IN THE MATTER OF *THE PARAMEDICS ACT* AND BYLAWS AND IN THE MATTER OF A COMPLAINT AGAINST DAVID VAN WERT

DECISION

Discipline Committee of the Saskatchewan College of Paramedics

Discipline Committee Members:

Jamie Struthers, Q.C., Public Representative, Chair
Danae Ackles, EMT-Paramedic, Member
Andrew Taylor, EMT-Paramedic, Member

Legal Counsel for the Discipline Committee: Merrilee Rasmussen Q.C.
Legal Counsel for the Professional Conduct Committee: Peter Bergbusch
Legal Counsel for the Member: David Rusnak

INTRODUCTION:

[1] The hearing by the Discipline Committee of the Saskatchewan College of Paramedics (the "College") into the complaints against David Van Wert, a Member of the College, was convened in the Travelodge, Regina, Saskatchewan, at 10:00 a.m. on January 9, 2012, being the location, time and date agreed to by the parties.

[2] Mr. Van Wert was present at the hearing, along with his legal counsel David Rusnak. Peter Bergbusch was present representing the College's Professional Conduct Committee (the "PCC").

THE FORMAL COMPLAINT:

[3] The notice of hearing served on Mr. Van Wert contained the following charges:

> *The Professional Conduct Committee of SCoP hereby recommends that the Discipline Committee hear and determine the following charges, that:*
>
> *Charge Number 1*
>
> *You, David Van Wert, are alleged to be guilty of professional incompetence contrary to subsections 24(a) and (b) and professional misconduct contrary to subsections 25(a), (b) and (c) of The Paramedics Act in that:*
>
> *On four occasions, you did monitor the administration of certain medications and substances by intravenous infusion (I.V.) during patient transfers, although you are not authorized to monitor the administration of such medications and*

substances and doing so exceeded the limitation of your scope of practice contrary to the Code of Professional Conduct of SCoP;

Particulars of the professional incompetence and professional misconduct are as follows:

1. The Saskatchewan Emergency Treatment Protocol Manual specifies which medications and substances emergency medical technicians can monitor and administer;

2. On or about April 5, 2009, you monitored a patient while that patient was receiving Pentaspan (500 ml/hr) by IV Infusion, during the patient's transfer from [redacted] *Hospital to* [redacted] *Hospital;*

3. On or about December 10, 2009, you monitored a patient who was receiving Pentaspan (100 ml/hr) by IV Infusion during the patient's transfer from [redacted] *Hospital to* [redacted] *Hospital;*

4. On or about February 7, 2010, you monitored a patient who was receiving alcohol (100 ml/hr) by IV infusion while transporting that patient from [redacted] *Hospital to* [redacted] *Hospital;*

5. On or about April 3, 2010, you monitored a patient while that patient was receiving Fentanyl by IV infusion during transportation from the [redacted] *Hospital Intensive Care Unit to the* [redacted] *Hospital, and you adjusted the rate of infusion of the medication during the patient transfer;*

6. In each case you were the senior attendant on the call and had primary responsibility for the patient;

7. The Saskatchewan Emergency Treatment Protocol Manual does not authorize you to monitor and administer any of the medications and substances listed above.

Charge Number 2

You, David Van Wert, are alleged to be guilty of professional incompetence contrary to subsections 24(a) and (b) and professional misconduct contrary to subsections 25(a), (b) and (c) of The Paramedics Act in that:

On two occasions, you failed to comply with the Protocol for Intraosseous Infusion (GP21) of the Saskatchewan Emergency Treatment Protocol Manual and exceeded the limitations of your scope of practice contrary to the Code of Professional Conduct of SCoP;

Particulars of the professional incompetence and professional misconduct are as follows:

1. The Saskatchewan Emergency Treatment Protocol Manual provides that Intraosseus Therapy (I/O) may only be initiated where the following circumstances exist:

(a) Children under the age of six years in a cardiac arrest where a peripheral vein is not visible (including the external jugular vein), or an IV has been unsuccessful on two attempts or 90 seconds has elapsed and a vein has not been successfully cannulized

(b) Children under the age of six years who are hypotensive where a peripheral vein is not visible (including the external jugular vein), or an IV has been unsuccessful on two attempts or 90 seconds has elapsed and a vein has not been successfully cannulized;

(c) In adults where peripheral vein cannulation has been unsuccessful on two attempts or 90 seconds has elapsed and a vein has not been successfully cannulized;

2. On or about January 1, 2010, you initiated Intraosseus Therapy (I/O) on a two-year old patient without first making two attempts to cannulize a vein;

3. On or about March 21, 2010, you initiated Intraosseus Therapy (I/O)for an adult patient without first making two attempts to cannulize a vein, and, immediately thereafter, an IV transfusion was successfully started.

