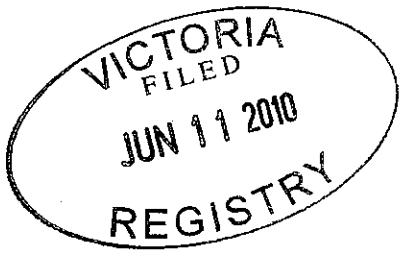

Dr. Janet Kushner Kow, Affidavit # 1
Sworn June 9, 2010

NO. 07 3415
and NO. 08 0327
VICTORIA REGISTRY

IN THE SUPREME COURT OF BRITISH COLUMBIA

IN THE MATTER OF THE *PATIENTS PROPERTY ACT*
R.S.B.C. 1996, CHAPTER 349 AS AMENDED

– AND –

IN THE MATTER OF KATHLEEN PALAMAREK, PATIENT

AFFIDAVIT

I, DR. JANET KUSHNER KOW of Vancouver, British Columbia, MAKE OATH AND SAY AS FOLLOWS:

1. I am a physician duly qualified and licensed to practice with the College of Physicians and Surgeons for the Province of British Columbia, and as such have personal knowledge of the matters and facts herein set forth, except where the same are stated to be made on information and belief, and as to such facts, I verily believe them to be true.

2. I am licensed in the specialty of Internal Medicine and have a special certification in the sub-specialty of Geriatric Medicine. I have experience in doing geriatric assessments in British Columbia of in-hospital patients, ambulatory patients and skilled nursing facilities.

3. Attached hereto and marked as Exhibit "A" to this my affidavit is the original of the report of

my assessment, dated June 2, 2010, which I have prepared at the request of Lois Sampson and Gil Sampson.

4. Attached hereto and marked as Exhibit "B" to this my affidavit is my curriculum vitae.

SWORN BEFORE ME at the City of Vancouver, in the Province of British Columbia, this 9 day of June, 2010.

A Commissioner for taking Affidavits within the Province of British Columbia

DR. JANET KUSHNER KOW

ASHA LOHIA
NOTARY PUBLIC
14 EAST BROADWAY
VANCOUVER, B.C. V5T 1V6
TEL:(604)879-8319 FAX:(604)879-9481

Dr Janet Kushner Kow Inc.
6973 Arlington St.
Vancouver BC V5S 3P1

June 2, 2010

Lois and Gil Sampson
#303 – 1015 Pandora Avenue
Victoria, BC V8V 3P6

Dear Mr. and Mrs. Sampson:

RE: Committeeship of Kathleen Palamarek

Attached, and forming part of this letter, is my report originally requested by your lawyer at the time, Irene Faulkner, pursuant to the Order of the B.C. Supreme Court of July 16, 2009, and the Order of the B.C. Supreme Court of December 18, 2009.

The purpose of my involvement was to examine Mrs. Palamarek's state of health and to review her medical chart with a view to assessing her in respect to her current and past medication regimens and her diagnostic and therapeutic interventions, as they pertain to her mental and physical health and her medical care needs.

I was asked to ascertain Kathleen Palamarek's true state of health and capabilities, and optimal medical treatment and care needs, and to provide independent medical opinion on the nature and quality of the medical treatment and care provided to Kathleen Palamarek over the past three years.

I prepared this report, and am solely responsible for its content and conclusions.

Sincerely,

Dr. Janet Kushner Kow MD, MEd., FRCPC
Consultant Geriatrician
Associate Head, Department of Medicine
Providence Health Care
Vancouver, BC

This is Exhibit "A" referred to in the Affidavit of DR. JANET KUSHNER KOW.
sworn before me at Vancouver in the Province of British Columbia, this 9 day of June A.D. 2010.

A Commissioner for taking Affidavits within British Columbia

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REPORT BY DR. JANET KUSHNER KOW MD, MEd., FRCPC

I am a licensed physician practicing in British Columbia since 2000. I am licensed in the specialty of Internal Medicine and have a special certification in the sub-specialty of Geriatric Medicine. I have experience in doing geriatric assessments in British Columbia of in-hospital patients, ambulatory patients and skilled nursing facilities.

