IN THE MATTER OF A HEARING BY THE DISCIPLINE COMMITTEE OF THE BRITISH COLUMBIA COLLEGE OF NURSES AND MIDWIVES CONVENED PURSUANT TO THE PROVISIONS OF THE *HEALTH PROFESSIONS ACT* RSBC 1996, c.183

BETWEEN:

The British Columbia College of Nurses and Midwives

The College

AND:

Paul Perry

The Respondent

DETERMINATION OF THE DISCIPLINE COMMITTEE

Corrected Determination: The text of this determination was corrected at paragraphs 130 and 131, where changes were made on February 12, 2021.

Hearing Dates:	September 14 to September 17, 2020
Discipline Committee Panel:	Sheila Cessford, Chair Dorothy Barkley Fernanda Polanco, NP
Counsel for the College:	Jennifer Groenewold and Michael Sherriff
Respondent:	Unrepresented by counsel and did not attend hearing

A. Introduction

1. A panel of the Discipline Committee (the "Panel") of the British Columbia College of Nurses and Midwives (the "College" or the "BCCNM") conducted a hearing to determine, pursuant to section 39 of the *Health Professions Act* RSBC 1996 c.183 (the "Act" or the "HPA"), whether the Respondent, Paul Perry, failed to comply with the Act, a regulation or a bylaw, whether he failed

to comply with a standard imposed under the Act, whether he committed professional misconduct, or whether he practised incompetently.

2. For the reasons set out below, the Panel determines pursuant to section 39 (1)(b), (c) and (d) of the Act, that the Respondent committed professional misconduct in relation to the allegations in paragraphs 1(a), 1(b), 1(d), 2 and 3 of the citation dated July 21, 2020 (the "Citation"); incompetently practiced his profession in relation to the allegations in paragraphs 1(c)(i), 1(c)(ii), 1(c)(iii), 1(c)(v), 1(e), 1(f) and 1(g) of the Citation; and breached a standard imposed under the Act in relation to the allegations in paragraphs 1(h)(i) and 1(h)(ii) of the Citation.

3. The Panel dismisses the allegation in paragraph 1(c) (iv) of the Citation.

B. Background

4. The particulars of the allegations against the Respondent are set out in the Citation as follows:

> The purpose of the hearing is to inquire into your conduct that:
>
> 1. From April 2014 to on or about June 2016, while a Nurse Practitioner at two sites, the HIM Clinic located at 1033 Davie Street, Vancouver and operated by Providence Health and the Three Bridges Clinic located at 1128 Hornby St, Vancouver and operated by Vancouver Coastal Health ("VCH"), and employed in the health authorities' prevention program with the specific mandate to work with the vulnerable and high risk population of men-who-have-sex-with-men ("MSM") you:
>
>   a. Solicited detailed and personal sexual histories from your clients when the level of detail in these histories was not clinically indicated and was contrary to the goals and/or mandate of the MSM program (the "Sexual Histories");
>
>   b. Recorded the Sexual Histories in the permanent clinical records of your clients in detail, using non-clinical descriptors;
>
>   c. Created documentation in your clients' permanent clinical records

that was not clear, concise, objective, and/or legible due to:

i. numerous spelling and grammatical errors;
ii. the use of abbreviations that were not standard and were out of the norm;

iii. the lack of a logical flow of information such that a clinician would be unable to follow your clinical decision making;

iv. your client intake and history taking occurring over numerous visits, which required a clinician to read several notes made over a longer period of time to attempt to understand the purpose of each visit and your clinical and intellectual footprint;

v. inconsistencies between the subjective and objective observations that you recorded;

d. Solicited extensive histories from your clients relating to what you described as “coming out” experiences, and on more than one occasion, these histories included information relating to significant past sexual, physical, and/or psychological trauma and you did not appropriately refer those clients to supportive services;

e. Engaged in providing psychological counselling with your clients when you were not appropriately qualified or trained to do so;

f. Did not adhere to best practice guidelines when you ordered diagnostic interventions and/or prescribed medications for your clients without a clear clinical indication;

g. Failed to document necessary clinical indicators for your clients, including allergies when you prescribed a drug;

h. Practised beyond the scope of a nurse practitioner when you:

i. diagnosed a client with hyperthyroidism on the basis of a single THC blood test and failed to refer the client to an endocrinologist and/or provide any appropriate follow up; and

ii. provided cognitive behaviour therapy (“CBT”) to a client, or a derivative of CBT called Cognitive Behaviour Interpersonal Skills, when you were not appropriately trained or qualified to do so.

This conduct also constitutes professional misconduct and/or unprofessional conduct, or breach of the Act or bylaws, under s.39(1) of the Act.

2. On or around February 12 to 18, 2018, you breached terms of a current consent agreement with the Former College, dated January 28, 2018, when you accepted employment with the University of Northern British Columbia, as a Registered Nurse, when you were obliged to provide specific disclosure to new employers as a term of the consent agreement and you did not do so.

   This conduct also constitutes professional misconduct and/or unprofessional conduct, or breach of the Act or bylaws, under s.39(1) of the Act.

3. On or about May 1 to 5, 2018, you breached the undertakings you had given to the Former College when you accepted employment with the University of Northern British Columbia, as a Registered Nurse, and you did not provide the University of British Columbia with comprehensive disclosure regarding the ongoing investigation into your nursing practice.

   This conduct also constitutes professional misconduct and/or unprofessional conduct, or breach of the Act or bylaws, under s.39(1) of the Act.

5. The Respondent worked as a Nurse Practitioner (NP) at various organizations from August 2009 until April 2014. In April 2014, he commenced employment as an NP at Providence Health Authority ("Providence Health"). Prior to 2009, he also worked as a Registered Nurse (RN) for approximately 10 years.

6. The Respondent was hired to work in the Vancouver Coastal Health ("VCH") Regional HIV Program. The VCH Regional HIV Program worked collaboratively with similar programming at Providence Health to provide HIV prevention services, testing and diagnosis, and HIV care and treatment services.

7. The Respondent worked at Three Bridges Community Health Centre located at 1128 Hornby Street, Vancouver. Three Bridges Community Health Centre

is operated by VCH. The Respondent also worked at the HIM Clinic (Health Initiative for Men) located at 1033 Davie Street, Vancouver.

8. The HIM Clinic is a non-governmental organization. The evidence was that it received some funding from VCH and Providence Health. The Citation refers to the HIM Clinic as being operated by Providence Health Authority. The College submits this was an inadvertent error which is immaterial to the subject of the allegations in the Citation. The Panel accepts this submission. It is immaterial to the allegations that Providence Health provided only funding but did not actually operate the HIM Clinic.

9. The HIM Clinic provided office space in which the Respondent saw clients as part of the Regional HIV Program in which he was hired to work.

10. The Respondent was hired as a primary care NP with the specific mandate to work with the vulnerable and high-risk population of gay, bisexual and men-who-have-sex-with-men.

11. At the material times, the Respondent was regulated by the College of Registered Nurses of British Columbia ("CRNBC" or the "Former College"). On September 4, 2018, CRNBC amalgamated with two other nursing regulators in the province to form the British Columbia College of Nursing Professionals (the "BCCNP" or the "Former College").

12. The Citation was issued by the Registrar of the BCCNP. On September 1, 2020, the BCCNP and the British Columbia College of Midwives amalgamated to form the BCCNM. Under Part 2.01 of the Act, the BCCNM remains seized of the complaints investigated and discipline proceedings initiated by the Former Colleges.

C. Virtual Discipline Hearing and Evidence Provided

13. Due to the ongoing COVID-19 pandemic, the Discipline Committee hearing (the "Discipline Hearing") took place from September 14 to September 17, 2020 by video conference on the WebEx platform.

14. The Respondent was not represented by legal counsel and did not attend the hearing.

15. The College provided a book of documents. The Panel marked the Citation and Affidavit of Service as Exhibit #1.

16. The remainder of the book of documents, containing the following documents, was marked as Exhibit #2:

    i. Tab 2: Complaint made to the College of Registered Nurses of British Columbia dated August 4, 2017.
    ii. Tab 3: Expert Report – Chaundra Willms, Nurse Practitioner.
    iii. Tab 4: Redacted Patient Care Records Group 1.
    iv. Tab 5: Redacted Patient Care Records Group 2.
    v. Tab 6: Paul Perry Resume Fall 2017.
    vi. Tab 7: UNBC Part Time Classroom and Clinical Instructor Position.
    vii. Tab 8: UNBC Nursing 451 Course Description.
    viii. Tab 9: UNBC Nursing 458 Course Description.
    ix. Tab 10: Perry UNBC Contract February 12-18, 2018.
    x. Tab 11: Perry UNBC Contract May 1-15, 2018.
    xi. Tab 12: Consent Agreement January 24, 2018 (redacted).
    xii. Tab 13: Voluntary Undertaking Pending Outcome of A Complaint signed March 20, 2018.
    xiii. Tab 14: Emails between UNBC and CRNBC.
    xiv. Tab 15: 2018 07 27 Email from Paul Perry to CRNBC.
    xv. Tab 16: Random Chart Review of Redacted Patient Care Records reviewed by Dr. Beaveridge.

17. The College called seven witnesses. The College's first witness was Ms. Chaundra Willms, an NP registered with the College. She holds a Bachelor of Science in Nursing from the University of Alberta (2003) and a Master of Nursing from University of Victoria (2007). She gained licensure as an NP in 2008 and has been employed as an NP since that time with the Island Health Authority ("Island Health"). From 2008 to 2017, Ms. Willms was employed as an NP in primary care; first in Mental Health and Addictions, then at a primary health care centre. In those roles, she performed primary care assessments, diagnosed and treated medical conditions, performed health maintenance and screening, and provided low-barrier primary care for patients who experienced marginalization. Ms. Willms began her current role of NP Clinical Lead in 2017, where she provides clinical support and oversight to NPs working at Island Health. This role includes assessing NP practice when there are concerns or complaints about the quality of practice of an NP.

18. Ms. Willms also holds a contract position with the College as a Nurse Practitioner Quality Assurance Assessor. In this role, she completes NP professional performance assessments by reviewing nurse practitioner records against the College's Standards of Practice.

19. The Panel qualified Ms. Willms as an expert in the standard of care for NPs practising in a primary care setting. Ms. Willms provided a report and oral testimony to assist the Panel with respect to the standards expected of an NP in the position held by the Respondent.

20. In addition to Ms. Willms, the College called the following six witnesses during the hearing:

    i. Dr. Jennifer Beaveridge, a primary care NP who has spent 15 years working as an NP at Raven Song Primary Care in Vancouver, providing primary health care to a downtown Vancouver patient

population. Dr. Beaveridge was the Clinical Professional Practice Lead for Nurse Practitioners. She performed a chart audit of a random selection of the Respondent's patient charts in 2016, which was entered into evidence. Dr. Beaveridge has held a leadership position in VCH, most recently as Regional Director and Department Head of Nurse Practitioners. She is also an adjunct professor at University of Northern British Columbia (UNBC) and a Quality Assessor of NPs with the College.

ii. Dr. Fraser Norrie, a primary care physician who works at Spectrum Health, a family practice clinic. Spectrum Clinic has expertise in gay men's health and HIV care. Dr. Norrie practiced at Three Bridge's Clinic from 1994 until approximately 2018. Dr. Norrie knew the Respondent from a time when the Respondent was working at Spectrum Health as an RN, prior to becoming an NP. After the Respondent assumed the NP position, Dr. Norrie agreed to provide him with informal mentorship.

iii. Dr. David Hall, a primary care physician, who is a co-complainant that brought the issues forming the subject matter of the Citation to the attention of the Former College. Dr. Hall graduated from the University of British Columbia in 2002 and has been a primary care physician in family practice for 15 years. Dr. Hall has worked in HIV care and the care of marginalized people for his entire career. He works with the Centre for Excellence in HIV and AIDS in the Downtown Eastside and he is the associate medical director of that clinic. Dr. Hall is also the head of the Department of Family and Community Practice for VCH for the Vancouver Community of Care, and the Regional Medical Director for the Vancouver Coastal Health Regional HIV program.

iv. Mr. Scott Harrison, the Executive Director for Urban Health and Integrated Substance Use and Addiction Programs at Providence Health. At the material times to the allegations in the Citation, Mr. Harrison was the Department Director for Urban Health HIV and Substance Use, and the Respondent's direct supervisor. Mr. Harrison's supervision did not relate to the Respondent's clinical practices but was focused on administrative issues.

v. Mr. Trevor Smith, a Senior Academic Budget and Planning Officer at the UNBC. At the material times to the allegations in the Citation, Mr. Smith was the manager for the UNBC's School of Nursing and was the Operations Manager for the faculty reporting to the Chair of the School of Nursing. In that capacity, Mr. Smith dealt with the Respondent as a two-time sessional instructor at UNBC.

vi. Mr. David MacDonald, a Professional Conduct Review Consultant, who has been employed with the College since 2009.

21. The College also provided written submissions and a Book of Authorities.

22. The Panel's determination considers the witness testimony adduced at the hearing, the documents tendered into evidence and marked as Exhibits #1 and Exhibit #2, the College's written and oral submissions and Book of Authorities provided.

D. Service of the Citation and Respondent's Non-Attendance of the Hearing

23. As noted, the Respondent did not attend the hearing and was also not represented by counsel. On the first day of the hearing, the College filed the Citation and an affidavit as proof of service. The affidavit of service confirms that the Respondent was properly served with the Citation on July 26, 2020. It also shows that on multiple occasions, the Respondent was advised by the College's counsel that the hearing may proceed in his absence.

24. The affidavit of service also shows the College attempted to provide the Respondent with materials that the College intended to introduce as evidence at the discipline hearing. These materials were provided to the Respondent by way of the email address through which he had consistently communicated with the College's counsel.

25. During opening submissions, the College's counsel advised the Panel that the Respondent sent an email to counsel the night before the hearing was to commence in which he stated: "I understand the College is holding a hearing in my absence."

26. On the basis of this evidence, the Panel was satisfied that the Respondent received the Citation, had notice of the date and time of the hearing, and chose not to attend. As such, the Panel was satisfied that the hearing could proceed in the Respondent's absence pursuant to section 38(5) of the HPA, which provides that "if the respondent does not attend, the discipline committee may (a) proceed with the hearing in the respondent's absence on proof of receipt of the citation by the respondent, and (b) without further notice to the respondent, take any action that it is authorized to take under this Act."

E. Burden and Standard of Proof

27. The College acknowledged that it bears the burden of proof and that it must prove its case on a "balance of probabilities".

