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" or "BCCNM")

AND:

Paul Perry

(the "Respondent")

DETERMINATION OF THE DISCIPLINE COMMITTEE
(Penalty and Costs)

Hearing Dates:	By written submissions.
Discipline Committee Panel:	Sheila Cessford, Chair Dorothy Barkley Fernanda Polanco NP
Counsel for the College:	Jennifer Groenewold and Michael Shirreff.
The Respondent:	On his own behalf.

Introduction

1. A panel of the Discipline Committee (the "Panel") of the British Columbia College of Nurses and Midwives (the "College" or "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 or Bylaws, or committed unprofessional conduct.

2. The Panel issued a written determination on February 4, 2021 which it corrected on February 12, 2021 (the "Conduct Decision") in which the Panel determined 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.

4. The Panel set a schedule for written submissions on penalty and costs. On March 2, 2021, the College provided written submissions on penalty and costs. On April 3, 2021, the Respondent provided his responding submissions, principally requesting a reduction of the amount of cost award the College requested to be made to the College. The College provided a reply submission on April 8, 2021.

5. The College is seeking the following orders pursuant to section 39 of the Act:

> a. The Respondent's registration is cancelled, and he be prohibited from reapplying for practising registration as a Registered Nurse and/or a Nurse Practitioner with the BCCNM for a period of not less than 5 years, at which time he would be required to meet all fitness, competence, and character requirements.
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> b. The Respondent pays BCCNM a fine in the amount of $20,000, payable immediately; and
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> c. The Respondent pays BCCNM their costs in the amount of $24,268.68.

6. On April 7, the Panel requested the College to address the following two questions arising from its submissions on Penalty and Costs:

    i. Is the College aware of any case law or decisions in which the BCCNM or another College has imposed a fine, in addition to cancellation of a

registrant's registration and a cost award, or are there any specific factors or considerations the College relies upon in support of this position?

ii. How did the College arrive at the $20,000 amount of the proposed fine?

7. On April 13, 2021, the College provided supplemental submissions and case law for the Panel's consideration. The Respondent made further submissions on April 14, 2021.

Legal Framework for Assessing Penalty

8. Having found that the Respondent breached a standard imposed under the Act, committed professional misconduct, and incompetently practiced his profession, the Panel must decide what, if any, penalty is appropriate.

9. Section 39 (2) of the Act authorizes the Panel to impose the following penalties:

> 39 (2) If a determination is made under subsection (1), the discipline committee may, by order, do one or more of the following:
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> (a) reprimand the respondent;
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> (b) impose limits or conditions on the respondent's practice of the designated health profession;
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> (c) suspend the respondent's registration;
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> (d) subject to the bylaws, impose limits or conditions on the management of the respondent's practice during the suspension;
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> (e) cancel the respondent's registration;
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> (f) fine the respondent in an amount not exceeding the maximum fine established under section 19 (1) (w).
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> (3) An order of the discipline committee under this section must
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> (a) be in writing,
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> (b) include reasons for the order,
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> (c) be delivered to the respondent and to the complainant, if any, within 30 days after the date the order is made, and
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> (d) advise the registrant of the registrant's right to appeal the order to the Supreme Court.
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> …
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> (5) If the discipline committee acts under subsection (2), it may award costs to the college against the respondent, based on the tariff of costs established under section 19 (1) (w.1).

(6) Costs awarded under subsection (4) must not exceed, in total, 50% of the actual costs to the respondent for legal representation for the purposes of the investigation under section 33 and the hearing.

10. If the discipline committee orders a suspension or cancellation, the following additional provisions apply:

39 (8) If the registration of the respondent is suspended or cancelled under subsection (2), the discipline committee may

(a) impose conditions on the lifting of the suspension or the eligibility to apply for reinstatement of registration,

(b) direct that the lifting of the suspension or the eligibility to apply for reinstatement of registration will occur on

(i) a date specified in the order, or

(ii) the date the discipline committee or the board determines that the respondent has complied with the conditions imposed under paragraph (a), and

(c) impose conditions on the respondent's practice of the designated health profession that apply after the lifting of the suspension or the reinstatement of registration.