This report is prepared by request of Irene Faulkner and responds to specific questions asked of me. I was able to meet and examine Mrs. Kathleen Palamarek on December 20, 2009 from 12 noon to 1315. I have also examined the documents provided to me from VIHA, Saanich Peninsula Hospital, the Lodge at Broadmead, Pharmanet, the Victoria Police Department and various affidavits and correspondence.

1) From my review of the records and based on examination, Mrs. Palamarek has the following medical conditions:
   a) Dementia – Probable vascular, possible mixed vascular and Alzheimer's, moderate dementia (5 on the global deterioration scale – attached as Appendix A, and the MDS Full Annual Assessment – attached as Appendix B).
   b) Behavioural and Psychological symptoms of dementia (BPSD), this was not seen during my brief visit but nursing notes refer to perceived occasional episodes of insomnia, anxiety, agitation and restlessness in 2008 which may have been caused by infection, medication changes, or responses to environmental stresses, or some combination thereof.
   c) Osteoporosis with compressions fracture in 2006 at levels Thoracic12, Lumbar1. Bone mineral density completed 2005. The fractures in themselves would not affect Mrs. Palamarek's day-to-day functioning.
   d) Recurrent cerebrovascular accidents (CVAs) clinically reported in 1987, 1994, 1998 but no Computed Tomography (CT) results provided and no confirmed diagnosis of CVA in the past 6 years.
   e) Decreased hearing – no formal testing is noted in the records but it was not an impediment to effective communication in my interview with her. The records do note that staff have at times been unable to communicate because of Mrs. Palamarek's hearing impairment.

2) Mrs. Palamarek has a previous history of:

a) Decreased left ventricular (LV) function 1997 ejection fraction (EF) 25% - normal usually approximately 60%. However no echocardiogram in records since that time and as such no clear information on the state of her ejection fraction which would indicate overall heart function. I note that ejection fraction and LV function of the heart can fluctuate over time up and down, and can be temporarily worse in hospital at times.

b) Upper gastrointestinal (GI) bleed 2006

c) Acute myocardial infarction 2006

d) Angioplasty 1992

e) Gastroesophageal reflux disease

f) Bilateral Cataracts resected 2004 or 2005 (unclear) and November 2008

g) Congestive heart failure 2007

h) Pharyngeal papilloma

i) Childhood mastoiditis

Medical History Record – no evidence found:

j) Serology from Nov 2006 shows no evidence of hepatitis B. There was apparently an episode of jaundice in her 40s but no etiology is known.

k) Diabetes – I found no evidence found on bloodwork 2003, 2005, 2007 that Mrs. Palamarek has diabetes mellitus. However a glucose tolerance test Jan 2003 did reveal 2h glucose of 8.7 indicating impaired glucose tolerance only.

3) Mrs. Palamarek may have Alzheimer's pathology, but her primary cause of dementia is most like vascular. This is evidenced by documented history of previous strokes, known history of arteriosclerosis and relative stability of function and cognition over nine years. Mini mental status exam (MMSE) by Dr. Prowse June 2005 27/30, MMSE December 20, 2009 22/30. Patients with pure Alzheimer's disease over 9 years would usually progress such that the MMSE would on average drop to below 15 and most patients would be fully dependent with inability to walk and feed oneself. The only evidence for any Alzheimer's pathology includes some possible response to galantamine in 2005, and lack of stepwise progression (intermittent worsening interspersed with relative stability). Determining the cause of dementia is always the best fit given the clinical, historical and physical evidence. There was no CT head of the brain provided to me that might help define her diagnosis. However there is no definitive way to make the diagnosis short of brain biopsy. As above her degree of dementia is moderate.

