QUEEN'S BENCH FOR SASKATCHEWAN

Date: 2014 08 13
Docket: Q.B.G. No. 228 of 2014
Judicial Centre: Saskatoon

BETWEEN:

TIM BODNARCHUK — APPLICANT

- and -

PROFESSIONAL CONDUCT COMMITTEE OF THE SASKATCHEWAN COLLEGE OF PARAMEDICS — RESPONDENT

Counsel:

Theodore F. Koskie — for the applicant
Andrew R. Heinrichs
Roger J.F. Lepage 306-347-8300 — for the respondent

KONKIN J.

JUDGMENT
August 13, 2014

[1] The applicant, Tim Bodnarchuk, appeals a decision of Council of the Saskatchewan College of Paramedics (the "Council") in its review of the decision of the Discipline Committee (the "Committee") of the Saskatchewan College of Paramedics (the "College").

[2] After the hearing, the Committee found Mr. Bodnarchuk guilty of professional misconduct by breaching s. 23 of *The Paramedics Act* (the "*Act*"), S.S. 2007,

c. P-0.1, and in failing to comply with s. 23 of that *Act*, breaching s. 25(c) of the *Act*.

[3] At his sentencing hearing the following sentence was ordered:

(a) That Tim Bodnarchuk satisfactorily complete, at his own cost, the ExpertRating Online Decision Making course on or before July 31, 2013, and that, if he fails to do so, his licence be suspended on and from August 1, 2013 until completion;

(b) That Tim Bodnarchuk pay a fine to the College in the amount of $3,000;

(c) That Tim Bodnarchuk pay costs to the College in the amount of $5,000; and

(d) That Tim Bodnarchuk pay the fine and costs required to be paid pursuant to clauses (b) and (c) in monthly installments of $300 commencing May 1, 2013 and continuing on the first day of each month thereafter until the total fines and costs are paid in full, and that if he fails to make a payment, his licence be suspended immediately until the total fine and costs are paid in full.

[4] That decision of the Committee and sentence was appealed to Council and confirmed by Council with the following order:

(a) That Tim Bodnarchuk is formally reprimanded and that reprimand is so noted in the register;

(b) That Tim Bodnarchuk pay a fine to the College in the amount of $3,000;

(c) That Tim Bodnarchuk pay costs to the College in the amount of $7,500;

(d) That Tim Bodnarchuk satisfactorily complete, at his own cost, the ExpertRating Online Decision Making course within three months of this decision, failing which his licence would be suspended until proof of completion has been provided to the College;

(e) That Tim Bodnarchuk pay the fine and costs in monthly installments of $300 commencing on February 1, 2014 and continuing on the first day of each month thereafter until the total fine and costs are paid in full, and if he fails to make a payment, that his licence be suspended immediately until the total fine and costs are paid in full.

[5] The notice of appeal contains the following grounds for appeal:

a) that the Council failed to review or properly review and reverse the Committee's failure [to] draw or properly draw to (sic) the inferences from the relevant facts and thereby failed to find the true facts or to find all of the facts necessary to arrive at a just and proper decision upon the evidence;

b) that the Council erred in its review of the Committee's interpretation of the *Act* and the relevant authorities as the same applied to the case before the Council and Committee;

c) that the Council erred by failing to review or properly review the onus of proof applied by the Committee in establishing a breach of the *Act*;

d) that the Council erred in failing to review or properly review

the Committee's consideration of the evidence, *inter alia*:

i) that in addition to the CP1 (Chest Pain) protocol and MP2 (Asthma/COPD) protocols, other protocols also applied–GP13 (Load & Go), MP14 (Nausea & Vomiting) and GP21 (Intravenous Therapy);

ii) that all these protocols had to be balanced and prioritized;

iii) that guidance could be gained from other materials and protocols, such as ACS, part 8, A46 (Morphine), GP3 (Destination & Bypass), TP5 (Shock), and GP9 (Conflict) as well as trauma-related protocols including TP12 (Electrical Shock) and TP16 (Orgamophostpate [sic]/Carbonate poisoning);