11. The College submits some of the more common factors to consider in determining an appropriate penalty are the following:

a. the nature and gravity of the conduct proven;

b. the age and experience of the respondent;

c. the previous character of the respondent, including details of prior discipline;

d. the impact upon the victim;

e. the advantage gained, or to be gained, by the respondent;

f. the number of times the offending conduct occurred;

g. whether the respondent has acknowledged the misconduct and taken steps to disclose and redress the wrong, and the presence or absence of other mitigating circumstance;

h. the possibility of remediating or rehabilitating the respondent;

i. the impact on the respondent of criminal or other sanctions or penalties;

j. the impact of the proposed penalty on the respondent;

k. the need for specific and general deterrence;

l. the need to ensure the public's confidence in the integrity of the profession; and,

m. the range of penalties imposed in similar cases.

[the “Penalty Factors”]

12. In *Law Society of BC v. Dent*, 2016 LSBC 05 held that it is not necessary to consider each of the Penalty Factors in every case. In *Dent*, the following consolidated and broader list of the Penalty Factors was also suggested:

    a. Nature, gravity and consequences of conduct;
    b. Character and professional conduct record of the respondent;
    c. Acknowledgement of the misconduct and remedial action; and
    d. Public confidence in the legal profession including public confidence in the disciplinary process.

13. The Panel finds that the Penalty Factors/Dent factors enumerated above provide the appropriate legal framework to assess the appropriate penalty in this case. Ultimately, a penalty must fall within a reasonable range of appropriate penalties, having regard to the circumstances of the misconduct and the evidence in mitigation, if any.

Analysis and Findings

Nature and gravity of the conduct proven

14. The Respondent’s proven conduct put vulnerable men at risk and was serious conduct. In his role as a primary care nurse practitioner in the men-who-have-sex-with-men (“MSM”) program the Respondent had to attempt to reengage this patient population with the health care system. This necessarily meant providing low barrier care and attending to the expressed concerns of the clients and meeting them where they are at.

15. The Panel heard from many witnesses on behalf of the College who testified, in a compelling and thoughtful manner, about the importance of this program and what was hoped to be accomplished by creating a new position for a nurse practitioner to focus on this vulnerable population.

16. The Respondent's "onboarding" of new patients included prying into their private sexual lives and sexual history in a systematic manner that was not for a clinical purpose. This invasion of his patients' privacy was systematic and not a "one-off". Regardless of the intent behind his invasive questioning of patients, the result was that patients often did not have their presenting concerns addressed.

17. Further, the Respondent's invasive questioning often solicited histories of past trauma which the Respondent did not appropriately provide care for or refer for supportive care. All of which put these vulnerable patients at risk of being retraumatized. These ethical and practice breaches, combined with his overall incompetence in taking appropriate sexual histories, put patients at a significant risk of harm and may have served to further alienate them from the health care system at direct cross purposes of the MSM program.

18. The Respondent's failure to adhere to best practice guidelines when ordering diagnostic tests/interventions and prescribing medications also put patients at risk of harm in that ongoing health condition may have been missed or an adverse drug reaction may have occurred.

19. The Respondent further practised outside of his scope of practice when he engaged in providing cognitive behavioral therapy [CBT] (or a derivative) and/or psychological counselling with these patients, and on one occasion diagnosed hyperthyroidism on the basis of a single lab test. The Respondent displayed a profound lapse in judgment in performing these skills when it was clear that he did not have the skill or experience to do so. The expert witness at the hearing remarked that the issues around the hyperthyroidism diagnosis was a critical error that could have caused serious harm to the patient.

20. The Respondent's sloppy, and often incomprehensible documentation, also put patients at risk of harm in that critical clinical information may be absent or not intelligible and made it difficult for another health care practitioner to understand what had happened with a particular patient. Documentation plays a critical role in communication between health care providers and the absence of clear, concise, and coherent documentation frustrates its primary purpose.