4) Given her primary diagnosis of vascular pathology the standard of care is to control vascular risk factors as well as possible without causing side effects. In the elderly the risk factors that are postulated to possibly improve vascular dementia outcomes are the major medical ones of hypertension and smoking. The other major risk

factors are diabetes and hyperlipidemia, however it is unclear in patients over 85 whether adding medications will result in improved outcomes and a healthy cardiac diet is recommended (ie no added sugar, no added salt). As far as I can tell her vascular risk factors appear to be well controlled, but there is no evidence of dietary restriction in the records. I would recommend limiting high calorie treats to very occasional 'treats' if acceptable to Mrs. Palamarek.

5) Generally atypical antipsychotics should be avoided in patients with dementia particularly if they have a history of cardiovascular events as Mrs. Palamarek does. However the risks of antipsychotics are usually balanced against the benefit of improved symptoms of BPSD. I cannot comment on the appropriateness of the use of olanzapine as I was unable to observe any behavioural symptoms on my visit. I note the olanzapine is being tapered off at this time and hopefully will be discontinued.

6) Mrs. Palamarek's main medical symptom is of dyspnea, shortness of breath and wheezing at times. This has been treated with ventolin and ipratropium. I cannot tell how much reversible obstruction she has as there is no history of pulmonary function tests. However wheezing may also be due to congestive heart failure or deconditioning. Additional tests can be done to confirm the diagnosis. Another possibility would be to try using inhaled steroids to prevent obstruction and seeing if her shortness of breath improves.

7) The only medication that may be causing symptoms would be the olanzapine which can cause increased appetite and weight gain, however this is being minimized and tapered. I have no concerns regarding side effects of the other medications. In terms of medications that may not be necessary, citalopram could be reassessed. I found no evidence of depression on my visit, however SSRIs can be used to prevent BPSD and as such I cannot comment whether it may be preventing other symptoms.

8) Regarding the wedge compression fracture and osteoporosis, the bone mineral density test was appropriate and the present management of calcium and vitamin D is appropriate. She has also been periodically checked for calcium level and TSH (last in June 2008) and I would suggest this continue. She is at high risk for a recurrent fracture spontaneously in her spine or in other sites if she falls. On examination Mrs. Palamarek's gait and level of consciousness were not high risk for falls but my conclusions are limited by the brief observation. One additional medication for prevention of osteoporosis would be bisphosphonates, but I note this was discontinued at the time of her hospitalization in 2006 and there is no strong indication for reintroduction.

9) Regarding Mrs. Palamarek's back pain I was unable to demonstrate this on examination on December 20. Also recently there have been infrequent (less than once a month) notes by nursing about mild back pain. This can be exacerbated by sitting in a chair that does not provide optimal support. The fentanyl patch was started in hospital in 2006 subsequent to an acute compression fracture. This was continued on entry to Broadmead and has remained at the same doseage until the

present. Pain following an acute fracture may resolve over time, in as little as 6 weeks or over the next year. I would suggest trying to discontinue the patch if possible with appropriate 'as needed' medications ordered at that time in case pain increases. This recommendation is made as the fentanyl patch may not be necessary at this time. Acetaminophen alone or smaller doses of narcotics may be sufficient to control any pain. If Mrs. Palamarek had no significant pain on acetaminophen alone then it could be gently tapered to an 'as needed' basis as tolerated. Withdrawal of pain medications should be accomplished over weeks to months if desired.

I found no objective evidence of osteoarthritis by clinical examination, and no x-rays were in the records that demonstrated this diagnosis.

10) In my opinion the increase in agitation charted and symptoms expressed of perineal pain from June 8-10, 2008 would be consistent with a developing UTI. The urinalysis, although mostly normal, still showed microhematuria and bacteria, and culture showed moderate growth of e.coli. This does not preclude other reasons for her symptoms.

11) Regarding the events of June and July 2008: The appropriate antibiotic was prescribed on June 16, 2008. On July 5, 2008 the nurse charted that the on-call doctor was informed of the positive repeat culture of e.coli 100cfu/L which is significant and of symptoms of back pain. It does appear from the charting that the nurse conveyed the new complaint of back pain. On review of the records and in retrospect the order to observe was not appropriate and Mrs. Palamarek should have received antibiotics at that time.