Charge Number 3

You, David Van Wert, are alleged to be guilty of professional incompetence contrary to subsections 24(a) and (b) and professional misconduct contrary to subsections 25(a), (b) and (c) of The Paramedics Act in that:

On or about April 14, 2010, you did fail to provide appropriate treatment given a patient's condition, by failing to follow a physician's prescription for the administration of morphine;

Particulars of the professional incompetence and professional misconduct are as follows:

1. On or about April 13, 2010, the attending physician for patient [redacted] *diagnosed lumbar pain and prescribed 5 mg morphine by intramuscular injection (IM) as required hourly for pain;*

2. On or about April 14, 2010, you attended at [redacted] Hospital to transport a patient to [redacted];

3. You were the senior attendant during the patient transfer;

4. While receiving the patient, you were advised by a registered nurse that the patient could have 5 mg of morphine IM, but you insisted that you would provide the morphine by IV infusion;

5. During the transfer from [redacted] to [redacted], you started an IV line at [redacted], Saskatchewan, after the patient complained of pain, but only provided 2 mg of morphine as you disagreed with the physician's order;

6. Despite further complaints of pain by the patient and requests for more pain relief during the transfer to [redacted], you refused to provide additional morphine and said that you would only do so on the return transfer;

7. You directed an EMT-A to provide 2 mg of morphine by IV infusion prior to departing from [redacted] for the return transfer to [redacted], but otherwise did not administer further morphine to the patient despite the patient's further complaints of pain.

Charge Number 4

You, David Van Wert, are alleged to be guilty of professional incompetence contrary to subsections 24(a) and (b) and professional misconduct contrary to subsections 25(a), (b) and (c) of The Paramedics Act in that:

On or about April 14, 2010, you directed an Emergency Medical Technician Advanced (EMT-A) to administer to a patient 2 mg of morphine by IV push although doing so exceeded the limitations of your and his scope of practice and was contrary to the Code of Professional Conduct of SCoP;

Particulars of the professional incompetence and professional misconduct are as follows:

1. On or about April 14, 2010, you were the senior attendant during a round-trip transfer of patient [redacted] from [redacted] Hospital to [redacted] and back;

2. Prior to beginning the return trip, you directed the second attendant, an EMT-A, to administer 2 mg of morphine by IV push to the patient while you supervised;

3. Administering morphine by IV push exceeded the limitations of the scope of practice of the EMT-A;

4. Supervising the administration of morphine by IV push exceeded the limitations of your scope of practice.

Charge Number 5

You, David Van Wert, are alleged to be guilty of professional incompetence contrary to subsections 24(a) and (b) and professional misconduct contrary to subsections 25(a), (b) and (c) of The Paramedics Act in that:

On or about April 14, 2010, you made a false declaration in a Patient Care Report (PCR), contrary to the Code of Professional Conduct.

Particulars of the professional incompetence and professional misconduct are as follows:

1. On or about April 14, 2010, you directed an EMT-A to administer 2 mg of morphine by IV push to a patient while you supervised;

2. The Patient Care Report for the patient transfer lists you as Attendant 1 and the Supplementary Patient Care Report indicates that you administered "2 mg morphine slow IV push" to the patient;

3. You signed both reports.

FACTS:

[4] An Agreed Statement of Facts was filed with the Discipline Committee as follows:

For the purpose of the discipline hearing between the Professional Conduct Committee of the Saskatchewan College of Paramedics and David Van Wert, the parties have agreed to the following facts:

1. At all times material to the charges set out in the Notice of Hearing attached as Exhibit P-1, David Van Wert (hereinafter the "member") was on the Register as an EMT-P, Registry No. 304935, and was a member of the Saskatchewan College of Paramedics (SCOP).

2. Agreed facts regarding Charge Number 1 are as follows:

(a) On or about April 5, 2009, David Van Wert monitored a patient while that patient was receiving Pentaspan (500 ml/hr) by IV Infusion, during the patient's transfer from [redacted] Hospital to [redacted] Hospital;

(b) On or about December 10, 2009, David Van Wert monitored a patient who was receiving Pentaspan (100 ml/hr) by IV Infusion during the patient's transfer from [redacted] Hospital to [redacted] Hospital;

(c) On or about February 7, 2010, David Van Wert monitored a patient who was receiving alcohol (100 ml/hr) by IV infusion while transporting that patient from [redacted] Hospital to [redacted] Hospital;

(d) On or about April 3, 2010, David Van Wert monitored a patient while that patient was receiving Fentanyl by IV infusion during transportation from the [redacted] Hospital Intensive Care Unit to the [redacted] Hospital, and David Van Wert adjusted the rate of infusion of the medication during the patient transfer;

(e) In each case David Van Wert was the senior attendant on the call and had primary responsibility for the patient;

(f) The Saskatchewan Emergency Treatment Protocol Manual specifies which medications and substances emergency medical technicians can monitor and administer;

(g) The Saskatchewan Emergency Treatment Protocol Manual does not authorize David Van Wert to monitor and administer any of the medications and substances listed under Charge Number 1.