28. The College cited several cases, including the leading authority of *F.H. v. McDougall*, 2008 SCC 53, in which the Supreme Court of Canada held that "evidence must be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test". The Panel accepts the College's characterization of the applicable burden and standard of proof.

F. Action by the Discipline Panel

29. Pursuant to section 39(1) of the Act, the Panel may, on completion of a hearing, dismiss the matters alleged in the Citation, or determine that the Respondent:

> 39(1)…
>
> (a) has not complied with this Act, a regulation or a bylaw,
>
> (b) has not complied with a standard, limit or condition imposed under this Act,
>
> (c) has committed professional misconduct or unprofessional conduct,
>
> (d) has incompetently practised the designated health profession, or
>
> (e) suffers from a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs their ability to practise the designated health profession.

G. The College's Principal Arguments

30. With respect to the allegations in paragraph 1 of the Citation, the College argues in its written submissions that the Panel should find that the Respondent:

    i. failed to comply with the professional standards imposed by the College [s.39(1)(b) of the HPA];
    ii. committed professional misconduct or unprofessional conduct [s. 39(1)(c) of the HPA]; and/or
    iii. incompetently practised the designated health profession [s. 39(1)(d) of the HPA].

31. In respect of the allegations in paragraphs 2 and 3 of the Citation, the College argues that the Panel should conclude the Respondent committed professional misconduct [s. 39(1)(c) of the HPA].

The College's Standards for Registered Nurses and Nurse Practitioners

32. The College notes that pursuant to section 19(1)(k) of the HPA, its board may establish "standards, limits or conditions" for practice other than through a bylaw.

33. The College's Bylaw in force at the material times of the alleged conduct was Bylaw 8.01, which provides that "Registrants must conduct themselves in accordance with the standards of practice and the standards of professional ethics".

34. The College argues that a standard "is an expected and achievable level of performance against which actual performance can be compared. It is the minimum level of acceptable performance". Accordingly, a registrant who does not comply with the standards of practice does not comply with Bylaw s. 8.01 [which is now BCCNM Bylaw 164(1)].

35. The College says that a review of the Respondent's charts and practices clearly reveals that he violated the Professional Standards, NP Scope of Practice Standards and Documentation Standard as set out below.

36. The College argues that this is not a situation where the Respondent violated one or two of the College's standards. Rather, his breaches of these provisions were pervasive, numerous, and serious.

37. In this regard, the College relies on Professional Standards 1, 2, 3, and 4, which confirm and codify both broad and more specific standards for registrants.

38. With respect to Standard 1, Professional Responsibility and Accountability, in clinical practice registrants are expected to, among other things:

    i. Be accountable and take responsibility for own nursing actions and professional conduct.

ii. Functions within their own level of competence, within the legal recognized scope of practice and within all relevant legislation.

iii. Assess their own practice and undertake activities to improve practice and to meet identified learning goals on an ongoing basis.

iv. Take action to promote the provision of safe, appropriate and ethical care to clients.

v. Advocate for and/or help to develop policies and practices consistent with the standards of the profession.

39. With respect to Standard 2, Knowledge-Based Practice, in clinical practice registrants are expected to, among other things:

i. Base practice on current evidence from nursing science and other sciences and humanities.

ii. Know how and where to access information to support the provision of safe, competent and ethical clients care.

iii. Use critical thinking when collecting and interpreting data, planning, implementing and evaluating nursing care.

iv. Collect information on client status from a variety of sources using assessment skills, including observation, communication, physical assessment and a review of pertinent clinical data.

v. Identify, analyze and use relevant and valid information when making decisions about client status.

vi. Communicate client status, using verifiable information, in terminology used in the practice setting.

vii. Develop and communicate plans of care that include assessment data, decisions about client status, planed interventions and measurement of client outcomes.

viii. Set client-centred priorities when planning and providing care.

ix. Implement the plan of care, evaluates client's response and revises the plan as necessary.

x. Document timely and appropriate reports of assessments, decisions about client status, plans, interventions and client outcomes.

40. With respect to Standard 3, Client-Focused Provision of Service, in clinical practice registrants are expected to, among other things:

i. Communicate, collaborate and consult with clients and other members of the health care team about the client's care.

ii. Coordinate client care in a way that facilitates continuity for the client.

41. With respect to Standard 4, Ethical Practice, in clinical practice registrants are expected to, among other things:

i. Make the client the primary concern in providing nursing care.

ii. Provide care in a manner that preserves and protects client dignity.

iii. Demonstrate honesty and integrity.

iv. Recognize, respect, and promote the client's right to be informed and to make informed choices.

v. Promote and maintain respectful communication in all professional interactions.

vi. Identify the effect of own values, beliefs and experiences in carrying out clinical activities; recognize potential conflicts and take action to prevent or resolve.

vii. Identify ethical issues; consult with the appropriate person or body, take action to resolve and evaluate the effectiveness of actions.

viii. Initiate, maintain and terminate nurse-client relationships in an appropriate manner.

<u>NP Scope of Practice Standard</u>

42. The College also points out that the Scope of Practice for Nurse Practitioners in British Columbia is set out in the Nurses (Registered) and Nurse Practitioners Regulation (the "Regulation") under the Act. The Regulation specifies that NPs provide activities in accordance with Standards, Limits and

Conditions established by the College on the recommendation of the NP Standards Committee.

43. The College submits that all registrants of the College including NPs are expected to meet all College Standards of Practice: Professional Standards, Practice Standards, and Scope of Practice Standards.

44. In addition, NPs must meet Standards for:

    i. Regulatory Supervision of Nurse Practitioner Restricted Activities
    ii. Diagnosing and Health Management (including ordering diagnostic services and providing advanced interventions)
    iii. Prescribing Drugs
    iv. Physician Consultation and Referral

45. Some limits and conditions apply to NPs practicing in specific streams. The stream in which the Respondent was practising at the relevant times was the Family Stream.

46. The College further points out that the Scope of Practice for NPs Standards underwent several revisions during the material times, however, none of the revisions changed a standard material to the allegations contained in the Citation. College counsel provided all iterations of the Scope of Practice Standard for NPs in its Book of Authorities.

47. The College submits the Scope of Practice for NPs elaborates on the four levels of controls on Nursing Practice, which are:

    i. The first level of control is the Regulation, which sets out the scope of practice in fairly broad strokes.

    ii. The second level is the College's standards, limits and conditions, which complement and further define and limit the scope of practice set out in the Regulation.

    iii. The third level of control is any organizational or employer policies that

may restrict the practice of NPs in a particular agency or unit. NPs providing services in or employed by an organization need to be familiar with any organizational/employer policies relevant to their practice.

iv. The fourth level of control is an individual nurse practitioner's competence to carry out a particular activity.

48. The Scope of Practice for NPs describes the Standards for Diagnosing and Health Management, which include:

i. Standard 1: Nurse practitioners diagnose and manage diseases, disorders and conditions within nurse practitioners' scope of practice, individual competence within that scope of practice, and the stream in which the nurse practitioner is registered to practise (family, adult, pediatric).

ii. Standard 2: Nurse practitioners engage in evidence informed diagnosing and management of diseases, disorders and conditions and consider best practice guidelines and other relevant guidelines and resources, including when recommending complementary and alternative health therapies.

iii. Standard 4: Nurse practitioners refer patients to a physician at any point in time as deemed necessary in accordance with the CRNBC's Standards Physician Consultation and Referral.

iv. Standard 5: Nurse practitioners order diagnostic services and provide appropriate follow-up that is consistent with nurse practitioners' scope of practice, individual competence within that scope of practice, and the stream in which the nurse practitioner is registered to practise (family, adult, pediatric).

49. The Scope of Practice for NPs describes the Standards for Prescribing Drugs, which include:

i. Standard 1: Nurse Practitioners prescribe drugs within the limits of nurse practitioners' scope of practice and individual competence within that scope of practice and the stream in which the nurse practitioner is registered to practice (family, adult, pediatric).

ii. Standard 5: Nurse Practitioners prescribe drugs in accordance with ethical, legal and professional standards of drug therapy.

iii. Standard 6: Nurse Practitioners engage in evidence informed prescribing and consider best practice guidelines and other relevant guidelines and resources when prescribing for clients, including when recommending complementary or alternative health therapies.

iv. Standard 7: Nurse Practitioners are solely accountable for their prescribing decisions.

50. The Scope of Practice for NPs describes Physician Consultation and Referral as follows:

> Consultation/referral, as used in the following standards, refers to a specific request by a nurse practitioner for a physician (including specialists) to become involved in the care of a client. The responsibility to consult with or refer to a physician lies with the nurse practitioner and is made in collaboration with the client. A nurse practitioner may also seek consultation with or transfer care to a physician at the request of the client.
>
> a. Standard 1: The NP consults with or refers to physicians when the client's health condition or needs are such that:
>
> i. The diagnosis and plan of treatment is beyond the knowledge, skill and judgment of the NP to determine;
>
> ii. The care that is required is beyond the nurse practitioner's competencies, scope of practice and stream of practice;
>
> iii. Signs(s), symptoms, or report(s) of diagnostic or laboratory tests suggest that a client's condition is destabilizing or deteriorating and is beyond the ability of the nurse practitioner to manage; or
>
> iv. The anticipated outcomes of therapy are not realized and further treatment is beyond the ability of the nurse practitioner to manage, or the target symptoms are not responding to treatment.

Documentation Practice Standard

51. The Practice Standard for Documentation requires Registered Nurses and Nurse Practitioners to document timely and appropriate reports of assessments, decisions about client status, plans, interventions, and client outcomes.

52. The College defines documentation as any written or electronically generated information about a client that describes the care or service provided to that client.

53. The Documentation Standard states that documentation serves three purposes:

    i. To communicate with other health care providers regarding the registrant's assessment and diagnosis of the client condition, the plan of care, and interventions that are carried out as well as the outcome of the intervention.

    ii. Documentation provides the rest of the health care team opportunity to review the care the registrant provides and to plan their own contributions to safe and appropriate care for the patient.

    iii. Documentation is a comprehensive record of care provided to a client. Documentation is generally accepted as evidence in legal proceedings and it establishes the acts and circumstances related to the care given and assists registrant to recall details about a specific situation.

54. The Principles underpinning the Documentation Standard include:

    i. Nurses are responsible and accountable for documenting on the health record the care that they personally provide to the client.

ii. When caring for clients, nurses document using a logical process.

iii. Nurses document all relevant information about clients in chronological order on the client's health record. Documentation is clear, concise, factual, objective, timely, and legible.

Professional Misconduct

55. The College relies on the case of *Pearlman v. Manitoba Law Society Judicial Committee*, [1991] 2 SCR 869, in which the Supreme Court of Canada defined "professional misconduct" as "conduct which would be reasonably regarded as disgraceful, dishonorable, or unbecoming of a member of the profession by his well respected brethren in the group – persons of integrity and good reputation amongst the membership".

56. The Court in *Pearlman* emphasized that a professional's conduct should be measured against the judgment of other members of the profession who are competent and in good standing. Accordingly, the College argues, the Respondent's conduct should be measured against the judgment of a competent NP practising in primary care.

57. The College points out that "professional misconduct" is defined in section 26 of the HPA to include "sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession". The College also points out that section 26 of the HPA defines "unprofessional conduct" to include "professional misconduct".

58. The College further relies on the case of *Re McLennan* CRNBC 2018, in which a discipline panel of the Former College held that unprofessional conduct is conduct "which violates the ethical code or rules of a profession or such conduct which is unbecoming a member of the profession in good standing."

59. The College argues that the Panel is not obliged to consider the evidence relevant to each individual allegation within a "silo" that is strictly separated from the evidence of other allegations. The Panel is permitted to consider the facts of several allegations together where they all relate to the Respondent's failure meet applicable nursing standards.

60. The College argues that the Respondent's conduct alleged in the Citation can be regarded as representing a pattern of professional misconduct on the part of the Respondent. The College submits that the legal test set out in *Pearlman* has been met on the facts of this matter and that the only reasonable conclusion based on the facts is that the Respondent's conduct was disgraceful, dishonorable, and unbecoming of a member of the profession.

Incompetent Practice

61. The College further submits that the Respondent has incompetently practiced his designated health profession.

62. The College argues that a finding of incompetence is not simply a general assessment of the qualifications, training, or intelligence of a professional, but a judgment that the professional "incompetently practised the designated health profession" (HPA s. 39(1)(d)). That is, it relates to the actual quality of services that the professional provided.

63. The College relies on *Mason v. Registered Nurses Association of British Columbia*, 1979 Canlii 419, which defines incompetence as the "want of ability suitable to the task, either as regards natural qualities or experience, or deficiency of disposition to use one's abilities and experience properly". The College points out that case has been adopted in many professional disciplinary proceedings.

64. The College also relies on *Reddy v. Association of Professional Engineers and Geoscientists of British Columbia*, 2000 BCSC 88 for the principle that incompetence is typically a finding based upon a pattern of incompetent behaviour, rather than on a single instance of negligence.