12) I do not feel it was optimal care for the July 4 request from nursing to be responded on July 9 for a repeat urine. I am unable to comment on the reason for the delay. Given her severe symptoms in June in my opinion a clear urine would be optimal in Mrs. Palamarek's case. However I note that Dr Nicoll had no information from nursing of the back pain on July 5 and this information may have changed the decision-making. This is very common in our medical system that the information given to an on-call doctor is not passed on to the attending physician. It is also common for family physicians to not respond to behaviours or symptoms that are not communicated to them by nursing.

13) Urinalysis was done on July 28, which is at the end of the Bactrim therapy. This was appropriately carried out and showed no evidence of abnormality. This result is consistent with the infection being eradicated.

14) During the delay in treating the UTI there were two episodes of agitation recorded, these might have been prevented in retrospect but there was no ongoing or permanent harm from the delay.

15) As above there is no evidence of diabetes, however Mrs. Palamarek does have glucose intolerance. If she remains on olanzapine occasional screening (not monthly) could be done but it would be controversial whether this would actually change outcomes. The risk of diabetes with these medications is a minor consideration.

16) Regarding her chronic renal insufficiency this has been stable and I do not think anything more needs to be done.

17) Mrs. Palamarek's weight gain is likely from a combination of decreased activity and there may be a contribution from the use of olanzapine. This may have caused some of her shortness of breath on exertion. However other than trying to discontinue the olanzapine and maintaining a healthy diet there is no evidence that more intensive interventions would be of use in improving outcomes given Mrs. Palamarek's age.

18) The medical records from Saanich Peninsula hospital do indicate Mrs. Palamarek likely had a small non- ST elevation MI on admission to hospital on November 22, 2006. Likely this was brought on by anemia from an upper GI bleed. The medical management of reversing the anemia and continuing a beta blocker was the appropriate management.

19) In the last 3 years there has been no reassessment of her congestive heart failure although some changes in diuretics were undertaken for wheeziness. As above it is not clear to me the actual cause of the wheeziness especially as Mrs. Palamarek was not wheezy on my examination. On examination on December 20 I found no evidence of CHF exacerbation. The present medications are reasonable to control her CHF. A cardiology review may be of some benefit. I am unable to determine prospectively at this time if any measurable benefit may ensue.

20) Mrs. Palamarek had cataract surgery Nov 2008, as far as I can discern this was not urgent or emergency surgery. She had previously had a cataract in her right eye extracted. It is normal practice to eventually have both cataracts removed to improve reading ability and reduce fall risk. I could find very little information about Mrs. Palamarek's vision in the chart. Dr. Nicoll's involvement was minimal which is usual practice, and the decision is usually made in consultation with the opthalmologist .

21) In conclusion the optimal medical care that Mrs. Palamarek requires at this time is the continuation of her oral medications but with the caveats above. The fentanyl and nitroglycerin patches, and the nebulizers may be of ongoing benefit for her also but as above I recommend reassessment of their benefit. She needs regular assessment and monitoring of her multiple chronic stable conditions with a primary care physician and prompt attention to any changes in her conditions, symptoms and mental status.

22) In regards to Mrs. Palamarek's living situation, she does require 24 hour supervision. She also requires supervised administration of her medications. In my experience this amount of supervision and intervention can be provided in a private residential setting (e.g. the person's home or a caregiver's home) or in a skilled nursing facility. The only specialized medical intervention she is receiving now is the use of nebulizers which would require minimal additional training to use. This medication is routinely administered in a private home setting by patients themselves or by caregivers.

23) Regarding Mrs. Palamarek's high blood pressure, congestive heart failure and chronic pain, in my opinion given her treatments for these conditions none of the conditions

or medications in themselves necessitate care in a skilled nursing facility, nor does her dementia. In my experience a home situation can be made appropriate with the appropriate environment and education and support of caregivers.