21. The Respondent's professional misconduct and his incompetence, as well as his failure to be honest with his employer and the College, and his failure to abide by the terms of his Consent Agreement and Voluntary Undertaking were not isolated, one-off events. Rather, his professional misconduct, incompetent practice, failure to comply with standards, were remarkable in its scope and seriousness.

22. Overall, the Panel finds that the Respondent's proven conduct was serious and also favours a serious penalty.

Character and professional conduct record of the respondent

23. Further, having practised as a nurse since 1997 and as a Nurse Practitioner since 2009, the Panel finds that the Respondent should have been aware of the applicable standards and expectations. His conduct cannot be excused due to inexperience. This also weighs in favour of a more serious penalty.

24. The Panel finds that the Respondent's past discipline history must also be regarded as an aggravating factor. The Respondent's discipline history is related to the failure to report criminal charges and was set out in the affidavit evidence the College placed before the Panel.

Acknowledgement of the misconduct and remedial action

25. Further, the best evidence about the Respondent's perspective arises from the events that led to his ultimate dismissal from the position. The Respondent appeared to lack insight and did not accept any responsibility for his inappropriate practices when he was confronted by Scott Harrison regarding the weekly CBT he was providing to a client who wore an inappropriate item of clothing to their consultations. Mr. Harrison gave evidence that the Respondent only reflected on the quality of his charting and how it could be "misconstrued" rather than the issues that this charting raised with his judgment, clinical assessment, and boundaries in allowing a patient to wear an item that he associated with his sexual arousal in the clinical environment.

26. The Respondent did not appear before the Panel to explain or acknowledge his conduct.

Public confidence in the profession including public confidence in the disciplinary process

27. In this case, the Panel opinion is that there is a need for both specific and general deterrence. It is important that both the Respondent, and other registrants in the profession, are made aware that violations of the Ethical Practice and Professional Responsibility and Accountability standards are serious. Adherence to professional, practice, and ethical standards is of vital importance to members of the profession and to members of the public. Patients rely on their primary care providers to be effective and efficient gatekeepers to the health care system. They are the primary point of contact for entry to appropriate and comprehensive care. This is of particular importance in this case because the Respondent's primary responsibility was to engage a group of patients that was effectively estranged from the health care system and at high risk for adverse health outcomes. The Respondent's failure to adhere to the primary goals of the program he was working in, and to practice competently and within his scope of practice, and invasive history taking all served to put these vulnerable patients at risk for harm, both physically and psychologically.

28. The Panel finds it is equally important that public confidence in the integrity of the nursing profession is maintained and that the public is aware that members are held to account for these shortcomings.

29. Practicing competently and within the scope of practice of one's designation is a core component of safe and ethical care. It is fundamental for all registrants of the College.

30. Creating appropriate and accurate documentation in a clinical record is a fundamental and basic nursing skill. It is critical for effective communication of the patient's status at a point in time, and the plan of care to address all patient concerns and variances in health. The failure to create documentation that is coherent and comprehensive is a serious breach of college standards.

31. Further, a significant consideration in assessing penalty is the protection of the public from other acts of misconduct by the registrant who is the subject of the hearing.

32. Adherence to agreements made with the College is vital to the College's public protection mandate. Flouting the requirements and obligations contained in Consent Agreements and Voluntary Undertakings can leave registrants unsupported by the measures contained therein and also pose a risk to the public. Being a self-regulated professional is a privilege and comes with obligations and responsibilities which cannot be ignored or disregarded.

33. A penalty should reinforce public confidence in the regulatory body's ability to effectively govern the profession, including the disciplinary process. In this case, this is an important concern given the fundamental principles of nursing care and self-regulation for professionals at issue and the potentially serious consequences of the Respondent's actions.

