File # 13-CRV-0387

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

Stephen Kovanchak, Designated Vice-Chair, Presiding
Michael Boucher, Board Member
Norma Grant, Board Member

Review held on February 6, 2014 in Ontario (by teleconference)

IN THE MATTER OF A COMPLAINT REVIEW UNDER SECTION 29(1) of the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act*, *1991,* Statutes of Ontario, 1991, c.18, as amended

B E T W E E N:

CARION FENN

Applicant

and

HENRY T. M. DEVLIN, MD

Respondent

Appearances:

The Applicant:	Carion Fenn
For the Respondent:	H. Michael Rosenberg, Counsel
For the College of Physicians and Surgeons of Ontario:	Tracy Baruch

DECISION AND REASONS

I. DECISION

1. It is the decision of the Health Professions Appeal and Review Board to confirm the decision of the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario to take no further action on this complaint.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by Carion Fenn (the Applicant) to review a decision of the Inquiries, Complaints and Reports Committee (the Committee) of the College of Physicians and Surgeons of Ontario (the College). The decision concerned a complaint regarding the conduct and actions of Henry T. M. Devlin, MD (the Respondent). The Committee investigated the complaint and decided as set out above.

II. BACKGROUND

3. The Applicant was involved in a motor vehicle accident on September 17, 2006. Subsequently, she developed a number of symptoms especially related to her neck, left shoulder, left trunk and headaches. The Applicant contends that prior to her involvement in the accident she was asymptomatic regarding these symptoms.

4. Superior Independent Medical Assessment Centres requested the Respondent, a specialist in physical medicine and rehabilitation medicine, to perform an independent medical assessment (IME) for the Applicant's insurance company. The Respondent examined the Applicant on March 8, and June 5, 2007. He subsequently provided two paper file review reports, dated September 12, 2007 and February 27, 2008.

5. After assessing the Applicant on March 8, 2007, the Respondent provided a report to the Applicant's insurer with the following conclusions:

    - The restriction of range of movement in her left shoulder girdle cannot be explained by an underlying impairment, similarly her history of no improvement in her pain complaints over the past 5 to 6 months has not been in keeping with an underlying musculoskeletal injury. At this time, the issue is that of ongoing pain, though the source of this is not known.
    - I do not believe any further testing is indicated.
    - On the basis of an identifiable musculoskeletal impairment, [the Applicant] does not have a substantial inability to carry on her essential care-giving tasks.
    - [The Applicant's] limitations are that of her ongoing pain complaints, though there are no objective findings, but rather just subjective findings with respect to pain.

6. The Respondent concluded that the Applicant was then able to return to care-giving activities and further expressed the opinion that he did not believe that the Applicant had a substantial inability to perform her pre-accident housekeeping or home maintenance activities given her current findings and history

7. The Respondent next assessed the Applicant on June 5, 2007 and was requested by the Applicant's insurer to offer an opinion regarding whether the proposed Treatment Plan dated April 18, 2007 was reasonable and necessary. The proposed Treatment Plan recommended a cervical epidural injection, a greater occipital neuralgia injection and a soft tissue injection. The Respondent provided an opinion to the Applicant's insurer that the treatment was neither reasonable nor necessary.

8. On September 12, 2007, the Respondent provided a paper review to the Applicant's insurer regarding whether a proposed physiatry assessment was reasonable and necessary for the Applicant's treatment and rehabilitation. The Respondent noted that the Applicant was being followed by Dr. A. Kachooie who is a physiatrist and advised the insurer that it was his opinion that the proposed physiatry assessment was neither reasonable nor necessary.

9. On February 29, 2008, the Respondent provided a further paper review to the Applicant's insurer regarding whether another proposed physiatry assessment was reasonable and necessary for the Applicant's treatment and rehabilitation. The Respondent concluded that there was no new information different from any previous information that he had reviewed regarding this issue and again noted that Dr. Kachooie continued to follow the Applicant on an ongoing basis. Accordingly, the Respondent provided an opinion to the insurer that the requested physiatry assessment was not reasonably required.

10. In February 2009, the Applicant filed a complaint with the College regarding the conclusions of the Respondent based on his assessments.

11. The Inquiries, Complaints and Reports Committee (ICRC) investigated the complaint and concluded, "the Respondent's opinion regarding the Applicant's condition was informed and based on the clinical information before him at the time." The ICRC decided to take no action regarding the matter.