iv) that ABCs precede a 12-lead application in protocol and are not just a basic life support layer;

v) that if a patient is an asthma patient, the provider is directed to MP2 to address the ABCs at the ALS level and this takes priority over chest pain as ABC is structured in sequence of necessity to treat;

vi) that the Appellant administered O_2 for both broncho constriction and chest pain;

vii) that the Appellant recognized nausea and vomiting are recognized as symptoms of an Acute Coronary Syndrome and that is why he decided to override [redacted] Hospital as a destination and transport to [redacted] Hospital in preparation for possible myocardial infarction – a decision the Appellant made due to proximity and the patient's complaint of chest pain and having a cardiac history;

viii) that the Appellant performs 12-leads frequently as required by protocol and ACLS and fully intended to perform a 12-lead for this Patient, but simply ran out of time;

ix) that ACLS allows for deviation from the algorithm in unique circumstances and this was just such a circumstance;

x) that, as per the Paramedic Clinical Practice Protocols,

Acetlsalicyclic [sic] Acid (Aspirin) is to be considered a precaution in asthmatics;

xi) that the necessity of prioritizing competing protocols inherent in paramedics' duties was reflected in the subsequently introduced protocol, GP25 (Protocol Deviation); and

xii) of core training requirements for drugs/drug therapy;

e) the evidence regarding the charge under sections 23 and 25 of the *Act* against the Appellant did not and/or could not constitute professional misconduct under the *Act*;

f) the Council erred in failing to review the Committee's error and quash its finding that the omission of a 12-lead test constitutes professional misconduct;

g) the Council erred in imposing increased costs on the Appellant effectively penalizing him for exercising his right of Appeal under section 36 of the *Act*; and

h) such further grounds as counsel may advise and may appear from a transcript of the of the [sic] evidence and of the decision and orders of the Committee, and/or the Council, respectively.

FACTS

[6] The salient facts in this case are not in much dispute. From the Committee's decision relevant facts can be stated as follows:

> [7] On October 29, 2011, [redacted] was taken by a group of her friends for dinner at the [redacted] restaurant to celebrate her 65th birthday. She said she had not been feeling well throughout the day and had taken two sprays of nitroglycerin for chest pain. There was a one and a half hour wait to get into the restaurant, and one of her friends ordered her a beer while they sat in the lobby. She only had two or three sips because she was not feeling well. When they were shown to their table, she said she could hardly walk, she couldn't speak, she was sweating, and had chest pain that was getting worse. She went into the washroom and sat down on a bench. One of her friends came in after her and got her a glass of water. A woman who was in the washroom said she was a physician and told them [redacted] was having a heart attack and to call 911, which they did.

[8] When the ambulance arrived, the attendants asked her if she could walk to the stretcher. She was feeling severely nauseated and had some projectile vomiting as they were loading her into the ambulance. She said one of the paramedics threw her a garbage can and told her to throw up in it. She said she thought he was irritated with her. ... She said she thought he smelled the beer and made assumptions. He asked another EMT to give her a nebulizer. She said she does have a permanent wheeze, which she has had for a number of years, having been diagnosed with asthma since the age of 12. She had a heart attack six or seven years ago and has been on medication ever since as a result, including daily low-dose aspirin. She said she knew that what she was experiencing was not asthma, but a heart attack, and she should have been treated for a heart attack but was not. She identified the EMT who was treating her in the back of the ambulance as Tim Bodnarchuk.

[9] [redacted] and Tim Bodnarchuk were the EMTs who were dispatched to the [redacted] to attend to [redacted]. [redacted] said when the call came in they were told it was a 56 year old woman who was having a heart attack. When they got to the [redacted], [redacted] came out of the bathroom clutching her chest. He had her sit down on a bench in the lobby and gave her oxygen. She told him that she had chest pain, had taken two sprays of nitro at home during the day and another two sprays since arriving at the [redacted]. He relayed this information to his partner, Tim Bodnarchuk. They decided to get her onto the stretcher and out of the crowded restaurant to the ambulance. As they were loading her into the ambulance, she began vomiting and [redacted] handed her the garbage can, he acknowledged that he was probably curt with her because she had vomited into the cabinets in the ambulance rather than onto the floor. He asked Mr. Bodnarchuk if he wanted help with the 12-lead ECG test, and Mr. Bodnarchuk said no, he would do it on the way. They then left with [redacted] driving and Mr. Bodnarchuk in the back with [redacted]. Mr. Bodnarchuk was in charge of the call because he had the higher level of training of the two of them.