Penalties in similar cases

34. The College submits that in many published cases where a discipline panel made findings that a registrant practiced incompetently and committed professional misconduct it ordered revocation of licence. In this regard, the College relies on the following cases:

    a. *Ontario (College of Physicians and Surgeons of Ontario) v. Marcin*, 2019 ONCPSD 4 (*Marcin*), where the registrant, a primary care physician, was bound by undertakings to limit their practice to only psychotherapy and to practice for a limited number of hours per week. The registrant went on to breach their undertakings and to practice in contravention of the limits imposed on their registration by failing to abide by the terms of a gradual return to work, failing to meet with the mandated clinical supervisor, practising incompetently by prescribing psychotropic drugs in inappropriate doses or in unsafe combinations with other drugs, practising family medicine in contravention of a limit on their practice, treating family members, borrowed money from a patient and then refused to pay it back, failing to comply with the terms of her probation following a criminal

conviction for defrauding OHIP. The registrant in *Marcin* ceased to be a registrant of their regulatory college during the course of the investigation into their practice and they also failed to attend the discipline hearing. The Discipline Panel ordered that the registrant be reprimanded, have their certificate of registration revoked, and was ordered to pay costs.

b. *Ontario (College of Physicians and Surgeons of Ontario) v. Sweet*, 2017 ONCPSD 40 (*Sweet*), in which case the registrant, practising family medicine, was subject to a previous discipline committee order whereby he was prohibited from prescribing controlled substances. Later he entered into an undertaking with the College to cease to practise addiction medicine, chronic pain medicine and psychotherapy. The registrant breached the Discipline order on three occasions. He also breached his undertaking by providing addiction and chronic pain management for a patient. Additionally, Sweet prescribed Botox to a former patient, who was not a regulated health care professional, and this patient used the Botox in her aesthetic business. In addition, there was a review of 25 medical charts of patients the registrant was treating and numerous practice deficiencies were found including prescribing Imovane to a 90 year old who was unsteady, used a walker, and had a falls history; prescribing a drug for a child when the drug was not approved for use in children, inconsistent documentation, failing to provide adequate preventative care and failure to adequately work up a patient's diagnosis, and pediatric patients' immunizations were incomplete or incompletely documented. The registrant had a significant prior discipline history, including past discipline action for incompetence, breaching limits and conditions on his medical licence; failing to have adequate signage at his clinic to indicate that he was working with limits and conditions on his registration; and then later again breaching limits and conditions on his registration. Two days prior to the hearing, Sweet resigned from the College and gave an undertaking to the College that he would never reapply. The Committee stated that it "expresses its abhorrence of Dr. Sweet's repetitive misconduct that resulted in multiple appearances before the Discipline

Committee." The Committee noted that despite the progressive discipline and attempt to remediate his practice, the registrant's practice never improved. The Committee determined that Sweet's disregard for the College's authority made him ungovernable and put the public at risk. They stated that had he not resigned that they would have revoked his registration. Sweet was also ordered to pay costs.

c. *Ontario (College of Physicians and Surgeons of Ontario) v. Gabrielle*, 2000 ONCPSD 25 ("*Gabrielle"*), where the registrant, a primary care physician, was responsible for the care of a newborn infant. The infant was noted to have a grade 5/6 heart murmur on birth. The baby failed to thrive and gain weight. In a review of the care of this infant, the College concluded that the registrant failed to appropriately assess and treat the baby. Further, the registrant created late entry clinical notes in an effort to deflect responsibility for the baby's failure to thrive on the infant's mother. Additionally, a review of Gabrielle's practice showed that he consistently prescribed an antibiotic every time a child presented with a sore throat in contravention of best practice; there were inadequate growth records kept; and children were not kept current with mandated immunization schedules. The registrant had past discipline hearings for incompetence and boundaries violations. The discipline panel ordered revocation of the registrant's registration. The Panel especially deplored the late entry clinical notes that the registrant added to the infant's chart to deflect responsibility from himself onto the infant's mother. They found that he was incompetent and therefore unfit to continue to practice.

35. Further, the College submits that in this case, the Respondent disregarded the restrictions on his registration by failing to comply with the disclosure requirement of the 2018 Consent Agreement and then again when he breached the terms of a Voluntary Undertaking when he worked for the University of Northern British Columbia on two separate occasions. The College submits that the Respondent's blatant disregard for the agreements he voluntarily entered into demonstrates that he is not governable by the College, and a declaration of ungovernability is required.