3. Copies of Patient Care Reports and Supplementary Patient Care Reports for each of these incidents are attached as Exhibit P-2.

4. A copy of the Scope of Practice Charts from the Saskatchewan Emergency Treatment Protocol Manual is attached as Exhibit P-3.

5. The Code of Professional Conduct of SCOP is attached as Exhibit P-4.

6. The member pleads guilty to Charge Number 1 regarding professional incompetence, as stated in Exhibit P-1.

7. Agreed facts regarding Charges Number 3 and 4 are as follows:

(a) On or about April 13, 2010, the attending physician for patient [redacted] diagnosed lumbar pain and prescribed 5 mg morphine by intramuscular injection (IM) as required hourly for pain;

(b) On or about April 14, 2010, David Van Wert attended at [redacted] Hospital to undertake a round-trip transfer of patient [redacted] to [redacted] and back;

(c) David Van Wert was the senior attendant during this round-trip transfer;

(d) While receiving the patient, David Van Wert was advised by a registered nurse that the patient could have 5 mg of morphine IM, but David Van Wert insisted that he would provide the morphine by IV infusion;

(e) During the transfer from [redacted] to [redacted] David Van Wert started an IV line at [redacted], Saskatchewan, after the patient complained of pain, but only provided 2 mg of morphine;

(f) Despite further complaints of pain by the patient and requests for more pain relief during the transfer to [redacted], David Van Wert refused to provide additional morphine and said that he would only do so on the return transfer;

(g) Prior to beginning the return trip from [redacted] to [redacted], David Van Wert directed the second attendant, an EMT-A, to administer 2 mg of morphine by IV push to the patient while David Van Wert supervised;

(h) Administering morphine by IV push exceeded the limitations of the scope of practice of the EMT-A;

(i) Supervising the administration of morphine by IV push exceeded the limitations of David Van Wert's scope of practice.

8. A Copy of an Inter-Agency Referral & Transit Record involving patient [redacted] is attached as Exhibit P-5.

9. Copies of Patient Care Reports and Supplementary Patient Care Reports for each of the incidents to which Charge Numbers 3 and 4 apply are attached as Exhibit P-6.

10. The member pleads guilty to charge number 3 regarding professional incompetence, as stated in Exhibit P-1.

11. The member pleads guilty to charge number 4 regarding professional incompetence, as stated in Exhibit P-1.

12. Agreed facts regarding Charge Number 5 are as follows:

(a) On or about April 14, 2010, David Van Wert directed an EMT-A to administer 2 mg of morphine by IV push to a patient while David Van Wert supervised;

(b) The Patient Care Report for the patient transfer lists David Van Wert as Attendant 1 and the Supplementary Patient Care Report indicates that David Van Wert administered "2 mg morphine slow IV push" to the patient;

(c) David Van Wert signed both reports.

13. The reports which are the subject of Charge Number 5 are included in Exhibit P 7.

14. The member pleads guilty to Charge Number 5 regarding professional misconduct, as stated in Exhibit P-1.

[5] Counsel for the PCC advised the Discipline Committee that Charge 2 was withdrawn.

THE LEGISLATION:

[6] Sections 24 and 25 of *The Paramedics Act* define the terms "professional incompetence" and "professional misconduct" as follows:

> 24 Professional incompetence is a question of fact, but the display by a member of a lack of knowledge, skill or judgment or a disregard for the welfare of a member of the public served by the profession of a nature or to an extent that demonstrates that the member is unfit to:
>
> (a) continue in the practice of the profession; or
>
> (b) provide one or more services ordinarily provided as a part of the practice of the profession;
>
> is professional incompetence within the meaning of this Act.
>
> 25 Professional misconduct is a question of fact, but any matter, conduct or thing, whether or not disgraceful or dishonourable, is professional misconduct within the meaning of this Act if:
>
> (a) it is harmful to the best interests of the public or the members;
>
> (b) it tends to harm the standing of the profession;
>
> (c) it is a breach of this Act or the bylaws; or
>
> (d) it is a failure to comply with an order of the professional conduct committee, the discipline committee or the council.