MEDICAL REPORT - APPENDIX A:

GLOBAL DETERIORATION SCALE

GLOBAL DETERIORATION SCALE (GDS)

Stage	Deficits in cognition and function	Usual care setting
1	**Subjectively and objectively normal**	Independent
2	Subjective complaints of mild memory loss. Objectively normal on testing. No functional deficit	Independent
3	**Mild Cognitive Impairment (MCI)** Earliest clear-cut deficits. Functionally normal but co-workers may be aware of declining work performance. Objective deficits on testing. Denial may appear.	Independent
4	**Early dementia** Clear-cut deficits on careful clinical interview. Difficulty performing complex tasks, e.g. handling finances, travelling. Denial is common. Withdrawal from challenging situations.	Might live independently – perhaps with assistance from family or caregivers.
5	**Moderate dementia** Can no longer survive without some assistance. Unable to recall major relevant aspects of their current lives, e.g. an address or telephone number of many years, names of grandchildren, etc. Some disorientation to date, day of week, season, or to place. They require no assistance with toileting, eating, or dressing but may need help choosing appropriate clothing.	At home with live-in family member. In seniors' residence with home support. Possibly in facility care, especially if behavioural problems or comorbid physical disabilities.
6	**Moderately severe dementia** May occasionally forget name of spouse. Largely unaware of recent experiences and events in their lives. Will require assistance with basic ADLs. May be incontinent of urine. Behavioural and psychological symptoms of dementia (BPSD) are common, e.g. delusions, repetitive behaviours, agitation.	Most often in Complex Care facility.
7	**Severe dementia** Verbal abilities will be lost over the course of this stage. Incontinent. Needs assistance with feeding. Lose ability to walk.	Complex Care

Adapted by Dr. Doug Drummond from Reisberg B, Ferris SH, Leon MJ, et al. The global deterioration scale for assessment of primary degenerative dementia. American Journal of Psychiatry 1982;139:1136-1139.

MEDICAL REPORT - APPENDIX B:

MDS FULL ANNUAL ASSESSMENT – SECTION G

Resident : Palamarek, Kathleen

SECTION G: PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

G1 **A. ADL SELF-PERFORMANCE** *(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days, not including setup)*

0. INDEPENDENT. No help or oversight — OR — help/oversight provided only 1 or 2 times during last 7 days.
1. SUPERVISION. Oversight, encouragement or cueing provided 3 or more times during last 7 days — OR — Supervision plus physical assistance provided 1 or 2 times during last 7 days.
2. LIMITED ASSISTANCE. Resident highly involved in activity; received physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3 or more times — OR — More help provided only 1 or 2 times during last 7 days
3. EXTENSIVE ASSISTANCE. Although resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   — Weight-bearing support
   — Full staff performance during part (but not all) of last 7 days.
4. TOTAL DEPENDENCE. Full staff performance of activity during entire 7 days.
8. ACTIVITY DID NOT OCCUR during entire 7 days.

B. ADL SUPPORT PROVIDED *(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification.)*

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
8. ADL activity did not occur during entire 7 days

			A	B
G1a	BED MOBILITY	How resident moves to and from lying position, turns from side to side, and positions body while in bed	0	0
G1b	TRANSFER	How resident moves between surfaces — to and from: bed, chair, wheelchair, standing position (EXCLUDE to and from bath and toilet)	0	0
G1c	WALK IN ROOM	How resident walks between locations in own room	0	0
G1d	WALK IN CORRIDOR	How resident walks in corridor on unit	0	0
G1e	LOCOMO-TION ON UNIT	How resident moves between locations in own room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	0	0
G1f	LOCOMO-TION OFF UNIT	How resident moves to and returns from off-unit locations (e.g. areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	0	0
G1g	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning and removing prosthesis	0	1
G1h	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition)	0	0
G1i	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	0	0
G1j	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair; brushing teeth; shaving; applying makeup; washing and drying face, hands, and perineum (EXCLUDE baths and showers)	0	1