It relies on *The Law Society of British Columbia v Hall,* 2007 LSBC 26 ("Hall") where the Court set seven factors that may lead to a finding of ungovernability, including:

a. A consistent and repetitive failure to respond to the governing body;

b. An element of neglect of duties and obligations to the governing body;

c. An element of misleading behaviour directed to a client and or the governing body;

d. A failure or refusal to attend at the discipline hearing convened to consider the offending behaviours;

e. A discipline history involving allegations of professional misconduct over a period of time and involving a series of different circumstances;

f. A history of breaches of undertaking without apparent regard for the consequences of such behaviour; and

g. A record or history of practising while under suspension.

36. The College submits that c, d, and e of the *Hall* factors enumerated above are present and mandate in favour of a declaration of ungovernability.

37. Additionally, the College requests a fine of $20,000 also be imposed on the Respondent. The College submits that while it has not had a previous case where its Discipline Committee has made an order for a registrant to pay a fine, and it is also not aware of another health regulation case in British Columbia where a discipline committee has imposed a fine in addition to the revocation of a registrant's registration, there are several cases from Ontario where a health regulator imposed a fine in addition to revoking the registrant's registration. In this regard the College relies on the following cases:

a. *College of Nurses of Ontario v Tomaszewska*, 2004 CanLII 73647 (ON CNO), where the registrant did not attend her disciplinary hearing which necessitated the College of Nurses of Ontario ("CNO") to prove the allegations of the citation. It was alleged that the Member crossed the boundary of the therapeutic nurse/client relationship by obtaining the Power

of Attorney and continuing Power of Attorney for Finances and Personal Care of a client. The registrant became the executrix and beneficiary of the client's last Will and Testament. The registrant was to remain as beneficiary to the Will as long as she continued to act as Power of Attorney for personal care and property for as long as the client is alive. The Panel found that these actions constituted professional misconduct and ordered revocation of the registrant's registration, a $15,000 fine (which was noted to be at the lower end of the range of a possible maximum fine of $35,000), approximately $50,000 in costs, and a reprimand (The penalty decision was affirmed on appeal, see *Tomaszewska v. College of Nurses of Ontario*, 2007 CanLII 14931 (ON SCDC)). The Panel stated in their reasons on penalty that they considered the vulnerability of the client, who suffered from psychiatric illness and the scale of potential damage to the patient, both financially and emotionally. The Panel found that the registrant Tomaszewska exploited the client's vulnerability and put their own personal interests ahead of the client.

b. *College of Nurses of Ontario v Besharah*, 2007 CanLII 82758 (ON CNO), where the registrant Besharah was found criminally guilty of theft over $5,000 and of defrauding the occupational health and safety scheme in Ontario of approximately $200,000. The Discipline Panel found the registrant guilty of professional misconduct. The Panel in this case stated: "*The Member was convicted of illegal activity including theft and making false statements for personal financial gain even after indicating to the College in 1995 that he was responsible and accountable. He was dishonest to those who trusted him and to authorities. The Member used funds gained dishonestly to further his nursing career. Although the Member's criminal activities were not directly related to the practice of nursing, they bring into question his integrity as a nurse."*. The Panel ordered that the registrant's registration be revoked and that they pay a fine of $2,500 as well as costs. The Panel stated that the registrant had proven himself to be ungovernable and that the severe nature of the penalty,

revocation and a fine, will ensure that a strong message to the membership that this type of behaviour would not be tolerated and would serve to preserve public trust in the profession.

c. *College of Nurses of Ontario v McClinton*, 2006 CanLII 81735 (ON CNO), where the registrant McClinton was alleged to have mishandled narcotics in numerous ways (administering without an order, without advising the physician, without having a witness see the wasted portion of the dose and failing to document her nursing actions with respect to narcotics appropriately or at all) which violated the health authority's policy and applicable practice standards. McClinton requested that that hearing take place in Ottawa at a time when she would be on vacation so that she could defend herself, rather than in Toronto where hearings were typically held. After these requests were accommodated, McClinton then failed to attend the hearing without notice to the College, which the College argued demonstrated ungovernability. The Discipline Panel found the registrant guilty of misconduct and ordered her registration revoked, imposed a $10,000 fine and ordered costs in the amount of $10,000.