65. The Panel now turns to determination of each of the College's allegations in the Citation.

H. <u>Citation - Paragraphs 1(a), (b) and (d)</u>:

"From April 2014 to on or about June 2016, while a Nurse Practitioner at two sites, the HIM Clinic located at 1033 Davie Street, Vancouver and operated by Providence Health and the Three Bridges Clinic located at 1128 Hornby St, Vancouver and operated by Vancouver Coastal Health ("VCH"), and employed in the health authorities' prevention program with the specific mandate to work with the vulnerable and high risk population of men-who-have-sex-with-men ("MSM") you:

a. Solicited detailed and personal sexual histories from your clients when the level of detail in these histories was not clinically indicated and was contrary to the goals and/or mandate of the MSM program (the "Sexual Histories");

b. Recorded the Sexual Histories in the permanent clinical records of your clients in detail, using non-clinical descriptors;

d. Solicited extensive histories from your clients relating to what you described as "coming out" experiences, and on more than one occasion, these histories included information relating to significant past sexual, physical, and/or psychological trauma and you did not appropriately refer those clients to supportive services;"

Evidence

66. Ms. Willms provided expert evidence on what steps and actions an NP should take in soliciting and obtaining a relevant sexual history from a patient. Her evidence included the following:

    a. The purpose of obtaining a sexual health history is to gather details about sexual activity and behaviours that may increase risk for disease. Information gathered is then used to inform treatment, screening, health promotion, and harm reduction in the patient plan.

    b. Adverse experiences such as sexual abuse may affect a patient's ability to discuss their sexual health comfortably. An NP should be aware of trauma informed practice to recognize and respond to patients without re-traumatizing them.

    c. The following list of information should be solicited by an NP while taking a sexual health history:

        i. Questions about sexual identity.

        ii. Questions about sexual activity which may include number of partners and types of sexual activity.

        iii. History of sexually transmitted infections (STIs).

        iv. If men report sex without condom use, the NP should inquire further about whether they are with a single partner with a known HIV status, or if they have sex with casual partners as well as whether alcohol and drug use is involved.

    d. The mandate of the health authority prevention program that the Respondent worked in was to provide primary care to the vulnerable and high-risk population of men-who-have-sex-with-men.

e. Because this population is at high risk for HIV and other sexually transmitted infections, an NP providing primary care in this population should gather a sexual health history on every patient at intake and update it at least yearly. This would then inform necessary screening, health education and harm reduction activities that are offered to the patients when developing a plan of care.

f. Ms. Willms indicated that her review of the Respondent's charts the College provided to her showed various deficiencies with respect to Respondent's documentation of his patients' sexual health histories, including:

   i. documenting detailed accounts of patients' 'lived experience of being gay'; and

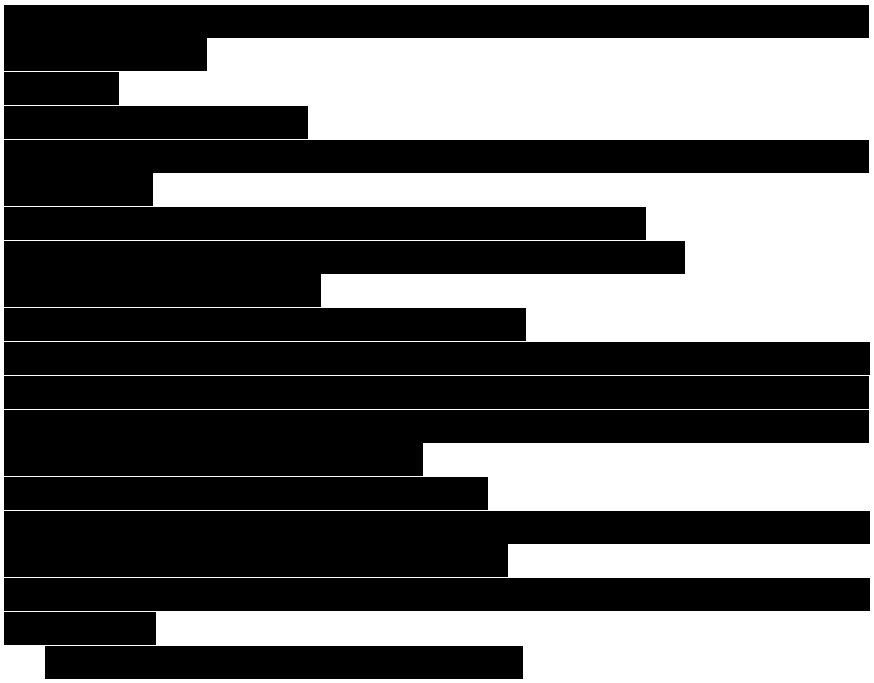
   ii. documenting extensive details about their experiences of 'coming out', including information about their first sexual encounters and other sexual experiences.

g. In Ms. Willms' opinion eliciting this type of information is not properly part of a primary care visit. Also, based on her review of the Respondent's patient charts, he did not, in her opinion, gather information sensitively and respectfully because there was often no documented rationale for the questions being asked, and the details the Respondent documented were not relevant to patients' reasons for seeking care.

h. Ms. Willms highlighted the Respondent's entries in the clinical records of Patient MW, Patient JB and Patient KG noting that the Respondent solicited and documented personal sexual histories from these patients in which the level of detail was not clinically indicated, the sexual history taken and documented was deficient or inappropriate

and the Respondent failed to provide appropriate care when his detailed questioning of patients elicited details of sexual encounters that resulted in disclosure of physical or sexual abuse as children.

i. With respect to Patient MW's visit during December 2014, the Respondent documented the following in the clinical record as part of the patient's subjective history:



j. In the plan of care, the Respondent documented the following:

> explained how PREP' works
> wants prep because wa shaving sex with aguy for some time
> gyu said he was neg
> then client got GC
> friend was tested and has hiv
> they had unprotected sex client receptive anally
> wanst more protection
> PREP (HIV pre-exposure prophylaxis

k. In Ms. Willms' opinion the details the Respondent solicited and recorded

about Patient MW's experience of coming out were inappropriate for a primary care visit. Also, she noted the chart shows the Respondent solicited a history of sexual activity as a child that might be traumatic for the patient but the Respondent did not document acknowledging that disclosure or questioning if the patient would benefit from supportive services to address the disclosure, for example, referral to counselling.

l. With respect to Patient JB's visit in January 2015 the Respondent charted the patient's visit as 'Health counseling" and documented the following information in the chart:

Coming out:
[redacted]

Sexual Hx: cismale, gay has sex with only men open to female encounter, open retatlonshipo condom use with anal sex both giving and recievetnq with partner no condom use for either person tends to be bottom
Condom topic easy to talk about
Trend ta be more kink - bondage usually tide up, not Into fisting no soundling, like mental play humiliation, stimulus deprevatlon, physical violence included nothing broken no marks
Discipline centred not Into cutting - manage that by messaging usaual/y upfront likes to get his limits tested, mild breath control some choking all os this done sober no poppers

Sti Hx" last one was last Feb had GC- 6 months ago was last test- due for an HIV test

m. Ms. Willms noted that in this chart the Respondent documented details

about the patient's sexual experiences that were not relevant to the stated purpose of 'health counseling' or appropriate patient information to gather in a primary care visit. Also, the sexual history the Respondent gathered was unclear and includes inappropriate non-clinical descriptors such as 'bottom' and 'fisting'. She testified this was not appropriate and did not meet the need of medical care of the patient.

n. Further, Ms. Willms indicated the Respondent documented behaviours or activities that Patient JB was not engaging in, which has no clinical relevance, chart showed inappropriate questioning in the sexual history taking, and that the Respondent documented risk behaviours, such as physical violence, which were then not subsequently addressed in the health plan as it should have been.

o. With respect to Patient KG, the Respondent documented a visit on October 13, 2015 as follows:

Health Counselling
no questions form last assessment
step father passed away last night
momis coping ok but has dementia
has been taking 1000IU Vit D and 1000mg Vit C every other day

lived experience as a gay man
[redacted]

[redacted]

[redacted]

A: depression

Plan:
very emotional meeting
extended the session for two houres as client was emotional unstable informed clelnt after that this was an acception not the rule\
low self concept
suggest he may need some support rom mental health team
but this will onlybe helpful if he can be honest with himsel=f to himself and other will focus on accepting the past and that good or bad it cannot be changed

> ity is not helpful to relive the night mares but understand they are a part of him ask in himself what It means to 'give it away'
> RTC next week for another talk then have CPX
> Has no other question at this tlme\agrees to care plan

p. Ms. Willms' noted that the Respondent documented a diagnosis of depression without documenting appropriate subjective and objective history to support this diagnosis. She also indicated that the Respondent failed to include appropriate interventions in the care plan for this diagnosis. In her opinion, the Respondent's care plan is also unclear and inappropriate for a patient who is emotionally upset due to their emotions being triggered by the disclosure of historical trauma. Also, the Respondent did not appropriately document a referral to a mental health team. Ms. Willms indicated it was unclear from the chart entry if the patient agreed to a referral or if one was ever made.

q. Further, in Ms. Willms' opinion, the Respondent's response to the patient about longer appointments being the exception, and his directions about what the patient must do for mental health to be helpful, does not show appropriate empathy and is not patient focused. This response could create further barriers for the patient to appropriately deal with the emotional trauma triggered by his disclosure in this visit. In Ms. Willms' opinion, the Respondent did not approach this visit with a trauma informed perspective and may have re-traumatized the patient during the visit.

r. In addition to the above instances, Ms. Willms identified the following four instances in the Respondent's patients' clinical records that showed the Respondent failed to provide appropriate care when his detailed questioning of these patients' sexual encounters resulted in disclosure by them of physical or sexual abuse suffered as children:

i. Patient AD;

ii. Patient HC;

iii. Patient MA; and

iv. Patient PB.

s. Ms. Willms indicated these charts also show that the Respondent did not consistently document in the patient's chart an appropriate assessment of the impact of their disclosure of physical or sexual abuse as children on their current functioning, including a mental health assessment, and the Respondent also did not document an appropriate offer of referral of the patients to appropriate services such as mental health counselling or other appropriate psychological treatment.

t. In Ms. Willms' opinion, if historical psychological, physical, or sexual abuse/sexual trauma are uncovered during the taking of a sexual history, the NP should be prepared to respond with strategies depending on the patient's needs. These strategies include acknowledgement of the disclosure and expression of empathy. The NP should also be certain to develop an immediate safety plan with the patient if appropriate as well as making appropriate referrals for additional support.

u. Ms. Willms indicated that appropriate documentation following disclosure of this nature would include:

i. That the patient was given the opportunity to discuss the impact of the event and the event's effects on current functioning, or the option to not provide details.

ii. That appropriate assessment of mental health symptoms was undertaken if appropriate (e.g., depression screen, anxiety screen, suicidal risk assessment).

iii. Appropriate offer of and referral to services if appropriate (e.g. mental health counselor, support group, law enforcement).

iv. Documentation of a safety plan to mitigate any risks the disclosure may present. The disclosure of trauma may trigger an emotional response and a safety plan would include how the patient would access help If needed after the visit concluded.

67. Dr. Beaveridge provided the following evidence:

a. Dr. Hall asked her to do a chart audit of the Respondent's practice due to concerns with his charts that were identified.

b. For her chart audit, which was performed in 2016, Dr. Beaveridge used the College's Quality Assurance Template for NPs, which sets out a variety of criteria for evaluating the quality of the charts.

c. She reviewed some charts provided to her by Dr. Hall and completed the audit by randomly choosing other charts. Dr. Beaveridge identified that the Respondent included "non-pertinent" data in numerous charts; specifically, patients' coming out and extensive sexual activity information.

d. Dr. Beaveridge testified that including such non-pertinent information in a patient's chart could have a negative impact on the patient because other providers who may also be accessing those charts would obtain extensive personal and non-relevant information about the patient, which is not necessary for their care. Dr. Beaveridge provided, as examples of this, those situations where patient records

are sent to another provider or requested for WCB or other legal reasons.

e. Dr. Beaveridge indicated that including so much information in a chart distracts, making it difficult to follow the chart. The next practitioner could be confused by what they are reading.

68. Dr. Norrie gave the following evidence:

a. He and the Respondent overlapped at Three Bridges Clinic one day a week.

b. Dr. Norrie stated that there may have been a “couple of times” that the Respondent asked him clinical questions but that their informal mentoring meetings were infrequent and were best described as “corridor consultations”.

c. Dr. Norrie said the Respondent was an “intelligent guy”, who worked independently, and he did not provide any input or advice to the Respondent regarding intake/onboarding procedures, or how to take an appropriate sexual history from a patient.

d. Dr. Norrie also testified that he had reviewed about six of the Respondent’s charts during their professional interactions but he had not identified any issues of concern with respect to the charts that he saw at the time.

69. Dr. Hall provided the following evidence:

a. He became aware of concerns regarding the Respondent’s practice after the Respondent went on leave from his NP position and other practitioners were transitioning into the HIM clinic.

b. During this transition period, while Dr. Hall was also taking over clinical

leadership for the Health Initiative for Men, he became aware of some patient concerns and concerns from other team members about the Respondent's nursing practices. In providing direct patient care at the HIM clinic, Dr. Hall said he saw some of the concerning documentation first-hand when he reviewed patient charts.

c. Dr. Hall testified that it was not one of the goals of the HIV Outreach MSM program for the Respondent to explore the "lived experiences of gay men" nor was it intended for the Respondent to explore the "coming out" experiences of the patients. If a patient wanted to discuss either of those topics because it was having an impact on them, that may have been appropriate. But such questions should not be routine in a primary care setting where the goal was to re-engage marginalized patients back into the health care system.

d. Dr. Hall was concerned for the patients when it came to light that the Respondent regularly asked these questions very early on in the therapeutic relationship, without sensitivity or relevance to the patient's care.

e. Dr. Hall further testified the Respondent's chart note of Patient KG's October 13, 2015 visit shows the patient was there to discuss mental health. The note also indicates the patient reported that his stepfather had passed away the previous night, but the Respondent documents the patient's vitamin regime before returning to the patient's sexual history and soliciting a story from the patient's childhood, and not following up on the concern (i.e. the death of a parent), which could be risky for a patient with underlying mental health concerns (in this case depression). Dr. Hall testified this was shocking. He said:

> "I feel bad for this client. They obviously had a lot of trauma in their life and I don't necessarily think that this would be the time or the place for a provider to be exploring that and you know there's a lot of – you know he has a history of sexual abuse and I don't think on a second visit even if someone's parent hadn't just passed away that you would be eliciting that. You know the risk of further traumatizing someone by bringing up past events of trauma in an insensitive way is very high not to mention someone who's parent just passed away so... It's shocking, frankly."

f. Dr. Hall testified that the Respondent's chart entry shows that the discussion resulted in the patient being triggered and upset. Dr. Hall said that based on what the Respondent had charted he was concerned that this visit may have been inappropriately harmful and difficult for the patient, particularly in the absence of a clinical indication to explore this sensitive subject.

g. Dr. Hall said he was concerned that after uncovering potential historical sexual abuse, the Respondent did not appear to undertake any safety planning to ensure that the client was safe after the visit concluded.

h. Dr. Hall testified that he would also have expected the Respondent to explore what mental health supports the patient may need. He said that if a primary care provider was unsure of the available resources due to inexperience or lack of knowledge that they should make a commitment to the client to try to do their best to find the appropriate resources.

i. Dr. Hall testified that the Respondent should also have explored if the disclosure involved criminality and then advised the patient that they may have options regarding legal avenues to find some sort of resolution.

j. Dr Hall provided the following evidence regarding with respect to the Respondent's chart notes for the Patient KG's October 5, 2015 visit :

Q. Dr. Hall, just to interrupt you, pardon me,under the social history the terminology that nurse practitioner Perry utilizes in the clinicalrecord is this -- would you document -- has the typesof sorry let me start again that was really inelegant. When we look at the social history we see that nurse practitioner Perry hasdocumented "K a couple of times, snorted and bootybump. MDMA tried once, cocaine snorted.All started in the last year. Has never injected.Wants to be in control. Not really interested in trying out anything else but not closing the idea rightdown but not chasing the stuff. Poppers were okay." Is this a clinical entry that you would expecton a patient's social history?