12. The Applicant requested the Board review that decision. In a January 2012 decision (HPARB 10-CRV-0073), the Board returned the matter for further investigation. Specifically, they instructed the ICRC "to have an independent physician review the matter and provide an opinion to the Committee concerning the standard of care" and for the Committee to reconsider its decision. In addition, the Board found that the Respondent's conclusions in his IME report appeared to be inconsistent with and contradicted by information in the Record.

13. The Committee reconsidered the matter as requested by the Board and issued a new decision dated February 14, 2013. The Applicant requested that the Board review the second decision of the Committee.

The Complaint

14. In her original complaint to the College, the Applicant alleged that the Respondent had failed to provide her with adequate care:

- by concluding that her syringomyelia was congenital and did not take into consideration that it was caused by the trauma from her car accident;
- by not taking into consideration the effect the car accident had on the syringomyelia; and
- by failing to comment on the "mass" over her left shoulder area.

15. Those issues remained before the Committee and, in addition, the Committee was to:

- obtain an expert opinion (IO) and
- reconsider the decision in light of the fact that the physician's conclusions in the IME report appear to be inconsistent with, and contradicted by information in the Record.

The Committee's Decision

16. The Committee investigated the complaint and decided to take no further action on the complaint.

III. REQUEST FOR REVIEW

17. Dissatisfied with the decision of the Committee, in a letter dated July 2, 2013, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

18. After conducting a review of a decision of the Committee, the Board may do one or more of the following:

    a) confirm all or part of the Committee's decision;
    b) make recommendations to the Committee;
    c) require the Committee to exercise any of its powers other than to request a Registrar's investigation.

19. The Board cannot recommend or require the Committee to do things outside its jurisdiction, such as make a finding of misconduct or incompetence against the member, or require the referral of allegations to a discipline hearing that would not, if proved, constitute either professional misconduct or incompetence.

V. ANALYSIS AND REASONS

20. Pursuant to section 33(1) of the *Health Professions Procedural Code* (the *Code*), being Schedule 2 to the *Regulated Health Professions Act, 1991*, the mandate of the Board in a complaint review is to consider either the adequacy of the Committee's investigation, the reasonableness of its decision, or both.

21. The Board has considered the submissions of the parties, examined the Record of Investigation (the Record), and reviewed the Committee's decision.

Adequacy of the Investigation

22. An adequate investigation does not need to be exhaustive. Rather, the Committee must seek to obtain the essential information relevant to making an informed decision regarding the issues raised in the complaint.

23. In its initial investigation the Committee obtained the following documents:

- the Applicant's letter of complaint, dated February 8, 2009 and further information provided by the Applicant including comments regarding the Respondent's response to the complaint;
- the Respondent's written response to the Applicant's complaint, dated March 30, 2009, his records, and additional information provided in response to the Applicant's comments regarding his initial response; witness information from Dr. A.Kachooie, a physiatrist; Dr. Rick Paulseth, a neurologist; Dr. Charles Tator, a neurosurgeon; a neurological evaluation conducted by Dr. Lance B. Majl, a specialist in internal medicine and adult urology; and an assessment of the Applicant conducted by the Health Recovery Clinic;
- the College's policy #8-02: *Third Party Reports*

24. In addition following the Board's decision to return the matter, the Committee also considered the following:

- An Independent Opinion (IO) provided by Dr. Gail Ann Delaney (IOP), a specialist in Physical Medecine and Rehabilitation;
- The Board's decision of January 2012 returning the matter; and
- Submissions from the Respondent in response to the report provide by the IOP.

25. The Applicant's submissions regarding the Committee's investigation were brief. She submitted that there were other reports from physicians that were not before the Committee but who quoted the Respondent and that these additional reports were important and should have been before the Committee.

26. Counsel for the Respondent submitted that the College conducted a thorough investigation and, accordingly, it was adequate.

27. The Board finds that the Committee's investigation covered the events in question and yielded relevant documentation to assess the complaint regarding the Respondent's conduct.

28. There is no indication of further information that might reasonably be expected to have affected the decision, should the Committee have acquired it. Accordingly, the Board finds that the Committee's investigation was adequate.

