainant has suggested that the manner in which his mother was treated by the Registrants did not take into account the family's religious beliefs in the sanctity of life. While the Disposition Letter does not address religious issues, it is clear that the Inquiry Committee has considered whether the Patient was provided with medically appropriate care and concluded that she was. There was ample evidence before them to support this decision. This includes the fact that ten ICU physicians agreed that it was medically appropriate to move the complainant from the ICU after three months and a stabilization of her condition. She had numerous complex ailments and survived for eleven days after the move. As noted by Registrant B, the Patient's primary medical issue at the time of her death was septic shock which would not be reversed with deep suctioning that the Complainant pleaded for.

[31] On my reading of the Record, there was a disconnect between the Complainant, and the Registrants and the medical support team, regarding the appropriate treatment for the Patient. The Complainant cites religion, indicating that any measure that might prolong life must be taken whereas, on my reading of the material, the treatment team had a more nuanced approach. Given the Patient's multiple, profound injuries the treatment team determined that certain interventions which would not lead to recovery and which would otherwise cause trauma to the patient, would not be employed. Indeed, even the Complainant, at one point, agreed that CPR should not be employed.

[32] The Complainant's repeated requests that deep suctioning should be employed are an example of the disconnect. In the Patient's final days the Complainant made this request numerous times. It was explained on these occasions that the Patient's oxygen uptake was good and the procedure he was asking for would likely cause trauma. Despite his apparent acceptance of this explanation on these occasions, in helplessly watching his mother struggle, the Complainant repeatedly reiterated this request. The Inquiry Committee was well aware of this disconnect and addressed it in their letter, acknowledging the apparent misunderstanding between the Complainant and Registrant B regarding the treatment plan. They state:

> It was necessary and appropriate for [Registrant A] to discuss and write a DNR-3 given your mother's grave illness and we are not critical of [Registrant A] for this decision to discuss this decision with you and write an order for the DNR. …It was appropriate for [Registrant A], an ICU specialist, to transfer your mother's care to the physician team working on the ward once your mother was discharged for the ICU.

[33] Registrant B and the treatment team were faced with the task of dealing with a patient requiring complex care while responding to a family member at the patient's bedside, who was insisting on care that was not medically appropriate, as it would likely further injure the patient without remediating the cause of the patient's illness. Indeed, one of the complaints noted in the statement of points is that Registrant B "did not listen to the family."

[34] The Complainant states that the Inquiry Committee did not address the issue he raised regarding antibiotic medications. This was addressed by the Inquiry Committee in the body of the disposition letter through reference to Registrant B's comments and in the conclusion of the disposition letter. Any concern about timing of the prescription of medication is a medical one and I defer to the Inquiry Committee's assessment that it did not warrant criticism of Registrant B. In my view, their assessment falls within the range of possible reasonable conclusions.

[35] The Inquiry Committee had evidence before them of the timing of the attendance of the respiratory team, just before the Patient passed away. I consider this complaint in the context of the medical chart which notes that there were nine visits from the Respiratory Therapist in the two days before the Patient passed away. There were also a number of visits from a dietitian/nutritionist, physiotherapist, occupational therapist, speech language therapist and a multitude of nurses who attended the Patient. From this distance, I am not in a position to come to a conclusion any different than the

Inquiry Committee which had no criticism of Registrant B's actions at the time of the Complainant's mother's passing.

[36] In his Statement of Points, the Complainant states that the Inquiry Committee failed to address the fact that Registrant B "ordered the patient next to my mom to be moved away which blocked access to the respiratory team at a critical moment." The Registrant has a perspective on this matter as a result of his proximity to the events. In addition, this must have been the most stressful of times for him, which may well impact on the objectivity of his assessment of the situation. While I do not see a specific reference in the disposition letter to the complaint about Registrant B ordering another patient to be moved, the Inquiry Committee was aware of the circumstances and concluded without regulatory criticism of Registrant B. I cannot see how the Inquiry Committee could be expected to place themselves in the position of Registrant B and second guess a decision to clear the treatment area of another patient, in a critical situation. In my opinion, the lack of a specific reference to the decision to move the other patient does not undermine the reasonableness of the Inquiry Committee's decision.

[37] Similar to my conclusion in para. [36] above, the complaint that Registrant B "shrugged her shoulders" when the respiratory team came is not something that the Inquiry Committee could deal with in a regulatory environment and the lack of a mention of this does not undermine the reasonableness of the decision.

[38] The decision of the Inquiry Committee was made after thoroughly canvassing the circumstances surrounding the complaints put forth by the Complainant. I cannot think of a more horrible circumstance than experienced by the Complainant, being at the bedside of his mother when she died while, in his eyes, others did nothing. Many of the concerns raised by the Complainant highlight the chasm between his perception of events and that of the medical care providers who were treating his mother. Having ensured that the appropriate information was before them, the Inquiry Committee considered all the evidence in a reasonable manner. The evidence before the Inquiry Committee supports their conclusion that Registrant A and Registrant B provided "medically appropriate" care in the circumstances.

[39] Considering all of the evidence before me I find that the Inquiry Committee's decision is a reasonable one as it is transparent, intelligible and justified. Based on my review of the Record I find that the Inquiry Committee's investigation of the complaint was adequate and that the disposition of the complaint in relation to both Registrant A and Registrant B was reasonable. Pursuant to s.50.6 (8)(a) of the Act I confirm the disposition of the Inquiry Committee.

[40] In making this decision I considered all of the information and submissions before me whether or not I have specifically referenced them.

"Duoglas Cochran"

Douglas Cochran, Panel Chair
Health Professions Review Board