A. So I think there aretwo issues. So there's using colloquial language that the community uses to describe types of substances and methods of substances and that's not inappropriate the rest of the health care services providers withinthe service would understand many of the colloquial terms and part of providing that culturally safe care may be to speak with clients so you would see both in a medical record. Somebody may use more medically appropriate terminology or may usethe colloquial terminology but there's a -- so I think either can be okay and sometimes it's setting and persons specific -- I may sometimes put in quotations if I'm using colloquial language thata client has used to delineate that, that's notthe case in this. I think it's -- there's sometimes more subtle stylistic things that can help increase the coherency of the clinical note but I don't think the colloquial language was one ofthe major concerns looking at this.I think it was more that there's some coherence becauseit doesn't necessarily flow in a logical way it's not necessarily itemized he kind of waffles back and forth between you know never did but then isn't you know not closing the idea down but not like it's maybe a little bit of -- I'm having troubleI guess following in a linear way what was being documented there and I would say that that'syou know in the scheme of all of our concernsbut doesn't rank as one of the higher ones butit's not the most coherent documentation and yesthe use of the colloquial language couldmake communication of this information toanother provider looking at the record challenging but it is also setting specific so.

Q. Okay?

A. And then in the sexual history we wouldn't you know -- his abbreviations and short cuts sometimes led to difficulties in understanding what he was trying to communicate. And I'm not sure I guess one of my concerns in seeing multiple exampleswas there haste in the documentation are there errors or is it he's using a different kind ofapproach in notation that I wasn'tfamiliar with.I feel like it's -- there's haste and there's a lack of attention to detail because it's variable –I don't necessarily see like -- I don't know –was born [indiscernible] is an

> abbreviation for something I'm not familiar with it or if it's a typo -- I think it's a typo -- and therewere various examples of that, you know, sex history. We would typically say sexual history and I don't know if that's brevity because of haste, because there's lot of other typos, the coherency issues. My feeling was, seeing this repeatedly in other records, is that it was because of haste and a lack of care in clinical documentation. And it's not that just seeing once someone writing sexual history writing sex history instead of sexual history is particularly an egregious erroror issue, it's that over time seeing multiple records there was enough kind of variations in how things were documented typos, missing letters that type of thing but the coherency of the clinical record was eroded because of that. And so his concern of the level of detail of sexual history that he goes into of sexual preferences and things it wouldn't be typical with a first visit of a provider when you're first meeting someone.I think you know are there circumstances where this would come up and be appropriate to come up sure if the concern was around that and the client was bringing forward those concerns but I don't see a clinical encounter here that begins with a concern around that. Seeing here there was a concern about sexual health and because it's care provided within a broader sexual health service as well in isolation it's not that -- it doesn't jump off the page as really that concerning in this one isolated case but seeing repeatedly show up when there wasn't client presenting complaints that would have naturally led to that with a level of detail that became concerning so to me looking at the records was this was a pattern this was happening for lots of people regardless of what concern they brought forward so is that clear.

70. Mr. Harrison gave the following evidence:

    a. The Respondent started his role as a nurse practitioner at the HIM and Three Bridges clinics during or about April 2014. The Respondent worked at these clinics for about two years before he went on medical leave in 2016.

    b. Before the Respondent went on medical leave no one alerted Mr. Harrison to concerns about the Respondent's clinical practice. Concerns about the Respondent's charting first came to light when a nurse educator performed a chart audit or review. This chart review was conducted as part of a research trial with the BC Centre for

Excellence on the effectiveness of pre-exposure prophylaxis (PREP). The Respondent's prescription of PREP to patients was part of that trial.

c. The nurse educator who conducted the chart audit alerted Mr. Harrison that there were significant concerns in the Respondent's charting and sent him a list of the public health numbers to review relevant patient charts. Mr. Harrison subsequently performed a chart review with a colleague who is a senior nurse.

d. Mr. Harrison said he was troubled by the sloppiness of the Respondent's charting, very poor grammar usage, and use of non-clinical language.

e. He testified that what was most concerning and alarming to him was that the content of some of the Respondent's chart entries showed patients were being asked about previous traumas, about coming out experiences, and about the first time they had sex.

f. Mr. Harrison also noted there were instances where clients disclosed historical child sex abuse and there was no evidence that the Respondent had done anything about that.

g. Mr. Harrison's testified that the very parochial language about sex acts the Respondent used should not be in a patient's chart because they are incredibly private intimate details, which were being asked about and recorded by the Respondent in the charts when clinically there were no indication for asking those questions.

h. A further concern Mr. Harrison identified was that the charts are permanent records, which remain with the patient as long as they are in the system. He testified that if a patient switched care providers, the

new doctor, or clinic would receive the patient's health records. Mr. Harrison testified that the very specific descriptions of patients' sexual acts the Respondent recorded in the charts could be hugely stigmatizing for those patients.

i. Mr. Harrison said he did not believe anyone would expect their sexual desires and bedroom activities to be charted in their medical records that could be read by anyone that is providing them with medical care.

j. Mr. Harrison testified that what he saw in the Respondent's charts went far beyond the information that is expected in a primary care sexual health assessment.

k. Mr. Harrison stated that a sexual health assessment should be aimed at providing information so the clinician will know "what he needs to swab and what potential risks there are". He indicated that questions for a sexual health history include, what does sex look like for you? If you have anal sex are you insertive or receptive? Do you do anything else that involves bodily fluids? Then, the clinically relevant facts of the sexual history taken would be charted and also if the patient's sexual activity indicates the need for x, y, and z tests. Mr. Harrison testified that he would not record the intimate nature and details offered by the patient in the clinical record.

l. Mr. Harrison also testified that the following sexual history the Respondent charted with respect to Patient DD was not charted in the manner in which a sexual history should be charted:

Sexual Hx: [redacted]

[redacted]

m. Mr. Harrison's said the Respondent's comment about the patient preferring to be insertive but cannot perform is totally beside the point for a sexual history, and the comment of not being able to ejaculate as an insertive partner masturbating to stay hard crosses the line into pornography rather than clinical charting.

n. With respect to the sexual history the Respondent documented in January 2015 in Patient JB's clinical record, Mr. Harrison testified that the Respondent's documentation of the patient's interest in "fisting" or "sounding", and whether he liked "mental play, humiliation, physical violence" or cutting", indicated to him that the Respondent had asked the patient about these particular sex acts.

o. Mr. Harrison said there was no part of him as a registered nurse that could understand why one would ever ask a patient these questions. He testified that this type of chart entry caused him concern, particularly because the specific patient population the Respondent was consulting with is very vulnerable.

p. Mr. Harrison testified that he was upset when he read this chart entry because clinical boundaries clearly had been crossed. He said this type of information is not what should be noted down in a chart when conducting a proper sexual history. He testified that he was left "speechless" by the Respondent's use of language like "situation poppers", "mild breath control", "some choking" in Patient JB's chart.

q. In response to questions by the Panel Mr. Harris also explained that he and others discussed the issues with his charting with the

Respondent. Mr. Harries testified:

Q. So Mr. Harrison, I won't take you I won't continue to take you through the charts I think the panel will be able to see sort of these various issues as they went along but you did say that you had an opportunity at some point after these issues came to light to sit down and talk with Mr. Perry about these things?

A. That's correct.

Q. Can you recall roughly when that occurred?

A. This would have been I believe 2016 or early 2017 I'm sorry my time line is so long.

Q. Yes, yes.

A. However so we called him in for a meeting with human resources professional practice and myself to have a meeting about the concerns we had and to let him know what the next steps were going to be.

Q. Right. And what was the ultimate step?

A. Reporting to the college.

Q. And what happened with his employment?

A. He was terminated.

….

Q. I did want to ask when you had your meeting with Mr. Perry to ask him about the charting that he'd done the kind of discussions he's had with different patients could I ask what his response was. Mr. Harrison I can't hear you?

A. My apologies. He was very defensive and demonstrated very little insight into why we would be so concerned. They took a quite a lot of conversation and particularly when we discussed the case that we just talked about on page 66 with the [redacted] mask he then acknowledged that that could be -- it could be misconstrued from someone reading the chart that didn't know the patient. He didn't actually acknowledge that it was his practice that was an issue.

…

Q. I have just a couple of questions for you Mr. Harrison how long after the meeting with Mr. Perry with yourself professional practice and HR was he terminated?

A. I can't remember the exact time line but it was quite close it was within a few weeks. He was expected to return for a further meeting

> and to have a learning plan put together and he failed to respond and attend that meeting.
>
> Q Okay. And that was going to tie into my next question was given that it was a newly established nurse practitioner position when those problems arose in his practice were there any interventions coaching mentoring done learning plans prior to him being terminated?
>
> A. We didn't have the option to do that because he didn't engage.
>
> …

Analysis and Findings of Fact

71. The College submits that the Respondent's intake and onboarding process routinely involved asking men about their sexual pasts, including an exploration of their first sexual feelings and experiences. Men were asked to provide personal details about "coming out experiences" that appeared to have included probing how family members responded to their news. The College submits that almost every patient chart and record in Exhibit #2 includes information that established this allegation in the Citation.

72. The College argues the prevalence of this kind of information contained in clinical records leads to the only reasonable inference being that the Respondent intentionally pried into his patients' private lives as a matter of course, without any clinical indication and with disregard for the potential harm this line of questioning may have for men who may have experienced historic physical, psychological and/or sexual abuse. Further, when historical sexual abuse was uncovered, the Respondent failed to take necessary steps to ensure patients were safe after leaving his office.

73. The College submits that without any evidence from the Respondent it is impossible to know exactly why he focused so heavily on these issues with his patients. These were concerning practices that were highly inappropriate and have the potential to visit harm on these patients in the years ahead.

74. The College further submits that the allegations are proven and demonstrated the Respondent's reckless disregard for the physical and mental well-being of his patients and represent a clear breach of the relevant nursing standards and constitute professional misconduct.

75. The College submits the conduct alleged in the Citation represents a pattern of professional misconduct by the Respondent. It argues the legal test set out in *Pearlman* above has been met and that the only reasonable conclusion based on the facts is that the Respondent's conduct was disgraceful, dishonorable, and unbecoming of a member of the profession.

76. The Panel agrees with the College's submissions.

77. In *Re McLennan* CRNBC 2018, a discipline panel of the Former College held that:

> 55. An important feature of professional misconduct, or unprofessional conduct, is that a professional standard of practice may arise from different sources: standards may arise from a profession's "culture", such as a common understanding within a profession as to the expected behaviour, or from formal written guidelines published by a regulatory body. One may reflect or influence the other.
>
> 56. The discipline committee may receive evidence on standards from an expert witness, but it may also rely on a written code of conduct or deduce standards from the fundamental values of the profession. Sometimes finding a standard is easy and straightforward, such as where a rule in written code is directly on point. Sometimes finding a standard involves difficulty, such as where a code expresses a standard as a general principle, and the committee must apply a more fact specific standard. A committee may find a more fact-specific standard by deducing the standard from the fundamental values of the profession, or form the values and principles expressed in a written code, and by interpreting general principles using its own expertise. A committee may also consider the rationales accepted and expressed by other panels of nurses or health professionals, which have applied standards in more or less similar circumstances. Finding a standard may be most difficult where different bodies of responsible professional opinion may differ about the propriety of conduct in a specific situation.

78. The Panel finds the evidence of Ms. Willms, Dr. Beaveridge, Dr. Hall, and Mr. Harrison, outlined above, is clear, convincing, and cogent, and it accepts their evidence.

79. The evidence before the Panel demonstrates that the Respondent failed to practice in a patient-centered manner, and consistently and repeatedly delved into private sexual histories and preferences of patients. The persistent and detailed focus on patients' private sexual activities and history had the potential to retraumatize patients who did or may have experienced past sexual abuse and further estrange members of this vulnerable population group from appropriate and timely engagement with health care. Further, this information now forms part of the Respondent's patients' permanent clinical records, that can be viewed by future health care providers, and may put patients at further risk of stigmatization.

80. As noted, Mr. Harrison testified that what he saw in the Respondent's charts went far beyond the information that is expected in a primary care sexual health assessment. He also testified that the very specific descriptions of patients' sexual acts the Respondent recorded in the charts could be hugely stigmatizing for those patients. Dr. Beaveridge testified that including such non-pertinent information in a patient's chart could have a negative impact on the patient because other providers who may also be accessing those charts would obtain extensive personal and non-relevant information about the patient, which is not necessary for their care. In Ms. Willms' expert opinion documenting detailed accounts of patients' 'lived experience of being gay'; and documenting extensive details about their experiences of 'coming out', including information about their first sexual encounters and other sexual experiences is not properly part of a primary care visit. Dr. Hall also confirmed that it was not one of the goals of the HIV Outreach MSM program for the Respondent to explore the "lived experiences of gay men" nor was it intended

for the Respondent to explore the “coming out” experiences of the patients. If a patient wanted to discuss either of those topics because it was having an impact on them, that may have been appropriate. However, Dr. Hall indicated that such questions should not be routine in a primary care setting where the goal was to re-engage marginalized patients back into the health care system. Dr. Hall expressed concern the Respondent regularly asked these questions very early on in the therapeutic relationship, without sensitivity or relevance to the patient’s care.

81. Based on the evidence before it, the Panel finds that the Respondent solicited detailed and personal sexual histories from his clients when the level of detail in these histories was not clinically indicated and was contrary to the goals and/or mandate of the MSM program. The Panel further finds that the Respondent recorded detailed and personal sexual histories of his patients in their permanent clinical records, using non-clinical descriptors. The Panel also finds that the Respondent solicited extensive histories from his clients relating to what he described as “coming out” experiences, and on more than one occasion, these histories included information relating to significant past sexual, physical, and/or psychological trauma and that he did not appropriately refer those clients to supportive services. A review of the Respondent’s clinical entries, some which have been replicated in these reasons, show repeated instances of this type of conduct.

82. The Panel finds that the Respondent’s conduct described in paragraphs 1(a), (b) and (d) of the Citation has been established by the evidence, on a balance of probabilities.