[10] [redacted] testified that the reason for doing the 12-lead was to identify as soon as possible whether or not the patient was having a STEMI (ST segment elevation myocardial infarction). The test only takes a minute or two to administer and if the result is positive, the patient can be diverted directly to [redacted] Hospital [redacted] and into the catheterization lab for treatment as soon as she arrives, rather than to a hospital that does not have the appropriate facilities to deal with heart attack patients. A failure to complete the test can delay treatment and could result in the patient being sent to the wrong hospital.

[11] [redacted] drove directly to [redacted], saying he believed that both he and Mr. Bodnarchuk assumed that's where they would go because she was a cardiac patient. However, because the 12-lead had not been done, he was not able to use lights and sirens according to the applicable protocol in that regard.

[12] When they got to [redacted], Mr. Bodnarchuk directed [redacted] to administer a nebulizer to [redacted], while she was still in the ambulance, because of her wheezing. [redacted] was frustrated by this direction because she was having serious chest pain that should have been treated without delay, but he followed it because it would take less time to do it than to argue about it with Mr. Bodnarchuk. Then, because the 12-lead test hadn't been done in the ambulance, there was a further delay in getting [redacted] to the cath lab while the test was performed at the hospital. Ultimately, [redacted] was admitted to the cath lab and properly treated.

...

[15] ... at the [redacted] ... Mr. Bodnarchuk observed that [redacted] airway was patent, she was talking in medium-length sentences, her skin was pale, she was cooling down, and she had audible wheezes when she was talking. His assessment was that this was a combined complaint, involving both a respiratory issue and a cardiac issue. While it was his intention to do the 12-lead while en route, [redacted] kept asking for pain relief and based on her vital signs and wheezing bilaterally, he said he needed to question her further as to whether her breathing was worse than her chest pain.

RELEVANT LEGISLATION

[7] Sections 23 through 25 of *The Paramedics Act* relate to this matter. They states as follows:

> 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.
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> ...
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> 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.

DECISION OF THE DISCIPLINE COMMITTEE

[8] At para. 23 of its decision, the Committee concludes that all witnesses are credible. It finds that [redacted] presented as a patient with severe chest pain and some breathing problems. It concludes in that paragraph:

> ... The crux of the issue is whether or not it was professional incompetence or professional misconduct for Mr. Bodnarchuk to fail to perform the 12-lead and administer medication according to the chest pain protocol CP1 prior to initiating treatment for [redacted] breathing problems.

At para. 30 the Committee concludes in part:

> ... In these circumstances, the Committee is not persuaded that Mr. Bodnarchuk's failure to prioritize the chest pain protocol can be described as a lack of judgment of such magnitude that it demonstrates he is unfit to continue in the practice of the profession or to perform any particular service ordinarily provided as part of the practice of the profession.

The Committee concludes at para. 31:

> However, his failure to follow the appropriate protocol is a breach of section 23 of the Act, as quoted above, which requires a practising member who provides an emergency treatment or administers a medication to do so in accordance with the approved protocols.

> Protocol CP1 is an approved protocol, and Mr. Bodnarchuk was required to follow it because he assessed chest pain as the most important of the patient's symptoms, as recorded on the PCR, and he testified that he diverted the ambulance directly to the [redacted] because he recognized the seriousness of her chest pain. ... His failure to administer the 12-lead test constitutes professional misconduct because it is a breach of section 23 of the Act and because a breach of the Act is professional misconduct, as defined in clause 25(c) of the Act.