Reasonableness of the Decision

29. In considering the reasonableness of the Committee's decision, the question for the Board is not whether it would arrive at the same decision as the Committee, but whether the Committee's decision can reasonably be supported by the information before it and can withstand a somewhat probing examination. In doing so, the Board considers whether the decision falls within a range of possible, reasonable outcomes that are defensible in respect of the facts and the law.

Applicant's Submissions

30. The Applicant submitted that the decision of the Committee was unreasonable. She relied upon the IOP's conclusions that the Respondent demonstrated a lack of knowledge on the condition of syringomyelia and that consequently, he should have referred the Applicant to another practitioner such as a neurologist for a further opinion.

31. The Applicant further relied upon the IOP's conclusion that the Respondent "ought to have known that wording his opinion the way he did would likely result in [the Applicant] being disqualified for benefits by her insurer." The Applicant submitted that the Respondent was responsible for her loss of benefits from her insurer and that it was crucial that the Respondent should have acknowledged a lack of expertise regarding the condition of syringomyelia and referred her to a specialist.

32. The Applicant noted that the Committee concluded that it was not the Respondent's role to refer her to a specialist but submitted that the Committee should have found that he was obliged to advise her insurer in his report that an expert's opinion should be obtained due to the fact that her condition was beyond his expertise.

33. The Applicant further submitted that it was important to ensure that no other person have to go through what she suffered as a result of the Respondent's report which she said was biased in favor of her insurer. Finally, the Applicant submitted that the Committee should have required the Respondent to undertake and obtain additional education in order to prevent further occurrences as in her case.

Submissions on Behalf of Respondent

34. Counsel for the Respondent submitted that this Review should be limited to the issues raised by the Board in its first decision namely, to obtain, assess and review an expert opinion in order to ensure the adequacy of the investigation and, secondly, to deal with the issue relating to the conclusion of the Board in the first decision that the Respondent's conclusions in his IME report appeared to be inconsistent with, and contradicted by information in the Record.

35. Counsel further submitted that the Committee did obtain an independent opinion from a specialist in physical medicine and rehabilitation with expertise in treating the condition of syrinx/syringomyelia, thus complying with the requirement of the Board regarding its concerns relating to the adequacy of the investigation.

36. Counsel noted that the IOP concluded that the Respondent had met the standard of care for an IME. However, Counsel disagreed with the conclusion of the IOP that the Respondent "did demonstrate a lack of knowledge on the condition of syringomyelia and demonstrated a superficial knowledge of the condition, and then only in the context of a traumatic spinal cord injury." Counsel submitted that the Respondent is not an expert in that condition and should be held to the standard of a physiatrist and not that of an expert regarding the condition of syringomyelia. Counsel urged the Board to confirm the Committee's decision that the Respondent, as a physiatrist, would not be expected to have expertise regarding the condition of syringomyelia and that the opinion he provided was as a physiatrist not as a neurologist or specialist in that condition.

37. Counsel further noted that the IOP concluded that the Respondent should have referred the Applicant to another practitioner for a further opinion and should have deferred his opinion report to a neurologist or a specialist familiar with syringomyelia issues. Counsel submitted that the IOP appeared to misunderstand the role of an IME and his obligation in connection with Third Party Reports. Counsel submitted that the Committee correctly concluded that it was not the Respondent's role as an IME to refer the Applicant and, further, that role was properly filled by the Applicant's treating physiatrist who managed her care.

38. Finally, Counsel for the Respondent reviewed the IOP's suggestion that the Respondent did not provide convincing reasons for dismissing the possibility that the Applicant's symptoms were related to a syrinx, or provide an alternative explanation, and further that he ought to have known that his wording would likely result in the insurer disqualifying the Applicant's application for benefits.

39. Counsel submitted that the IOP's opinion regarding this issue is incorrect and should be disregarded. Counsel noted that the Respondent's knowledge regarding the genesis of the Applicant's syrinx was irrelevant to his IME opinion since he reasonably concluded that her impairment was not related to a syrinx. Counsel further noted that the Respondent's conclusion was confirmed by a subsequent imaging report that verified the Applicant did not have a syrinx. Counsel further submitted that the Respondent was entitled to express his opinion that the Applicant's diagnosis was that of chronic pain and that there were no findings that could be related to a syrinx. Finally, Counsel submitted that the Committee's decision regarding this issue was reasonable and should be confirmed.