83. Further, based on the evidence, the Panel finds that the Respondent's conduct described in paragraphs 1(a) and (d) of the Citation did not comply with the following College Standards:

> **Professional Standards for Registered Nurses and Nurse Practitioners**
>
> **Standard 1, Professional Responsibility and Accountability**
>
> **Clinical Practice**
>
> 1. Is accountable and take responsibility for own nursing actions and professional conduct.
>
> **Standard 2, Knowledge-Based Practice**
>
> **Clinical Practice**
>
> 8. Sets client-centred priorities when planning and providing care.
>
> **Standard 3, Client-Focused Provision of Service**
>
> **Clinical Practice**
>
> 2. Coordinates client care in a way that facilitates continuity for the client.
>
> **Standard 4, Ethical Practice**
>
> **Clinical Practice:**
>
> 1. Makes the client the primary concern in providing nursing care.
> 2. Provide care in a manner that preserves and protects client dignity.

84. With respect to the Respondent's conduct in paragraph 1(d) of the Citation, the Panel finds that the conduct also did not comply with the following College Standards:

> **Professional Standards for Registered Nurses and Nurse Practitioners**
> **Standard 3, Client-Focused Provision of Service**
>
> **Clinical Practice**
>
> 1. Communicates, collaborates and consults with clients and other members of the health care team about the client's care.
> 2. Coordinates client care in a way that facilitates continuity for the client.

Standard 4, Ethical Practice

Clinical Practice:

7. Promotes and maintains respectful communication in all professional interactions

85. With respect to the Respondent's conduct described in paragraph 1(b) of the Citation, the Panel finds that the Respondent's conduct did not comply with the following College Standards:

Professional Standards for Registered Nurses and Nurse Practitioners

Standard 2, Knowledge-Based Practice

Clinical Practice

6. Communicates client status, using verifiable information, in terminology used in the practice setting.

Standard 4, Ethical Practice

Clinical Practice:

2. Provides care in a manner that preserves and protects client dignity.
7. Promotes and maintains respectful communication in all professional interactions.

86. The Panel also finds the Respondent's conduct described in paragraph 1(b) of the Citation, did not comply with the following principles of the Documentation Practice Standards in force at the relevant times:

Principles

1. Nurses are responsible and accountable for documenting on the health record the care they personally provide to the client…
2. When caring for clients, nurses document using a logical process (e.g. assessment, nursing diagnosis, planning, implementation and evaluation), including information or concerns reported to another health care provider and that provider's response.

3. Nurses document all relevant information about clients in chronological order on the client's health record. Documentation is clear, concise, factual, objective, timely and legible.

87. The College argued that the Standards are "an expected and achievable level of performance against which actual performance can be compared. It is the minimum level of acceptable performance".

88. Based on the evidence of Ms. Willms, Dr. Beaveridge, Dr. Hall and Mr. Harrison, the Panel finds that the Respondent's proven conduct, described in paragraphs 1(a), 1(b) and 1(d) of the Citation, presents such a marked departure from the minimum level of acceptable performance or conduct which the College expects of its Nurse Practitioner registrants that it constitutes professional misconduct. The Panel finds the Respondent's proven conduct disgraceful, dishonorable, and unbecoming of a member of the Nurse Practitioner profession.

89. As such, the Panel determines that by conducting himself in the manner described in paragraphs 1(a), 1(b) and 1(d) of the Citation, which was established on a balance of probabilities, the Respondent committed professional misconduct pursuant to section 39(1)(c) of the Act.

I. <u>Citation – Paragraphs 1(c)(i), 1(c)(ii), 1(c)(iii) and 1(c)(v):</u>

"From April 2014 to on or about June 2016, while a Nurse Practitioner at two sites, the HIM Clinic located at 1033 Davie Street, Vancouver and operated by Providence Health and the Three Bridges Clinic located at 1128 Hornby St, Vancouver and operated by Vancouver Coastal Health ("VCH"), and employed in the health authorities' prevention program with the specific mandate to work with the vulnerable and high risk population of men-who-have-sex-with-men ("MSM") you:

c. Created documentation in your clients' permanent clinical

records that was not clear, concise, objective, and/or legible due to:

i. numerous spelling and grammatical errors;

ii. the use of abbreviations that were not standard and were out of the norm;

iii. the lack of a logical flow of information such that a clinician would be unable to follow your clinical decision making;

iv. …

v. inconsistencies between the subjective and objective observations that you recorded;"

Evidence

90. Ms. Willms provided the following evidence:

a. The expectation of a primary care NP for documenting a patient visit includes:

i. Documentation of a health history including the reason for the visit, a history of the presenting issue, past medical history, family history, sexual history, allergies, prescription and over the counter and/or complementary therapies.

ii. Documentation of the patient's social history including screening for alcohol, drug, and tobacco use.

iii. Documentation of a physical exam based on assessment findings with the use of screening tools were appropriate.

iv. Documentation of the formulation of a differential diagnosis and confirms most likely diagnosis if appropriate.

v. Documents a plan of care, which includes (as applicable):

i. Appropriate diagnostic interventions.

ii. Education/health promotion–including risk reduction counselling if applicable.

iii. Follow up plan.

iv. Collaboration, consultation, and referral as necessary.

v. Appropriate prescription of pharmacotherapy.

b. Additionally, requirements for NP documentation of a primary care visit also include that:

   i. Documentation must demonstrate safe and appropriate care.
   ii. Documentation must demonstrate evidence-based practice.
   iii. Documentation must be organized and systematic.
   iv. Documentation must show a decision-making process to demonstrate the care that was provided.
   v. Documentation must meet legal and professional standards.

c. In Ms. Willms' opinion, the Respondent's charting reflected serious gaps in his professional practice. In her opinion, the Respondent's clinical records provided to her for review contained numerous documentation deficiencies, including:

   i. Spelling and grammatical errors and inappropriate usage of acronyms.
   ii. Missing or unclear chief complaint or reason for visit.
   iii. Incomplete or missing subjective history.
   iv. Incomplete or inappropriate documentation of objective findings.
   v. Incomplete or inappropriate diagnosis/differential diagnosis.
   vi. Incomplete or inappropriate plan of care.
   vii. Lack of organization, logic and flow to documentation.

<u>Spelling and grammatical errors and inappropriate usage of acronyms</u>

d. Ms. Willms evidence was that the Respondent's charts contained so many spelling and grammatical errors that sometimes the charts did not make sense. Often, she had to guess what words meant. In her opinion,

if another provider had to take over care this would pose a serious risk to the patient.

e. Ms. Willms also noted the Respondent inappropriately used acronyms. She pointed to the clinical record of Patient NT which contained both spelling errors and inappropriate acronym usage. In this chart, the Respondent documented that Patient NT:

> was told he may have been in contact with CL
> would liek rectal swab throat swab and urien tested

f. Ms. Willms said she guessed that “CL” meant Chlamydia, however it is not appropriate for her to have to guess that. The Respondent also misspelled the words “urine” and “like”.

g. Ms. Willms further described the Respondent’s documentation of Patient PB’s visit on Jun 4, 2015 as “riddled” with typos. She said she had no idea what the phrase “no camoing” in meant.

<u>Missing or unclear chief complaint or reason for visit</u>

h. Further, Ms. Willms noted that the Respondent did not consistently document the reasons for a patient’s visit in his charts, or it was not clear from the charts what was the reason for a visit. Instead, many of the Respondent’s chart notes contained vague statements such as ‘here to define health and lived experience’, ‘here for discussion about health and goals and lived experience as a gay man', and ‘here to talk about lived experience as a gay man’.

i. Ms. Willms indicated that some visits were documented as mental health screening but did not demonstrate appropriate mental health screening and instead had extensive histories of “coming out” or details about the patient's experience of being gay documented. She pointed to the Respondent’s charting of visits by Patient JD, Patient SB and Patient

NT as specific examples of his clinical records that contained this type of sub- standard charting.

Incomplete or missing subjective history

j. Ms. Willms also testified that in many of the Respondent's charts, he did not gather a complete subjective history, including pertinent positives and negatives that would support the process of formulating differential diagnosis and a treatment plan. This most often occurred when the Respondent was gathering history related to mental health screening or when he was documenting 'the patient's experiences' of physical or mental health.

k. Ms. Willms also noted the Respondent documented questions regarding the patient's views of physical and mental health, which often elicited specific symptoms related to physical and mental health. However, the Respondent did not then investigate the reported symptom with an appropriate approach such as OLDCART for physical symptoms (onset, location, duration, characteristic, aggravating factors, relieving factors and treatment), or SIGECAPS for depression (sleep, interest, guilt, energy, concentration, appetite, psychomotor, suicidality).

l. In Ms. Willms' opinion, the Respondent's charting also often lacked pertinent positive and negative history for reported symptoms or complaints. She pointed to the Respondent's charting of Patient MA's intake visits on March 5 and 10, 2015 which contained an incomplete or missing subjective history. In this chart, the Respondent documented a history of 'depression situational has tried many medications'. In the subjective history, the Respondent documented the following:

> mental health Is about not wanting to kill yourself every day thinks Its ok to think about reevaulate self anxiety In his life is about personal safety and safety

m. In Ms. Willms' opinion, these statements should have prompted the Respondent to document more questions surrounding anxiety and depression, including screening for risk of suicide, however, the Respondent failed to do so. Ms. Willms further noted that during a subsequent visit, Patient MA reported 'feeling very anxious at work', 'not sleeping well', 'wakes up anxious and screaming' and 'has been feeling very low'. However, the Respondent failed to gather a subjective mental health history or pertinent positives/negatives related to these concerns at any of the visits, as he should have.

n. In her opinion, the following chart entry with respect to Patient JC's visit during April 2016 did not contain a sufficient subjective history about the patient's concern:

> Today wants his skin: haNDS
> Rash started a year ago started off as a hard then he picked

<u>Incomplete or inappropriate documentation of objective findings</u>

o. Ms. Willms noted the following deficiencies with respect to the Respondent's documentation of objective findings:

   i. Physical exam incomplete or no physical exam documented and no clear reason for visit. Example Patient PB.

   ii. Physical exam not congruent with subjective findings. Example (chest rash) Patient JL.

   iii. Pertinent negatives not documented. Example (chest pain): Patient BB.

   iv. Heart rate not documented when required. Example Patient MW.

   v. Use of appropriate depression screening tools not documented. Example Patient KG.

vi. The Respondent performed physical exams that were more extensive than required by patient age, history and presenting complaint, including extensive neurological and cardiac exams on patients with no related diagnosis or complaints. Example, Patient NT.

vii. Inconsistent documentation of patient allergies. Example, Patient SN.

Incomplete or inappropriate diagnosis

p. In Ms. Willms' opinion, the Respondent's charts that she reviewed also displayed the following deficiencies in respect of his documentation of diagnosis/differential diagnosis:

i. Missing diagnosis. Example Patient JL.

ii. Diagnosis without appropriate supporting objective/subjective history. Example (depression), Patient KG.

iii. Diagnosis unrelated to chief complaint. Example (Erectile Dysfunction) Patient MW.

iv. Unclear diagnosis. Example, Patient PB.

v. Diagnosis without meeting diagnostic criteria. Example (Erectile dysfunction) Patient MW.

Inappropriate or incomplete plan of care

q. Further, Ms. Willms noted that the Respondent's documentation of plans of care were consistently inadequate or inappropriate. In her opinion, the Respondent's charts contained the following sub-standard documentation of plans of care:

i. Missing education or health promotion. The Respondent does not document education regarding safe sexual practices or harm reduction regarding risk behaviours. Example, Patient GA.

ii. Prescription of medication without appropriate chief complaint, subjective/objective or diagnosis. Example, Patient SN.

iii. Prescription of Viagra medication without documenting allergy history. Example, Patient SN.

iv. Incomplete documentation of teaching regarding medications prescribed. Example, Patient KG.

v. Diagnostic testing ordered without appropriate supporting subjective or objective findings. Example (Echocardiogram for flutter) Patient NT.

vi. Missing plan for documented diagnosis. Example (skin lesion) Patient MW.

Lack of organization, logic and flow to documentation

r. In Ms. Willms' opinion the Respondent's charts also often lacked organization and were difficult to follow. His charts often missed content essential to primary care. She indicated the following specific deficiencies with respect to the Respondent's charts' content organization and flow:

i. The Respondent does not document all elements of a primary care visit in the chart and notes are missing either the chief complaint, objective history or assessment/diagnosis. Example, Patient MA.

ii. He writes 'ROS' (review of systems} and then does not document a review of systems. Example, Patient KJ .

iii. He does not articulate reason for visit and documents several patient complaints or concerns without identifying what is being assessed or treated. Example, Patient BB.

iv. Numerous spelling and grammatical errors and sentences that do not make sense. Example, Patient PB.

v. Repeated patient visits with unclear purpose. Example, Patient KG.

91. Dr. Hall provided the following evidence with respect to Patient KG's clinical records:

a. As already noted, Dr. Hall testified that the Respondent's chart notes for the patient's October 5, 2015 visit lacked clarity about the presenting clinical concern, or chief presenting complaint. He said that the use of colloquial language could make communication of the patient's information to another provider looking at the record "challenging". He said that overall, there was also a lack of coherence to the chart note and it did not logically flow. The title "sex history" in the note should have been "sexual history". Dr. Hall testified that the typographical errors, spelling mistakes, and use of abbreviations that were unknown him, resulted in a note that was "eroded" and lacked coherence.

b. With respect to the Respondent's clinical note of the patient's October 19, 2016 visit, Dr. Hall indicated that the flow of the clinical entry was difficult to follow, there was no subjective complaint from the patient, in the objective section there was no tie in to assessment from a mental health perspective – which was the subject of the previous entry and of concern, and then the plan is to return for a full physical, which Dr. Hall stated "felt inappropriate" because there was no urgent presenting

physical complaint and even if there was, Dr. Hall testified that he might have delayed it himself, given the disclosure of sexual abuse as well as the report of the recent death of a step parent.

c. Dr. Hall further testified the Respondent did not complete a full assessment of the patient's mental health which he would have expected in the circumstances.

d. With respect to the clinical note of the patient's October 26, 2015 visit, Dr. Hall said the brevity of the note of the physical examination the Respondent performed was not necessarily concerning, but what was concerning was that the physical examination included a sensitive genital urinary pelvic examination in the absence of a clear indication for that examination. This was particularly concerning in the setting of a client who has suffered sexual abuse and was experiencing current mental health issues.

e. With respect to the Respondent's clinical note of the patient's November 4, 2015 visit, Dr. Hall testified that the second line under the heading "health counselling" indicated that "scope showed some blood on stool", which left Dr. Hall to be concerned that the Respondent may have performed an anoscope procedure, that is, the anus is cannulated with a plastic speculum to visualize the rectal tissues.

f. Dr. Hall testified that the note did not appear to contain a reason for performing this procedure, and it was problematic to do it particularly when a patient has a history of sexual abuse. Dr. Hall indicated that even if a patient disclosed they had a rectal concern, like blood on stool, the assessment should have been to perform a history by asking questions and then asking permission to examine the anus and rectum, and that examination might then only be external. If an internal assessment was required, then Dr. Hall said he would seek patient

permission and likely would only have done a finger examination. All these elements were missing from this clinical note the Respondent made.

g. Dr. Hall's testimony on the rest of this note was that it lacked organization and was difficult to understand. He testified that the note overall was disorganized, there were several issues that were not fully explored, and subjective/objective assessments were incomplete or missing. The Respondent documented cognitive concerns that may be related to marijuana use but also documented that these concerns may be attributable to a past brain injury and had been assessed by a specialist. Dr. Hall testified that when a patient is struggling with mental health, a past neurological work-up is necessary information – especially when considering a referral to a brain injury clinic.

h. With respect to the Respondent's clinical note of the November 9, 2015 patient visit, Dr. Hall testified that there are several issues discussed, hyperthyroidism, a sore on the patient's penis, and colon issues, as well as further detail about sexual activity, which were all mixed together and hard to follow.