[7] Section 23 of the Act requires practising members to comply with the protocol manual:

> 23 A practising member who provides an emergency treatment or administers a medication must do so in accordance with any protocols respecting the provision of emergency treatment or administration of medication by a paramedic, an emergency medical technician or an emergency medical responder that are approved by the College of Physicians and Surgeons of Saskatchewan.

[8] Section 10 of the Regulatory Bylaws of the College requires that each member comply with the Code of Professional Conduct, which is attached to those Bylaws as Appendix A. The Code sets out principles of ethical behaviour and responsibilities to the profession. A breach of the Code is therefore a breach of the Regulatory Bylaws and thus constitutes professional misconduct as defined in the Act. In addition, any conduct that can be objectively described as being harmful to the best interests of the public or the members or that brings the standing of the profession into disrepute is also professional misconduct as defined.

SUBMISSIONS OF THE PARTIES:

[7] The parties made a joint submission as to disposition, agreeing that Mr. Van Wert should be suspended from practicing in Saskatchewan for a period of 30 days and pay costs to the College in the amount of $1,500, as well as re-write the licensing examination for advanced care paramedics before resuming practice in Saskatchewan.

[8] Counsel for the PCC advised that Mr. Van Wert had co-operated fully with the College, taking responsibility for his actions and agreeing to the facts and disposition to be submitted to the Discipline Committee, thus reducing what was originally estimated to be a three-day hearing to a submission involving a little more than an hour and significantly reducing the costs to the College. On the other hand, counsel submitted that these were serious charges and there were several of them. In particular, the charges relating to failing to follow the specific prescription of a physician and supervising another member to perform tasks beyond their scope warrant the imposition of a suspension. Re-taking the examination will ensure that he specifically understands the limitations on his scope of practice.

[9] Counsel for Mr. Van Wert pointed to a number of mitigating factors. Mr. Van Wert had been employed for 11 years at the time these complaints occurred, and as a result of which he lost his job and has relocated to Alberta. Without deflecting from Mr. Van Wert's responsibilities for his actions, counsel pointed out that there had been a practice of administering pentaspan and fentanyl is now within the scope of an EMT-P, but Mr. Van Wert realizes now that he should have refused the transfer when he was unable to administer the medications required at the time. Counsel also pointed out the charges 3, 4 and 5 all arose out of

the same incident, so this was not a situation where a member was out of control. Mr. Van Wert has been working in Alberta without incident since losing his position in [redacted].

ANALYSIS:

[10] The Discipline Committee accepts the joint submissions of the parties. Specifically, the Discipline Committee determines that David Van Wert is guilty of professional misconduct as defined in clause 25(c) of the Act:

> (a) as outlined in charge 1, in that he monitored the IV infusion of pentaspan, fentanyl and alcohol when he was not authorized to do so by the approved protocols, thus breaching section 23 of the Act and paragraph 1 of the Responsibilities to the Profession contained in the C ode of Ethics;
>
> (b) as outlined in charge 3, in that he failed to follow a physician's prescription contrary to paragraph 1 of the Responsibilities to the Profession contained in the C ode of Ethics;
>
> (c) as outlined in charge 4, in that he directed an EMT-A to administer 2 mg of morphine by IV push, thus breaching paragraph 1 of the Responsibilities to the Profession contained in the C ode of Ethics;
>
> (d) as outlined in charge 5, in that he falsified a patient care report, thus breaching subsection 10(2) of the Regulatory Bylaws.

[11] The Discipline Committee accepts the joint recommendation as to penalty submitted by the parties.

ORDER:

[12] Having determined that David Van Wert is guilty of professional misconduct in relation to Charges 1, 3, 4 and 5 as set out in the formal complaint contained in the notice of hearing, the Discipline Committee of the Saskatchewan College of Paramedics, pursuant to section 31 of *The Paramedics Act*, hereby orders that:

> (a) the licence of David Van Wert is suspended for the period from January 9, 2012 to February 8, 2012 and until the costs ordered to be paid pursuant to clause (b) are paid in full and he completes the examination described in clause (c);
>
> (b) that David Van Wert pay costs to the College in the amount of $1,500; and
>
> (c) before resuming practice as a paramedic in Saskatchewan, David Van Wert shall successfully complete the Saskatchewan advanced care paramedic licensing examination or any alternate examination adopted by the College in its place.

DATED at Regina, Saskatchewan:

January 27, 2017
Date

Jamie Struthers, Chair
Discipline Committee
Saskatchewan College of Paramedics