DECISION OF COUNCIL

[9] The Council upheld the decision of the Committee. At page 7 of that decision, Council states:

> Section 23 of the *Paramedics Act* is a mandatory directive to a practicing member requiring that he "must" provide medical treatment in accordance with protocols. The fact that Mr. Bodnarchuk did not comply with the CP1 Protocol in (sic) undisputed. It was reasonable for the Discipline Committee to accept or reject Mr. Bodnarchuk's explanation of prioritizing protocols. It chose not to accept his explanation. As a consequence, the Discipline Committee found he failed to comply with Section 23 in not complying with the CP1 Protocol.
>
> Council's review of the evidence and the Discipline Committee's decision supports its view that Mr. Bodnarchuk showed a lack of judgment and inability to identify the proper emergency protocols. The evidence supports the finding that Mr. Bodnarchuk's focus and decision-making shifted between protocols and, in doing so, he failed to appropriately determine the necessary protocol to follow given the patient's primary symptom was severe chest pain.
>
> ...
>
> Council notes that the Discipline Committee struggled with whether the breach of Section 23 was professional incompetence or professional misconduct. It decided Mr. Bodnarchuk's conduct did not rise to professional incompetence i.e. a display of "lack of knowledge, skill or judgment or disregard for the welfare of the patient". However, based on the Discipline Committee's review of the evidence, it found professional misconduct.

ANALYSIS

[10] The parties agree rightly that the test for review from *Dunsmuir v. New*

Brunswick, 2008 SCC 9, [2008] 1 S.C.R. 190, is reasonableness. In its decision at para. 24 the Committee states:

> In order for a member to be found guilty of professional incompetence it is necessary to show that the member has displayed a lack of knowledge, skill or judgment or a disregard for the welfare of a patient that is of such magnitude that it demonstrates that the member is not fit to perform some or all of the services normally provided in the practice of the profession. Thus, the question is: was Mr. Bodnarchuk's decision to delay performing the 12-lead, in accordance with the chest pain protocol, a decision that demonstrates a lack of knowledge, or a lack of skill, or a lack of judgment, or a disregard for the welfare of the patient and, if it does, was that lack or disregard of such significance that it can be concluded that he should not practice or should be restricted in his ability to practice?

[11] After another brief review of the events and the procedures attempted by Mr. Bodnarchuk, the Committee concludes at para. 27:

> The Committee concludes that Mr. Bodnarchuk displayed a lack of knowledge, skill or judgment, or a disregard for the welfare of the patient, when, having recognized that the patient's chest pain was her most serious complaint and having diverted to [redacted] directly because of her chest pain, he failed to follow the protocol for chest pain CP1.

[12] However, at para. 30 the Committee states:

> In this case, there is no allegation that Mr. Bodnarchuk was not competent to perform any of the services provided by the profession; the complaint is that he did not provide the services that he should have provided, based on the patient's presenting symptomology. In these circumstances, the Committee is not persuaded that Mr. Bodnarchuk's failure to prioritize the chest pain protocol can be described as a lack of judgment of such a magnitude that it demonstrates he is unfit to continue in the practice of the profession or to perform any particular service ordinarily provided as part of the practice of the profession.

[13] The Committee has, therefore, concluded that Mr. Bodnarchuk has breached s. 24 of the *Act*, the section on professional incompetence, but then concluded that his breach was not of a nature that he could not continue in the practice of the profession or provide one or more of the services ordinarily provided as part of the practice of the profession.