92. As already noted above, Mr. Harrison testified that:

a. He was troubled by the sloppiness of the Respondent's charting, very poor grammar usage, and use of non-clinical language.

b. After they became known, he and others discussed the issues with his charting with the Respondent, but he was very defensive and demonstrated very little insight into why they were so concerned about it, and that the Respondent failed to attend a further meeting for a learning plan to be put together.

Analysis and Findings of Fact

93. The College submits that the clinical records for Patient KG clearly illustrate the allegations contained in paragraph 1(c) of the Citation, and that the Panel should have no issue concluding that the allegations have been proven on a balance of probabilities.

94. The Panel finds the evidence of Ms. Willms, Dr. Beaveridge, Dr. Hall, and Mr. Harrison, outlined above, clear, convincing, and cogent, and it accepts their evidence.

95. The Panel also finds that the Respondent's conduct alleged in paragraphs 1(c)(i), 1(c)(ii), 1(c)(iii) and 1(c)(v) of the Citation has been established by the evidence. The evidence before the Panel shows, on a balance of probabilities, that the Respondent repeatedly created documentation in his patients' permanent clinical records that was not clear, concise, objective, and/or legible due to numerous spelling and grammatical errors, the use of abbreviations that were not standard and out of the norm, that lacked a logical flow of information that would enable a clinician to follow his clinical decision making, or contained inconsistencies between the subjective and objective observations that he recorded. It was a pattern of behavior by the Respondent.

96. Based on the evidence, the Panel finds that the Respondent's conduct in paragraphs 1(c)(i), 1(c)(ii), 1(c)(iii) and 1(c)(v) of the Citation did not comply with the following College Standards:

> **Professional Standards for Registered Nurses and Nurse Practitioners**
>
> **Standard 2, Knowledge-Based Practice**
>
> **Clinical Practice**
>
> 3. Uses critical thinking when collecting and interpreting data, planning, implementing and evaluating nursing care.

6. Communicates client status, using verifiable information, in terminology used in the practice setting.

97. The Panel also finds that the Respondent's conduct in paragraphs 1(c)(i), 1(c)(ii), 1(c)(iii) and 1(c)(v) of the Citation did not comply with the following principles of the Documentation Practice Standards that were in force at the relevant times:

> **Principles**
>
> 1. Nurses are responsible and accountable for documenting on the health record the care they personally provide to the client…
> 2. When caring for clients, nurses document using a logical process (e.g. assessment, nursing diagnosis, planning, implementation and evaluation), including information or concerns reported to another health care provider and that provider's response.
> 3. Nurses document all relevant information about clients in chronological order on the client's health record. Documentation is clear, concise, factual, objective, timely and legible.

98. The Panel determines that the Respondent's conduct in a paragraph (1)(c) meets the definition and test for incompetent practice, as explained by the Court in *Mason* and *Reddy,* above. In creating these sub-standard clinical documentations, the Respondent displayed a want of ability suitable to the tasks of proper clinical documentation as prescribed by the College's above-mentioned Professional and Documentation Practice Standards. There was also a pattern of incompetent behaviour in this regard by the Respondent, as opposed to a single instance. A review of the Respondent's clinical entries, some which have also been replicated in these reasons, shows repeated instances of the type of conduct alleged by the College in the Citation.

99. Accordingly, the Panel finds that by conducting himself in the manner described paragraphs 1(c)(i), 1(c)(ii), 1(c)(iii) and 1(c)(v) of the Citation, which

has been proven on a balance of probabilities, the Respondent has incompetently practiced his profession, contrary to section 39(1)(d) of the HPA.

J. Citation – Paragraph c (iv):

> ***"From April 2014 to on or about June 2016, while a Nurse Practitioner at two sites, the HIM Clinic located at 1033 Davie Street, Vancouver and operated by Providence Health and the Three Bridges Clinic located at 1128 Hornby St, Vancouver and operated by Vancouver Coastal Health ("VCH"), and employed in the health authorities' prevention program with the specific mandate to work with the vulnerable and high risk population of men-who-have-sex-with-men ("MSM") you:***
>
> > ***c. Created documentation in your clients' permanent clinical records that was not clear, concise, objective, and/or legible due to:***
> >
> > > ***iv. your client intake and history taking occurring over numerous visits, which required a clinician to read several notes made over a longer period of time to attempt to understand the purpose of each visit and your clinical and intellectual footprint;"***

Evidence

100. Ms. Willms provided evidence about the alleged long onboarding issue. She noted that spreading initial assessments over three to four visits was not patient centered and potentially delayed appropriate treatment, health promotion and illness prevention.

101. Dr. Hall provided the following evidence:

a. The intake and onboarding of clients to the Respondent's practice were supposed to be two steps. The first step of "intake" dealt with how people get connected to the service, either through referral from another service, word of mouth, or self- referral.

b. Dr. Hall testified that with respect to the specifics of the "onboarding

process", meaning how histories were taken and a client received care from the Respondent, that there was no detailed involvement by him or the leadership in that process. Rather, the principles of low barrier and culturally safe care were discussed with the Respondent and it was thought that those principles would be key to the way patients were re-engaged with the system.

c. Dr. Hall also explained why a lengthy, rigid onboarding process is problematic, which is because a lengthy process is expressly contrary to the principle of "low barrier care".

d. Dr. Hall stated that the Respondent's onboarding process was concerning because he asked patients to verbally affirm that they would receive their primary care from him. Then they were asked to return for multiple visits in a manner that was certainly a high barrier to these patients.

e. In response to a question of the Panel, Dr. Hall noted that there were conversations with the Respondent to encourage him to become more flexible in his approach to onboarding.

f. Dr. Hall stated that the Respondent had been advised that flexibility and "meeting the patient where they were at" was important in providing low barrier care.

102. In response to questions by the College's counsel, Mr. Harrison provided the following evidence regarding his discussions with the Respondent about intake processes:

> A: No. He had discussions with us about what he thought would be best for an intake process and not to try to do everything in one long appointment. Remember we're talking about patients that have not had access to primary care for some time, so we're likely to have multiple problems or multiple issues that we needed to address so a vast – or a large number of our group

> are stimulant users as well who generally find being in a health care environment quite difficult and challenging. They're quite disorganised, they need to get up and pace around, they're not going to sit for an hour and answer questions for you, when have to be kind of quite rapid in the way we do things and chunk it out for them so they can cope with the experience. So, we were aware that it may be three or four visits before we actually got the full history of someone and we'll be able to start sorting through what their health priorities were.
>
> Q: And in terms of undertaking that sort of an assessment, so when you have a new patient or a new client meet with this role can you walk through with the panel how it was envisioned that that – in terms of what issues would be addressed during the course of that intake?
>
> A: We would – we work from a bio-psychosocial framework so we would look at kind of the biology of the patient. What is their disease background and history? Have they got any current issues, infections, disease processes that are of concern? We look at the psychological well being, whether there's any history of mental illness, whether they're suffering from something right now. Are they using substances, or alcohol? And social, how they socially function. Are they working? Where do they hang out, have they got concerns, are they in a relationship, have they got good support network? So, we take a very holistic approach through that biopsychosocial framework.
>
> Q: And it's also my understanding is that there's a patient centered element to this process as well?
>
> A: Absolutely. If a patient comes in and their primary concern is that they found a lump on their arm I'm not going to start talking to them how they doing psychologically. At that time we work on the patient's priorities and that's particularly important for this group of patients because they've often have experiences of not being listened to in the past so if you don't validate the presenting problem then they're unlikely to build a trusting rapport with you.

Analysis and Findings of Fact

103. The Panel accepts Ms. Willms and Dr. Hall's evidence that spreading an initial assessment or intake over three or four visits is generally problematic to low-barrier care. However, in the specific circumstances of this case, the Panel prefers the evidence of Mr. Harrison on the onboarding issue. It is clear from his evidence that finding the right intake procedures was not black and white, and was a continually evolving process. As noted, Mr. Harrison testified that

the clinic's management was aware from the outset that due to the special characteristics of the MSM patient population it would be necessary to adjust the intake process to the specific client needs, and that it might be three or four visits before the Respondent would obtain a patient's full history and then be able to establish the patient's health priorities.

104. The Panel accordingly determines that the evidence before it does not satisfy the balance of probabilities test with respect to the breaches of the Act, bylaws or Standards as alleged in paragraph 1(c)(iv) of the Citation. This allegation is dismissed.

K. Citation – Paragraphs 1(f) and (g):

"From April 2014 to on or about June 2016, while a Nurse Practitioner at two sites, the HIM Clinic located at 1033 Davie Street, Vancouver and operated by Providence Health and the Three Bridges Clinic located at 1128 Hornby St, Vancouver and operated by Vancouver Coastal Health ("VCH"), and employed in the health authorities' prevention program with the specific mandate to work with the vulnerable and high risk population of men-who-have-sex-with-men ("MSM") you:

f. Did not adhere to best practice guidelines when you ordered diagnostic interventions and/or prescribed medications for your clients without a clear clinical indication;

g. Failed to document necessary clinical indicators for your clients, including allergies when you prescribed a drug."

Evidence

105. A review of the Respondent's patients' clinical records that the College tendered into evidence as Exhibit #2 indicates the following:

a. Patient MW was diagnosed by the Respondent with erectile dysfunction on December 22, 2014 and given a prescription for Tadalafil (a drug used to treat same) with no history recorded regarding erectile dysfunction despite a very lengthy, detailed physical

examination which included examination of the patient's genitals, including a rectal examination.

b. Patient NT, on May 5, 2016, appears to have had lab work ordered, however the College was not entirely sure if the Respondent made another typo here or was using an acronym known only to him. However, there is a reference to a LACF one yellow top and there is no clinical indication for same. Later, during for the encounter of May 12, 2016, there is a reference to "have blood work collected". The College says, it is unclear what lab work was to be collected and for what clinical indication. Later on May 19, 2016, after an exploration of Patient NT's "lived experience as a gay man" which also revealed incidents of childhood sexual abuse with a family member prior to puberty, there is another reference to "get blood work collected" but there is no documented clinical indication or details of what laboratory tests were to be done.

c. Patient JL, on January 27, 2015 the Respondent documented his allergies as: "Grout-kiwi tongue gets itchy and swollen, no known drug allergues [sic], degenerative bone disease in mouth, lots of mouth". The College submits this allergy status is bizarre and not in keeping with proper charting practices and it is not possible to understand what information the Respondent intended to convey.

d. With respect to Patient KG, the Respondent diagnosed hyperthyroidism on the basis of a single TSH test and neglected to do a physical examination of Patient KG's thyroid, failed to document heart rate, and the pertinent negative findings one would expect if a practitioner suspected hyperthyroidism. The Respondent then provided a three-month prescription for a drug to treat hyperthyroidism.

Ms. Willms characterized these actions as a “critical error” in her report.

e. Patient SN, on July 29, 2015, the Respondent prescribed Viagra for the patient with no documentation regarding the clinical basis for same. In the note dated July 27, 2015, the Respondent documented that Patient SN had “nothing to date” under his past medical history. On August 21, 2015 the Respondent conducted an extensive physical examination and ordered extensive lab work without a stated clinical indication.

Analysis and Findings of Fact

106. The College submits the Panel should have no difficulty in finding that these sub-allegations are proven and demonstrated the Respondent’s incompetence and professional misconduct.

107. The Panel finds that the above-mentioned evidence establishes, on a balance of probabilities, that the Respondent ordered diagnostic interventions and prescribed medications for clients without a clear clinical indication to do so, and he also failed to document necessary clinical indicators for clients, including allergies when he prescribed a drug.

108. The Panel finds that the Respondent’s conduct described in paragraph 1(f) of the Citation did not comply with the following College Standards:

> **Professional Standards for Registered Nurses and Nurse Practitioners**
>
> **Standard 2, Knowledge-Based Practice**
>
> **Clinical Practice**
>
> 3. Uses critical thinking when collecting and interpreting data, planning, implementing and evaluating nursing care.

109. The Panel also finds that the Respondent’s conduct described in paragraph 1(f) of the Citation also did not comply with Standard 5 of the College’s Scope

of Practice Standard for NPs for Diagnosing and Health Care Management, which provides:

> **Standard 5**
>
> Nurse practitioners order diagnostic services and provide appropriate follow-up that is consistent with nurse practitioners' scope of practice, individual competence within that scope of practice, and the stream in which the nurse practitioner is registered to practise (family, adult, pediatric).

110. With respect to the conduct described in paragraph 1(g) of the Citation, the Panel finds that the Respondent failed to comply with Standard 6 of the College's Scope of Practice Standard for NPs for Prescribing Drugs, which provides:

> **Standard 6**
>
> Nurse practitioners engage in evidence-informed prescribing and consider best practice guidelines and other relevant guidelines and resources when prescribing for clients, including when recommending complementary or alternative health therapies.

111. With respect to the Respondent's conduct described in paragraph 1(g) of the Citation, the Panel also finds that the Respondent did not comply with the following principles of the Documentation Practice Standards that were in force at the relevant times:

> Principles
>
> 1. Nurses are responsible and accountable for documenting on the health record the care they personally provide to the client…
> 2. When caring for clients, nurses document using a logical process (e.g. assessment, nursing diagnosis, planning, implementation and evaluation), including information or concerns reported to another health care provider and that provider's response.
> 3. Nurses document all relevant information about clients in chronological order on the client's health record. Documentation is clear, concise, factual, objective, timely and legible.