Analysis

40. The Board observes that the IOP concluded that the Respondent's care overall met the standard of practice required of the profession. She further concluded that the Respondent did not display any disregard for the patient nor any obvious lack of skill during his assessment of the patient. She expressed no concerns regarding the Respondent's clinical judgment. The Board also notes the Committee reasonably relied upon these opinions in reaching the conclusion that the Respondent's care in this matter met the standard expected of the profession.

41. However, the IOP raised an issue regarding the Respondent's lack of knowledge of the condition of syringomyelia. On this issue she concluded as follows:

> In terms of lack of knowledge, [the Respondent], in my opinion, did demonstrate a lack of knowledge on the condition of syringomyelia and demonstrated a superficial knowledge of the condition, and then only in the context of a traumatic spinal cord injury.
>
> However, he ought to have known that wording his opinion the way he did would likely result in [the Applicant's] insurer disqualifying her. He stated that her marked impairment could not be explained on the basis of an underlying impairment, but he failed to offer an explanation as to what the reason was. He seemed to dismiss the idea that the syrinx could have anything to do with her symptoms.

42. The Committee however, concluded that the Respondent nonetheless did not fail to meet the standard of practice of a physiatrist in respect of the opinion requested by the insurer, ie as to the appropriateness of the treatment plan proposed. The Committee found that he was requested to provide an opinion as a physiatrist and not as a neurologist or a specialist in syringomyelia.

43. The medical standard of care by which a physician's practice is assessed has long been settled by the Courts. In *Bogdon v. Folmon*[1] it was held:

> The standard of care required of a physician who is specialized, as is Dr. Folman in pediatrics, is that of the reasonably competent practitioner practicing in the same specialty, considering all the circumstances.
>
> As stated by Schrader J.A. in *Crits v. Sylvester*:
>
> Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him then than of one who does not profess he [is] so qualified by special training and ability.

44. While the above observations about the standard of care required by physicians were made in the context of addressing treating physicians, they would also apply to a non-treating physician providing a professional opinion to a third party.

45. The IOP expressed the opinion that the Respondent should have advised the insurer that a neurologist's opinion should be obtained or he should have deferred to a physician with more experience in dealing with the issues in question.

46. The Committee, on the other hand, concluded that it was not the Respondent's role to refer the Applicant since that role was to be left to the treating physiatrist currently managing her care. The Committee further noted that the Applicant did in fact see a neurologist, a neurosurgeon and other specialists for investigation and treatment recommendations. The Committee relied upon the College's *Third Party Reporting* policy in coming to its conclusion. It noted that the independent medical examiner is expected to be unbiased and impartial and should not either initiate treatment or make treatment recommendations.

47. The Board notes that the Respondent was requested to provide a third party assessment of the Applicant by her insurer. He was asked to determine if a proposed physiatry assessment was reasonable and necessary for her treatment and rehabilitation. The Respondent provided an opinion that the requested treatment plan for a further physiatry assessment was not indicated. The Respondent during the course of his opinion concluded that the Applicants diagnosis was that of chronic pain rather than an identifiable musculoskeletal impairment. He further concluded that the Applicant's syrinx did not explain her presentation.

48. In reviewing the Record, the Board further notes that the Respondent's opinion is supported by Dr. Rick Paulseth a neurologist to whom the Applicant was referred by Dr. Kachooie, her treating physiatrist. In his report dated February 29, 2008 Dr. Paulseth concluded as follows:

> The Sensory Findings Are Unusual. Perhaps they relate to an underlying syrinx will hold they are a typical distribution. I doubt that the syrinx is playing a major factor in the dystonia.

Dr. Paulseth also stated that: there is a prominent central canal or ***possibly a syrinx*** (emphasis added).

49. The Applicant had also been referred to the Scarborough Hospital Rheumatology Clinic where she was seen by Dr. Felix Leung who provided a report March 14, 2008 stated as follows:

> I see it that she had MRIs last year, and the one done in May 2007 demonstrated some degenerative disc disease in the neck as well as a ***possible syrinx*** (emphasis added). A repeat MRI with contrast was done which showed a prominent central canal ***but it was felt that this is an incidental finding of no clinical consequence*** (emphasis added).

Dr. Leung further noted that the Applicant complained of chronic aches and pains.