d. *Ontario (College of Physicians and Surgeons of Ontario) v. Chandra*, 2018 ONCPSD 28 (CanLII), where a physician was found guilty of professional misconduct when he defrauded OHIP of approximately two million dollars and failed to respond appropriately to the regulator during the course of the investigation into his practice. Dr. Chandra declined to attend the disciplinary hearing. In coming to their decision about penalty, the Panel noted a number of aggravating factors, in particular, that Dr. Chandra used his position, one of authority and control, to induce patients to assist him in his financial malfeasance, the length of time that this illegal scheme went on for (4 years), and Dr. Chandra's failure to cooperate with the regulator. The only mitigating factor was that Dr. Chandra did not have a history of discipline with the college. Given the scale of the financial fraud, the Panel ordered the maximum fine of $35,000, revoked the physician's registration

and ordered that he attend for a public reprimand, and ordered that he pay the tariff for the three-day hearing in costs.

38. The College submits that the primary purpose of a penalty is to meet the College's public protection mandate. The penalty must also convey the Panel's disapproval and denunciation of the Respondent's multiple instances of professional misconduct and should be proportional to the Panel's finding.

39. The College submits that the imposition of a fine, in addition to revocation of licensure and a cost award, would serve to maintain the integrity of the profession, and public confidence in the College's ability to regulate the profession in the public interest. The proposed fine would also serve as a specific deterrent to the Respondent because he would no longer be eligible to practice, and as a general deterrent to the entire profession.

Penalty

Cancellation

40. The Panel has carefully considered both the College's and the Respondent's submissions and has taken into account the factors cited above when considering the appropriate penalty.

41. The Panel finds that c, d, and e of the *Hall* factors enumerated above are present in this case and also mandate in favour of a declaration of ungovernability here.

42. The Panel also finds that the Respondent, and the evidence, have demonstrated that the Respondent is not governable. The Panel finds the facts in the *Sweet, Marcin,* and *Gabrielle* cases to be comparable to the facts of this case. In those cases, as in this one, the registrants all had a history of incompetence in their respective primary care practices as well as a discipline history of varying lengths that resulted in limits and conditions on their practices. All three primary care providers also disregarded the limits and conditions that were placed on their practice in order to protect the public interest, which also resulted in findings of ungovernability.

43. The Panel finds that in cases of professional misconduct such as this one, where a Respondent demonstrates ungovernability, incompetence, and practising outside of their scope of practice, that revocation or cancellation of licensure is within the range of reasonable outcomes. Accordingly, the Panel finds the following penalty reasonable and appropriate:

    a. That the Respondent's registration is cancelled, and he be prohibited from reapplying for practising registration as a Registered Nurse and/or a Nurse Practitioner with the BCCNM for a period of not less than 5 years, at which time he would be required to meet all fitness, competence, and character requirements

Costs

44. Further, section 39 of the HPA authorizes the Panel to impose costs, as follows:

> (5) If the discipline committee acts under subsection (2), it may award costs to the college against the respondent, based on the tariff of costs established under section 19 (1) (w.1).
>
> …
>
> (7) Costs awarded under subsection (5) must not exceed, in total, 50% of the actual costs to the college for legal representation for the purposes of the hearing.

45. Section 212 of the College's Bylaws establish the tariff of costs for a discipline hearing. Schedule J sets out the tariff and qualifying expenses:

> For the purpose of assessing costs under this tariff, qualifying expenses incurred from the time the inquiry committee directs the registrar to issue a citation under section 33(6)(d) of the Act until the time
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> (a) the inquiry committee accepts a written proposal for a consent order under section 37.1(2) or (5) of the Act,
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> (b) the discipline committee dismisses the matter under section 39(1) of the Act, or
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> (c) the discipline committee issues an order under section 39(2) of the Act,
>
> are deemed to be expenses incurred in the preparation for and conduct of the hearing.
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> 2. (1) The value for each unit allowed on an assessment of costs is $120.
> (2) Where maximum and minimum numbers of the units are provided for in an Item in the Tariff, the discipline committee has the discretion to allow a number within that range of units.