112. The College submit the Standards are the expected and achievable level of performance against which actual performance can be compared. It is the minimum level of acceptable performance for an NP. The Panel's view is that the College's Standards are the primary guidelines for best practice for NPs. Accordingly, by not complying with the College's above-mentioned Diagnosing and Health Care Management and Documentation Practice Standards, the Respondent failed to adhere to best practices.

113. The Panel further determines that the Respondent's proven conduct in paragraphs (1)(f) and 1(g) of the Citation meets the definition and test for incompetent practice as set out in *Mason* and *Reddy*. By engaging in this type of conduct, the Respondent displayed a want of ability suitable to the tasks of proper clinical practice, chart documentation, and diagnosis and prescription of drugs as prescribed by the College's above-mentioned Professional and other Scope of Practice Standards.

114. The evidence further confirms there was a pattern of incompetent behaviour in this regard by the Respondent, as opposed to a single instance. A review of the Respondent's clinical records shows repeated instances of this type of conduct as alleged in the Citation.

115. Accordingly, the Panel finds that by conducting himself in the manner described paragraphs 1(f) and 1(g), which has been proven on a balance of probabilities, the Respondent has incompetently practiced his profession, contrary to section 39(1)(d) of the HPA.

L. Citation – Paragraphs 1(e) and (h):

"From April 2014 to on or about June 2016, while a Nurse Practitioner at two sites, the HIM Clinic located at 1033 Davie Street, Vancouver and operated by Providence Health and the Three Bridges Clinic located at 1128 Hornby St, Vancouver and operated by Vancouver Coastal Health ("VCH"), and employed in the health authorities' prevention program with the specific mandate to work with the

vulnerable and high risk population of men-who-have-sex-with-men ("MSM") you:

e. Engaged in providing psychological counselling with your clients when you were not appropriately qualified or trained to do so;

h. Practised beyond the scope of a nurse practitioner when you:

i. diagnosed a client with hyperthyroidism on the basis of a single THC blood test and failed to refer the client to an endocrinologist and/or provide any appropriate follow up; and

ii. provided cognitive behaviour therapy ("CBT") to a client, or a derivative of CBT called Cognitive Behaviour Interpersonal Skills, when you were not appropriately trained or qualified to do so."

Evidence

116. With respect to the issue of a primary care NP diagnosing hyperthyroidism, Dr. Hall reviewed the Respondent's clinical records for Patient KG, and gave the following evidence regarding this issue:

a. In respect of the clinical note of November 9, 2015, he testified that the patient's TSH level (a thyroid stimulating hormone) was elevated, the Respondent titled the diagnosis "hyperthyroidism" when, in fact, if the TSH is elevated, that is usually a sign of *hypo*thyroidism. He said there was an inconsistency there which Dr. Hall said could confuse the issue for another practitioner reviewing the chart. It is not clear if this is a simple typographical error (in that perhaps the Respondent meant to type hypothyroidism and inadvertently labelled it hyperthyroidism) or if this confusion speaks a lack of pathophysiological knowledge on the part of the Respondent. As noted below, the Respondent did go on to prescribe medications used in the treatment of *hyper*thyroidism.

b. Dr. Hall noted that the Respondent provided a prescription for hyperthyroidism without confirming the diagnosis and that the failure to

do so raised concerns for him. Dr. Hall stated that he has diagnosed hyperthyroidism in his primary care practice, but he would look for secondary causes of the hyperthyroidism, which would include an appropriate physical examination and laboratory tests and would likely involve referral to a specialist like an endocrinologist.

117. Dr. Beaveridge gave the following evidence with respect to the Respondent's diagnosis of hyperthyroidism:

    a. It was out of scope for an NP to diagnose hyperthyroidism based on one TSH test. The patient should have had a repeat TSH, cardiac and thyroid examinations, and should also have been referred to an endocrinologist.

    b. Dr. Beaveridge also noted that the Respondent provided a three-month prescription for medication to treat hyperthyroidism with no follow up thyroid test ordered.

118. Ms. Willms provided the following evidence regarding this allegation:

    a. An NP has no specific limits or conditions on diagnosing medical disease or disorder, rather, they must diagnose in accordance with the NP Standard of Practice and based on their individual competencies.

    b. With respect to the care provided by the Respondent for Patient KG, Ms. Willms' opinion was the following:

> NP Perry made a diagnosis of hyperthyroidism based on a measurement of the thyroid hormone TSH. He did not indicate that this was a provisional diagnosis. He also did not gather a complete subjective history of related medical, family, medication, diet history or pertinent negatives. He did not do a complete physical exam to assess pertinent positives and negatives and did not palpate the thyroid. He did order appropriate additional lab testing but did not document review of results or reminders to patient to get lab work done in two subsequent visits.

> NP started treatment with medication inappropriately. The medication prescribed is dosed based on the specific clinical presentation and thyroid gland size which the NP did not determine. The initiation of this medication would be outside the clinical competence of primary care NPs who do not have specific training in endocrinology. The NP also did not discuss the potential adverse effects of the medication with the patient. Three months of medication was prescribed without a follow up bloodwork documented as would be expected.
>
> NP Perry's failure to refer the patient to endocrinology and initiating treatment with this medication is a critical error that could have resulted in serious harm to the patient

119. The College noted that there were also numerous examples in the clinical records of the Respondent engaging in "health counselling" and exploration of psycho-social topics, often to the detriment in addressing the patient's stated concerns. In that regard, Ms. Willms provided the following evidence:

    a. She acknowledged that NPs may spend time counselling patients with a mental and physical health conditions and unhealthy behaviours to support other pharmacological, non-pharmacological, education and health promotion components of the treatment plan.

    b. She noted that NPs may sometimes incorporate brief CBT strategies or motivational interviewing techniques into the primary care visit if they have the appropriate training.

    c. Ms. Willms indicated that when the Respondent documented "CBT counselling" or "Health Counselling" for patients' plan of care there was often no documented chief compliant, and the subjective or objective history was missing. The Respondent also documented the client's view of mental and physical health along with their life goals.

    d. Ms. Willms also noted there were instances where the patient would express a physical or mental health concern, but the Respondent failed to provide appropriate primary health care for those stated

concerns.

120. Dr. Beaveridge gave evidence that even after obtaining three degrees in nursing, she would not be competent to provide CBT to clients. Further, it would be inappropriate in a primary care practice to do so unless the NP was appropriately trained and had the approval of their employer to do so.

121. With respect the allegation that the Respondent provided CBT, Dr. Hall's evidence was that:

    a. Even he does not provide CBT to his patients. He testified that many primary care providers have some basic training in CBT but would not offer it as a bona fide service – where they could make an additional charge for this service - without additional training.

    b. Dr. Hall also testified that, to his knowledge, the Respondent did not have additional training to provide CBT to patients, and that doing so in a primary care practice with a focus on providing care to men who were previously unattached to health care would have been inappropriate.

122. Mr. Harrison gave the following evidence regarding this issue:

    a. CBT is not part of a primary care practice and is normally offered by mental health specialists and registered clinical counsellors.

    b. There was a whole team of counsellors at the HIM clinic who were very skilled at working with the MSM population and could provide talk therapy and other interventions. If the Respondent identified primary care concerns for patients that he thought warranted some level of CBT, he had access to a qualified team of specialists to provide just that therapy. His failure or refusal to utilize these resources has never been explained.

c. In reference to Patient MA, Mr. Harrison stated that he felt there was evidence of boundary crossing when the Respondent allowed MA to wear a [redacted] in the clinical space, after he documented in the note for the previous clinical visit that wearing a [redacted] was a sexual behaviour for the client. Mr. Harrison was troubled by the fact that although the purpose of the visit was ostensibly to discuss "mental health", all that was recorded was irrelevant and highly sexualized content in the clinical record, for example that the client spent hours masturbating at home.

d. The chart shows Patient MA later disclosed to the Respondent that he had "consensual sex" at the age of 13 and was a survivor of childhood sexual molestation. Mr. Harrison questioned whether the Respondent was aware of the age of consent and the fact that a child of 13 cannot give consent. Mr. Harrison also noted that there was no follow up documented or referral to mental health counselling or law enforcement to ensure the patient was supported to deal with the sexual abuse history. Mr. Harrison stated that an NP in the position of the Respondent ought to take steps to ensure child protection and safeguarding.

e. Lastly, with Patient MA, Mr. Harrison testified that this chart was one that the Respondent was confronted with at a subsequent Human Resources Meeting. This chart was selected to confront the Respondent because Mr. Harrison felt that "boundaries had been severely breached". In the clinical note dated June 9, 2015, the Respondent had documented that "he is going to introduce me to little Marty, what did he think of himself as a boy". Mr. Harrison testified that he thought that perhaps this was another example of the

Respondent attempting to do psychotherapy work for which he was not qualified.

f. In response to a question from the Panel, Mr. Harrison testified that when the Respondent was confronted with the concerns Mr. Harrison perceived arose from the clinical records of Patient MA, the Respondent's response was one that was "very defensive" and that the Respondent "demonstrated very little insight into why we were so concerned".

g. Mr. Harrison testified that after discussing the issue with the Respondent, the Respondent acknowledged that the content of the chart could be misconstrued by someone who did not know the patient but that he did not recognize that it was his own nursing practice that was concerning. In response to another question from the Panel, Mr. Harrison testified that the Respondent had advised him that his training to provide CBT came from reading a book.

Analysis and Findings of Fact

123. The College argues that the totality of the clinical records for Patient MA demonstrate that he returned on a weekly basis for "CBT" with the Respondent.

124. The College submits an example with respect to psychological counselling the Respondent provided was with respect to Patient JL. Starting with the visit of February 2, 2015, the Respondent engaged with the patient in a discussion of "defining health" and "client goals for health" under the title of "health counselling", the Respondent noted under his "plan" that Patient JL could benefit from some CBT – "will think about it" and the last line of the clinical note is, "go slow with unpacking this mans mental health".

125. The College submits that the only reasonable inference is that the Respondent intended to "go slow" with an exploration and "unpacking" of Patient JL's

mental health himself, possibly involving CBT, given there was no apparent referral to a qualified clinical counsellor, psychologist, or mental health professional.

126. The College points out that the Respondent did not indicate any advanced training or certification in CBT or in Cognitive Behaviour Interpersonal Skills on his resume that he provided to the UNBC in 2017. There was nothing in the Respondent's resume about this training despite the fact that his resume appears to have been updated in 2017 to connote further education at a doctorate level, which post-date the concerns arising in the Citation.

127. The College submits that the evidence shows that the Respondent practiced out of scope for a primary care NP by providing “psychological counselling” and CBT (or a derivative thereof) to men in his primary care practice as well as by diagnosing hyperthyroidism and prescribing a three-month course of medication to treat that condition without completing the required and appropriate clinical assessments, skill, or referral to a specialist.

128. The College argues that the Respondent breached the Scope of Practice Standard for NPs, breached appropriate nurse-client boundaries, ethical boundaries, practiced in an incompetent manner and committed professional misconduct.

129. The Panel finds the evidence of Ms. Willms, Dr. Beaveridge, Dr. Hall, and Mr. Harrison, outlined above, to be clear, convincing, and cogent, and it accepts their evidence.

130. Based on the evidence and submissions before it, the Panel considers that the reference to THC in paragraph 1(h)(i) of the Citation is an obvious typographical error. The allegation against the Respondent pertained to the diagnosis of hyperthyroidism based upon a single blood test. The relevant blood test is a TSH test. The Panel finds that the Respondent diagnosed a

client with hyperthyroidism based on a single TSH blood test and failed to refer the client to an endocrinologist and/or provide any appropriate follow up. The Panel further finds that the Respondent provided "psychological counselling" and CBT, or a derivative of CBT called Cognitive Behaviour Interpersonal Skills, to patients when he was not appropriately trained or qualified to do so.

131. The Panel finds that this conduct by the Respondent, as also described in paragraphs 1(e), (h)(i) and (h(ii) of the Citation, has been established by the evidence, on a balance of probabilities.

132. Based on the evidence of before it, the Panel finds that the Respondent's proven conduct in paragraphs 1(e), (h)(i) and (h(ii) of the Citation breached the following College Standards:

> **Professional Standards for Registered Nurses and Nurse Practitioners**
>
> **Standard 1, Professional Responsibility and Accountability**
>
> **Clinical Practice**
>
> 1. Is accountable and take responsibility for own nursing actions and professional conduct.
> 2. Functions within their own level of competence, within the legal recognized scope of practice and within all relevant legislation.

133. The Panel further finds that the Respondent's conduct described in Paragraphs 1(e), (1)(h)(i) and (1) (h(ii) of the Citation also breached Standard 1 of the College's Scope of Practice Standard for NPs for Diagnosing and Health Management, which provides:

> **Standard 1**
>
> Nurse practitioners diagnose and manage diseases, disorders and conditions within nurse practitioners' scope of practice, individual competence within that scope of practice, and the stream in which the nurse practitioner is registered to practise (family, adult, pediatric).

134. With respect to the Respondent's conduct described in paragraph 1 (h)(ii) of the Citation, the Panel finds that also breached Standard 4 of the College's Scope of Practice Standard for NPs for Diagnosing and Health Management, which provides:

> **Standard 4**
>
> Nurse practitioners refer patients to a physician at any point in time as deemed necessary in accordance with CRNBC's Standards Physician Consultation and Referral (Section D)

135. These Standards were established by the Former College's board pursuant to bylaw 8.01 that provides: "Registrants must conduct themselves in accordance with the standards of practice and the standards of professional ethics". That bylaw was enacted pursuant to section 19(1)(k) of the HPA.

136. As such, the Panel finds that by engaging in the conduct described in paragraphs 1(h)(i) and (h(ii) of the Citation, the Respondent has not complied with standards imposed under the Act, contrary to section 39(1)(b) of the HPA.

137. With respect to the Respondent's proven conduct in paragraph (1)(e) of the Citation, the Panel finds it meets the definition and test for incompetent practice as explained by the Court in *Mason* and *Reddy,* above.

138. The Panel finds that by providing psychological counselling to patients when he was not appropriately qualified or trained to do so, the Respondent displayed a want of ability suitable to the tasks of proper clinical practice, and Scope of Practice Standard for NPs for Diagnosing and Health Management, as prescribed by the College's Professional and other Scope of Practice Standards. There was a pattern of incompetent behaviour by the Respondent, as opposed to a single instance. The Respondent failed to practice within his scope of practice and competence by offering psychotherapy under the guise of "health counselling" to the detriment of providing primary care and addressing stated concerns of his patients. A review of the Respondent's

clinical records shows repeated instances of this type of conduct as alleged in the Citation.