50. The Committee came to the following conclusions:

- The Committee is of the view that [the Respondent] presented factual information regarding [the Applicant's] condition, appropriately based on his reasonable knowledge of the condition as a physician with a practice in physiatry, and on his assessment of [the Applicant].
- [The Respondent] did not report that she had no disability, but rather, that he could not find a defined musculoskeletal abnormality to explain her pain. Many persons with chronic pain do not have a defined musculoskeletal abnormality but nonetheless are disabled.

51. The Board finds that regarding this aspect of the matter the Committee appropriately addressed the concerns raised regarding this concern and arrived at a conclusion that was reasonable based upon the Record.

52. An additional issue was raised by the IOP who further expressed the opinion that the Respondent's conclusions regarding the linkage between the Applicant's motor vehicle accident and her medical complaints were unreasonable.

53. On this, the Committee disagreed with the IOP's conclusion The Committee noted that the Respondent did not deny that the Applicant had a disability but explained that he could not find a defined musculoskeletal abnormality to explain her pain. The Committee further noted that it is not uncommon for persons with chronic pain to be disabled but not have a defined musculoskeletal abnormality. Further, the Committee, on reviewing the Applicants medical records, found that there was uncertainty regarding whether she in fact had syringomyelia, and, if she did, when it might have developed.

54. The Committee noted that the IOP agreed with the Respondent that most of the literature dealing with syringomyelia is in the context of spinal cord injury or spina bifida and that only anecdotal evidence exists regarding syringomyelia following a minor motor vehicle accident. Accordingly, the Committee concluded that the Respondent's conclusions regarding this issue were reasonable having regard to the IOP's description of the current literature and did not therefore reflect a lack of knowledge on his part. The Committee then concluded as follows:

> In short, the Committee is satisfied that [the Respondent] appropriately based the IME report on his reasonable knowledge of the condition as a physiatrist, that he appropriately followed an evidence-based approach, and that his conclusions were not unreasonable.

55. To summarize, and as noted previously, the IOP in response to the main concern concluded that the Respondent's care met the standard of practice, and he did not display a lack of skill during the assessment.

56. In the Board's view, the IOP raised an ancillary issue in her report suggesting that the Respondent failed to give convincing reasons for dismissing the possibility that the Applicant's symptoms were related to a syrinx.

57. The Board observes regarding this ancillary issue that in her report the IOP did in fact agree with the Respondent when she stated:

> [The Respondent] is correct in referring to the preponderance of the literature on post-traumatic syringomyella being in the context of spinal cord injury.
>
> I am not aware of any good rigorous trial or report of syringomyella after minor trauma.

58. Ultimately, as previously noted, the evidence regarding whether the Applicant even had a syrnx was at the very least unclear and in any event was found to be of no clinical consequence by two of the Applicant's treating physicians one being a neurologist and the other a rheumatologist.

59. The Board observes that the opinions noted above are consistent with the Respondent's findings as stated in his response:

> On June 5, 2007, on the basis of her history and her physical examination, I did not feel there were any findings on examination in keeping with a syrnx being a clinically relevant issue, but rather the issues were that of chronic pain.
>
> I further commented that I did not believe the syrnx was MVA related issue; post traumatic syrngomyelia has been discussed in the literature but in the setting of a previous traumatic paraplegia: therefore I did not feel that her syrnx was a MVA related issue.
>
> I did take into consideration that her syrnx was caused by trauma from a car accident and I concluded that it was not.

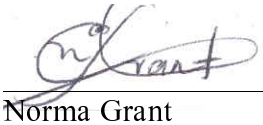
60. In its decision, the Committee has addressed the concerns raised by this Board in its 2012 decision and addressed the issues raised by the IOP in her report The Board appreciates that the issues in question could have more than one viewpoint in the medical community. The question for the Board is whether the Committee's conclusions fall within a scope of reasonableness. Having considered all of the information in the Record and the submissions of the parties, the Board finds that the Committee's conclusions fall within a range of possible, acceptable outcomes that are defensible in respect of the facts and the law.

V. DECISION

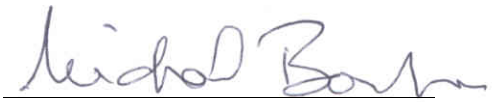
61. Pursuant to section 35(1) of the *Code*, the Board confirms as reasonable the Committee's decision to take no further action on this complaint.

ISSUED July 30, 2014

Stephen Kovanchak



Norma Grant



Michael Boucher