THE UNIVERSITY OF BRITISH COLUMBIA
Curriculum Vitae for Faculty Members

Date: 09 June 2010
Initial:

1 **SURNAME:** Kushner Kow **FIRST NAME:** Janet
MIDDLE NAME: Vivian

2 **DEPARTMENT/ SCHOOL:** Medicine

3 **FACULTY:** Medicine

JOINT APPOINTMENTS:

4 **PRESENT RANK:** Clinical Assistant Professor **SINCE:** July 1, 2007

5. POST-SECONDARY EDUCATION
(a)

University or Institution	Degree	Subject Area	Dates
McGill University	B.Sc.(Hons)	Biology	July 1, 1989 – May 1, 1992
University of Calgary	M.D.		August 23, 1992- May 15, 1995
University of British Columbia	M.Ed.	Adult Education	May 1, 2001 – May 2004

(b) Title of Dissertation and Name of Supervisor
Dr. Tom Sork, "The Real World: A Case Study of Planning a Geriatrics Interdisciplinary Educational Module"

(c) Special Professional Qualifications
1 FRCP(C) Internal Medicine January 19, 2000

2 Certificate of Special Competence Geriatric Medicine Geriatric Medicine December 31, 2000

3 Diplomate American Board of Internal Medicine 2000

This is Exhibit "B" referred to in the Affidavit of DR. JANET KUSHNER KOW, sworn before me at Vancouver in the Province of British Columbia, this 9 day of June, 2010.

A Commissioner for taking Affidavits within British Columbia

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TEL:(604)879-8319 FAX:(604)879-9481

14

6. EMPLOYMENT RECORD

Prior

University, Hospital, or Organization	Appointment Title	Dates
University of Calgary	Resident, Internal Medicine	July 1, 1995 – June 30, 1998
University of British Columbia	Resident Geriatric Medicine	July 1, 1998 – Dec. 31, 1998 July 1, 1999 – Dec. 31, 2000

Present

University, Hospital, or Organization	Appointment Title	Dates
Providence Health Care	Consultant	January 1, 2001 – present
Vancouver Hospital	Consultant	May 27, 2003 – present
UBC Division of Medicine	Associate Director for Expansion, Undergraduate Education	June 2004- June 2009
UBC Division of Medicine	Director, Undergraduate Education	July 2009-Present

7. OTHER ACTIVITIES

1. UBC Undergraduate Education Director, Division of Geriatric Medicine July 1, 2004- present
2. UBC Course coordinator Geriatrics Clinical Skills 2004 - present
3. UBC Brain & Behaviour Week 9 Chair 2004 – present
4. Examiner, Internal Medicine Clerkship 2004-present
5. Fellowship Director, Geriatric Medicine Sub-specialty program January 1, 2005- present
6. Ethnogeriatrics committee, American Geriatrics Society 2003-2006

(a) Memberships on other societies or committees, including offices held and dates (National)

1 Canadian Geriatrics Society 1995 – present

2 Specialty Committee in Geriatric Medicine , Canadian Geriatrics Society Dec 2005 – present

3 Education Committee, Canadian Geriatrics Society Oct 2005 – present

4 Royal College of Physicians and Surgeons of Canada: Geriatrics Medicine Examination Committee Dec 2005 – present

5 Royal College of Physicians and Surgeons of Canada: Geriatrics Medicine Examination Committee Vice-Chair December 2006 – present

6 Canadian Geriatrics Society, Continuing education Committee, Associate director July 2006- December 31, 2007

7 Canadian Geriatrics Society, Continuing education Committee, Director January 1, 2008 – present

1 Reviewer and consultant, Restraints Use Committee Vancouver General Hospital 2004

2 Education Consultant, Care for Elders Project, UBC Division of Family Medicine, Strategic Teaching Initiative 2001-present