139. Accordingly, the Panel finds that by conducting himself as described in paragraph 1(e) of the Citation, which has been proven on a balance of probabilities, the Respondent has incompetently practiced his profession, contrary to section 39(1)(d) of the HPA.

M. Citation – Paragraphs 2 and 3:

Paragraph 2: "On or around February 12 to 18, 2018, you breached terms of a current consent agreement with the Former College, dated January 28, 2018, when you accepted employment with the University of Northern British Columbia, as a Registered Nurse, when you were obliged to provide specific disclosure to new employers as a term of the consent agreement and you did not do so."

Paragraph 3: "On or about May 1 to 5, 2018, you breached the undertakings you had given to the Former College when you accepted employment with the University of Northern British Columbia, as a Registered Nurse, and you did not provide the University Northern British Columbia with comprehensive disclosure regarding the ongoing investigation into your nursing practice."

Evidence

140. Mr. Smith and the documentary evidence before the Panel was the following:

a. Mr. Smith is currently a Senior Academic Budget and Planning Officer of the University of Northern BC. Prior his current role he was the manager for the school of nursing and was the operations manager for the faculty reporting to the chair of the school of nursing. In that capacity, Mr. Smith dealt with the Respondent as a two-time sessional instructor at the university.

b. The Respondent was hired as a sessional instructor pursuant to the collective agreement for the faculty association of the University of

Northern British Columbia to work as a student evaluator for Nursing 451 for a period that ran from February 12 – 18, 2018.

c. A written contract for the position was signed by the Respondent.

d. To be an eligible candidate for the position, the applicant was required to have active and practicing registration with the Former College, CRNBC. The requirement was explicitly stated in the job description which was included when the position was advertised.

e. Mr. Smith confirmed that the Respondent was later hired as a sessional instructor for an evaluative workshop for Nursing 458 and ran from April 30 to May 4, 2018.

f. The contract for that position was electronically signed by the Respondent on April 23, 2018.

g. As with Nursing 451, to be an eligible candidate for this position, the Respondent was required to have active practising registration with the Former College, CRNBC. This requirement was also explicitly spelled out in the job description for the position.

h. Mr. Smith confirmed that at no time did the Respondent advise UNBC that he had any limits and conditions on his nursing registration at the time that he was teaching at UNBC as a sessional instructor in Nursing 451 or 458. After the College investigation began, Mr. Smith investigated what had been provided to the university by the Respondent prior to taking that position.

i. Mr. Smith confirmed through relevant inquiries with the Chair of the Department, the Head of the program, the undergraduate coordinator, the human resources department, and the dean’s office that nobody associated with the university had received notice from the Respondent that his nursing registration was subject to limits and conditions.

j. Mr. Smith alerted the Former College that the Respondent had been employed by UNBC as a sessional instructor in the nursing program in February and May of 2018 and that no disclosure of any limits and conditions was shared with UNBC by the Respondent.

141. Mr. MacDonald, a Professional Conduct Review Consultant, who has been employed with the College since 2009, provided the following evidence:

a. He testified that he was advised by the CRNBC Monitor, Robert Powrie, of the Respondent's employment as a sessional or temporary instructor with UNBC. This raised a concern for the Former College that the Respondent may have breached the terms of a Consent Agreement and Voluntary Undertaking that he was bound by at the relevant times and Mr. MacDonald was asked to look further into the matter.

b. Mr. MacDonald testified that he communicated with Mr. Smith by email to inquire if the Disability Management Office (or equivalent at UNBC) were advised by the Respondent of any conditions and limits on his nursing registration.

c. Mr. MacDonald indicated that Mr. Smith confirmed that UNBC had not been notified that the Respondent had conditions or limits on his nursing registration.

d. Mr. MacDonald further testified that he contacted the Respondent to ask him if he had worked at UNBC in February and May of 2018. Specifically, on July 25, 2018, Mr. MacDonald sent a letter to notify the Respondent that the College had become aware that he may have been employed at UNBC as a sessional instructor in February and May of 2018 and that the Inquiry Committee had commenced an "Own Motion" investigation pursuant to the Act.

e. Mr. MacDonald testified that the Respondent responded to his letter by email on July 27, 2018 and advised that he had worked at UNBC as a class instructor. The Respondent's email indicated he misunderstood the Consent Agreement and Voluntary Undertaking to mean he must inform employers and potential employers in a clinical setting of the limitations of on his practice. The Respondent acknowledged he was wrong and apologized. He provided an assurance that nothing like this would occur again.

f. Mr. MacDonald also gave evidence regarding the Consent Agreement dated January 28, 2018 (which was the date the Inquiry Committee approved of the Consent Agreement and it came into force). The Respondent had signed the Agreement and that signature was witnessed.

g. Mr. MacDonald testified that the Consent Agreement is a binding agreement negotiated between the College and a Respondent and entered into on recommendation of the Inquiry Committee. Such agreement resolves a complaint about the Respondent's practice. The agreement is concluded in the realm of the Inquiry Committee processes and is entered into by consent. If a registrant does not consent to the terms of the agreement as negotiated by the College, then it brings the matter back to the Inquiry Committee. The Inquiry Committee may then make a direction which may include a referral to a discipline panel or hearing. A consent agreement accordingly helps alleviate a discipline hearing and resolve the relevant complaint under the auspices of the Inquiry Committee.

h. Mr. MacDonald confirmed that the applicable Consent Agreement concluded with the Respondent was dated January 28, 2018 and in force in February and May of 2018. He further confirmed that the

Consent Agreement required the Respondent to do the following during the course of its two-year term:

i. Paragraph 24(f) states that the Respondent will notify CRNBC *prior* to returning to work of his return to work date, location of work, the name of the disability manager and provide a return to work agreement, if any, to CRNBC.

ii. Paragraph 24(h) states that the Respondent agrees to provide CRNBC with any new personal contact information, new or additional employer information, contact information, including notification if the registrant has resigned from the employer on record or was suspended or terminated by any employer.

iii. Paragraph 32 states that the Respondent states that the Respondent agrees to specific disclosure for the duration of the agreement.

iv. Paragraph 33 states that the Respondent agrees to disclose the limit on his nursing practice to new or prospective employers and consents that CRNBC may do the same for the duration of the term of the Consent Agreement.

i. Mr. MacDonald also testified about the Voluntary Interim Undertaking that the Respondent had given to the College. He explained that a Voluntary Undertaking was an interim risk mitigation tool used by the College. It is an agreement between a registrant and the College with risk mitigation terms directed by the Inquiry Committee. The intention is to limit potential risk to the public while a registrant is under investigation and the conduct of the complaint if not yet admitted or proven. The

terms of a Voluntary Undertaking may allow the registrant under investigation to work with terms or promises in place depending on the nature of the matter being investigated. For example, the promise in the Voluntary Undertaking could be to disclose allegations of the complaint to any new or current employers, or in serious matters even stipulate that the registrant will convert their registration to non-practicing during the course of the investigation of the complaint.

j. Mr. MacDonald confirmed that the Voluntary Undertaking to which the Respondent was subject is dated March 20, 2018, and that pursuant to the undertaking the Respondent agreed to work in accordance with the following limits and conditions, and the fact he was subject to limits and conditions would be reflected on the public register and nurse verification on the College's website:

    i. The Respondent would not work in a role where he was the sole Registered Nurse or NP on duty;

    ii. The Respondent would not independently be responsible for patient care including assessments, documentation, and clinical decision making;

    iii. The Respondent agreed to ensure that his nursing practice had daily oversight of a manager, direct supervisor or educator;

    iv. The Respondent agreed to random audits of his nursing practice and that those reports would be shared with the College.

    v. He agreed to notify the College of the name and contact details of all employers including prior to practice.

k. Mr. MacDonald also testified that the Respondent further agreed, pursuant to his Voluntary Undertaking, that *prior* to starting practice the College would confirm with his employer and direct supervisors that the position he obtained met with the limits and conditions.

l. He also confirmed that under the terms of the Voluntary Undertaking if the Respondent wished to be relieved of the above obligations, he would need to give the College notice and the College would have 30 days to consider what, if any, steps to take, including consideration of whether to take extraordinary action pursuant to section 35 of the Act.

m. Mr. MacDonald confirmed on behalf of the College that at no time did the Respondent advise the College that:

   i. he wished to be relieved of the terms of his Voluntary Undertaking; or

   ii. he had taken employment at UNBC as a clinical instructor.

n. Mr. MacDonald confirmed that the Consent Agreement and the Voluntary Undertaking make no distinction between caring for patients or clients or instructing nursing students.

Analysis and Findings of Fact

142. The College submits that the Respondent breached the terms of both the Consent Agreement and the Voluntary Undertaking when he accepted employment at UNBC in 2018 and did not comply with the terms of these agreements.

143. The College argues that these agreements are important tools that the College uses to fulfil its public interest mandate, and the Respondent's blatant disregard for his obligations under these agreements reflects his lack of

governability as a registrant and should be found by the Panel as being two further instances of professional misconduct.

144. The Panel agrees. The Panel finds that the Respondent's conduct described in paragraphs 2 and 3 of the Citation has been established by the evidence. The Panel finds that the Respondent failed to comply with the terms of his agreements with his regulator. The Panel finds that the Respondent breached the terms of his Consent Agreement with the Former College, dated January 28, 2018, when he accepted employment with UNBC, as a Registered Nurse, and failed to disclose to UNBC, the limits, and conditions on his nursing practice. He also breached the Consent Agreement by failing to disclose to the Former College that he started employment with UNBC as stipulated.

145. The Panel finds that during May 1 to 5, 2018, the Respondent breached the Voluntary Undertakings, dated March 20, 2018 that he had given to the Former College. The Panel finds that the Respondent failed to advise the Former College that he accepted employment with UNBC. By failing to do so, the Respondent breached the Voluntary Undertaking and deprived the Former College of the opportunity to, prior to the Respondent starting the employment, confirm with UNBC and direct supervisors whether the position the Respondent obtained met with the limits and conditions on his practice.

146. The Panel finds that the Respondent's conduct described in Paragraphs 2 and 3 of the Citation did not comply with the following College Standards:

> **Professional Standards for Registered Nurses and Nurse Practitioners**
>
> **Standard 1, Professional Responsibility and Accountability**
>
> **Clinical Practice**
>
> 1. Is accountable and take responsibility for own nursing actions and professional conduct.
>
> **Standard 4, Ethical Practice**
>
> **Clinical Practice:**

3. Demonstrates honesty and integrity.

147. As already noted above, the Standards are “an expected and achievable level of performance against which actual performance can be compared. It is the minimum level of acceptable performance” for a Nurse Practitioner.

148. The Panel finds that the Respondent’s failure to abide by the terms of his agreements with the College, which agreements are fashioned and agreed to in the public interest and for public safety, presents such a marked departure from the minimum level of acceptable performance or conduct which the College expects of its Nurse Practitioner registrants that it constitutes professional misconduct. The Respondent’s proven failure to abide by the terms of the agreements, is conduct that easily falls within the definition of section 26 of the HPA, that is, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession.

149. As such, the Panel determines that by conducting himself in the manner described in paragraphs 2 and 3 of the Citation, which was established on a balance of probabilities, the Respondent committed professional misconduct pursuant to section 39(1)(c) of the Act.

N. Order

150. The Panel determines that pursuant to section 39(1)(b), (c) and (d) of the Act that the Respondent has:

a. Committed professional misconduct in relation to the allegations in paragraphs 1(a), 1(b), 1(d), 2 and 3 of the Citation;

b. Incompetently practiced his profession in relation to the allegations in paragraphs 1(c)(i), 1(c)(ii), 1(c)(iii) and 1(c)(v), 1(e), 1(f) and 1(g) of the Citation; and

c. Breached a standard imposed under the Act in relation to the allegations in paragraphs 1(h)(i) and 1(h)(ii) of the Citation.

151. The Panel dismisses the allegations in paragraph 1(c) (iv) of the Citation.

152. The Panel directs that the Registrar of the College notify the public of the Panel's determination, pursuant to section 39.3(1)(d) of the HPA.

O. Schedule for Submissions on Penalty and Costs

153. The Panel requests that the parties provide written submissions regarding the appropriate penalty and costs.

154. The Panel requests that the parties provide the written submissions in accordance with the following schedule:

a. Submissions must be delivered by counsel for the College to the Respondent and the Panel no later than February 17, 2021;

b. Submissions must be delivered by the Respondent to counsel for the College and the Panel no later than March 10, 2021; and

c. Reply submissions may be delivered by counsel for the College to the Respondent and the Panel no later than March 17, 2021.

155. Submissions for the Panel should be delivered to Fritz Gaerdes, independent legal counsel for the Panel and may be delivered electronically to the following email: fritz@preciousgaerdes.com.

P. Notice of right to appeal

156. The Respondent is hereby advised that under section 40(1) of the Act, a person aggrieved or adversely affected by an order of the Discipline Committee under section 39 of the Act may appeal the decision to the Supreme Court of British Columbia. Under section 40(2), an appeal must be commenced within 30 days after the date on which this order is delivered.

Signed:
"Sheila Cessford", Chair
"Dorothy Barkley"
"Fernanda Polanco", NP

CORRIGENDUM TO DETERMINATION OF THE DISCIPLINE COMMITTEE OF FEBRUARY 4, 2021

157. This is a corrigendum to the Panel's determination initially signed and dated on February 4, 2021 (the "determination").

158. Paragraph 130 of the determination is deleted and replaced with the following:

> Based on the evidence and submissions before it, the Panel considers that the reference to THC in paragraph 1(h)(i) of the Citation is an obvious typographical error. The allegation against the Respondent pertained to the diagnosis of hyperthyroidism based upon a single blood test. The relevant blood test is a TSH test. The Panel finds that the Respondent diagnosed a client with hyperthyroidism based on a single TSH blood test and failed to refer the client to an endocrinologist and/or provide any appropriate follow up. The Panel further finds that the Respondent provided "psychological counselling" and CBT, or a derivative of CBT called Cognitive Behaviour Interpersonal Skills, to patients when he was not appropriately trained or qualified to do so.

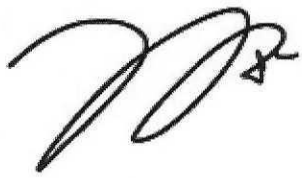
159. Paragraph 131 of the determination is deleted and replaced with the following:

> The Panel finds that this conduct by the Respondent, as also described in paragraphs 1(e), (h)(i) and (h(ii) of the Citation, has been established by the evidence, on a balance of probabilities.

Signed and dated: February 12, 2021.

Sheila Cessford, Chair

Dorothy Barkley



Fernanda Polanco, NP