> (3) In assessing costs where the Tariff indicates a range of units, the discipline committee must have regard to the following principles:
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> a) One unit is for matters upon which little time should ordinarily have been spent;
>
> b) The maximum number of units is for matters upon which a great deal of time should ordinarily have been spent.
>
> 3. In addition to the Tariff, actual reasonable disbursements are recoverable.

46. In this case, the discipline hearing was conducted by in-house legal counsel, who is a salaried employee of BCCNM, and by external counsel, who bills on an hourly rate. The total costs for external counsel to date is $ 30,415.53. A final bill is still anticipated.

47. The total number of units claimed by the College for costs are 122 x $120 per unit, which equals $14,640. This is less than 50% of the costs of external counsel. The College seeks $9,628.68 in disbursements.

48. The Respondent submits he has already experienced significant financial hardship and income loss as a result of the College's disciplinary and other actions; he has not been able to work as a nurse practitioner for years, and he will also not be able to work in his chosen profession for years to come.

49. As noted, the Respondent's misconduct and incompetent and sub-standard conduct proven by the College in this case is serious. The most serious of the allegations against the Respondent were all proven. The proven allegations addressed the primary concerns that were raised in the hearing regarding the Respondent's conduct and the protection of the public. The hearing was diligently pursued and prosecuted.

50. The Panel therefore finds the College's units and scale claimed for legal costs to be fair and reasonable. The Panel also finds the College's disbursements to be reasonable. Accordingly, the Panel orders that the Respondent pays the costs to the College in the amount of $ 24,268.68 consisting of:

    a. $14,640 of legal fees; and

    b. $9,628.68 in disbursements.

51. In making this award for costs, the Panel has taken into consideration the Respondent's current financial circumstances. Based on that, the Panel directs the Respondent to pay costs within one year from the date of this Order.

Fine

52. Section 39 of the HPA permits the Panel to impose both revocation (or cancellation) of registration and also a fine against a respondent in a disciplinary hearing.

53. The Panel has, however, decided it would not be appropriate to do so in this case. Cancellation of the Respondent's registration for 5 years is a very serious penalty which will also indirectly impose a serious financial impact on the Respondent – he will for 5 years not be able to work in and earn a livelihood from his chosen profession. Cancellation of his registration will also impose a significant burden on him in future to become current and eligible for registration again. Additionally, having his name and professional misconduct made public through publication of the Conduct and Penalty decisions would, no doubt, also have some professional impact on him.

54. Accordingly, in the Panel's opinion, on the specific facts of this case, cancelling the Respondent's registration for 5 years is the appropriate penalty, that will appropriately serve as significant personal deterrence, general deterrence, and will also promote the public's trust in the profession.

Order

55. The Panel orders pursuant to ss. 39 and 39.3 of the HPA that:

    a. The Respondent's registration is cancelled, and he will be prohibited from reapplying for practising registration as a Registered Nurse and/or a Nurse Practitioner with the BCCNM for a period of not less than 5 years, at which time he would be required to meet all fitness, competence, and character requirements.
    b. The Respondent is ordered to pay costs to the College in the amount of $24,268.68 within one year from the date of this Order.

Publication

56. The Panel directs the Registrar to notify the public of its decisions pursuant to section 39.3(1)(e) of the HPA.

Notice of right to appeal

57. The Respondent Paul Perry is advised that under section 40(1) of the Act, a respondent 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. Under section 40(2), an appeal must be commenced within 30 days after the date on which this Order is delivered.

Dated: July 13, 2021

Sheila Cessford, Chair

Dorothy Barkley

Fernanda Polanco, NP