[14] The Committee goes on in para. 31 to conclude that Mr. Bodnarchuk's failure to follow the appropriate protocol is a breach of s. 23 of the *Act*. The Committee states at para. 31 in part:

> ... Protocol CP1 is an approved protocol, and Mr. Bodnarchuk was required to follow it because he assessed chest pain as the most important of the patient's symptoms, as recorded on the PCR, and he testified that he diverted the ambulance directly to the [redacted] because he recognized the seriousness of her chest pain. In spite of his own assessment, however, he did not follow the CP1 protocol, since he did not administer the 12-lead ECG test, ASA, and nitroglycerine. The reasons he provided for why he didn't do these things were that he applied other protocols, but as outlined above, it is the Committee's view that there was no factual basis on which the other protocols to which Mr. Bodnarchuk referred would apply, based on the patient's symptoms as he recorded them and as he testified about them. Even if the contraindications he described with respect to the administration of ASA and nitroglycerine were valid reasons for not administering those medication (sic), he nevertheless failed to administer the 12-lead, which ultimately had to be performed when the patient arrived at the hospital. His failure to administer the 12-lead test constitutes professional misconduct because it is a breach of section 23 of the Act and because a breach of the Act is professional misconduct, as defined in clause 25(c) of the Act.

[15] The Committee relies, in its decision, on s. 23 concluding that as chest pain was the most serious condition listed by Mr. Bodnarchuk, he had a duty to provide the CP1 protocol. Further, under s. 23 in administering to this patient he had a duty to do so in accordance with the protocol, in this case CP1. However, s. 23 states that:

> 23 A practising member who provides an emergency treatment ... must do so in accordance with any protocols respecting the provision of emergency treatment ... approved by the College of Physicians and Surgeons of Saskatchewan.

[16] It is Mr. Bodnarchuk's evidence that he was providing care to this patient following the ABC's protocol. The Committee states at para. 26 that Mr. Bodnarchuk argued that he was following the ABC's and his first priority was the patient's breathing. "However, he was focussed on starting an IV (which addressed Circulation) rather than administering the Ventolin to deal with her Airway and Breathing problems, which was

not administered until they had arrived at the hospital, thus failing to properly address the ABC's also." However, from the evidence in para. 8 of the Committee's decision and from the patient's own evidence it appears that she was given a nebulizer while in the ambulance at the restaurant. It is therefore not clear that Mr. Bodnarchuk was not following the ABC's protocol, and under s. 23 so long as he was following the protocol he presumably is not in breach and therefore could not be found to have exercised professional misconduct under s. 25(c) of the *Act*. It is possible that the Committee could have found Mr. Bodnarchuk to have exercised professional misconduct under s. 25(a) or (b), but chose not to. To find professional misconduct based on an infraction of s. 23 the Committee would have to conclude that the member did not apply the protocol appropriately. This would be any protocol that a member chose to apply, not a protocol which the Committee felt the member should have applied. In this case, it is clear from the decision that the Committee felt Mr. Bodnarchuk was applying the ABC's protocol and concluded, perhaps inappropriately, that he was not even applying that protocol appropriately. However, as stated before, the evidence even in their decision does not necessarily support that conclusion.

[17] I find that the conclusion of the Committee that Mr. Bodnarchuk was not following the ABC protocol appropriately is not borne out in the written decision of the Committee. It is not made clear in the decision how Mr. Bodnarchuk was not applying this protocol appropriately as the evidence of the patient and the Committee suggests that Mr. Bodnarchuk had complied with the "B" in the ABCs while still at the restaurant. The Committee does not state that the ABCs were not an appropriate protocol, only that in their view the CP1 was a "more" appropriate one. This is not what s. 23 on its face contemplates.

[18] For the foregoing reasons, I find that the decision of the Committee to find Mr. Bodnarchuk guilty of professional misconduct based on an infraction of s. 23 is not reasonable and cannot be sustained. As stated earlier, the Committee had concluded that Mr. Bodnarchuk had demonstrated a lack of knowledge, skill or judgment or disregard for the welfare of the patient which would have potentially led to a professional incompetence determination, but concluded as there was no allegation that Mr. Bodnarchuk was not competent to perform the services, they would not find him incompetent as his "lack of judgment" was not of such a magnitude that it demonstrated he was unfit to continue the practice of the profession or to perform any particular services ordinarily provided as part of the practice of the profession .

[19] I find that the appropriate remedy in this matter is to remit the matter back to the Committee for a re-hearing to determine whether or not the actions of Mr. Bodnarchuk demonstrated professional misconduct or professional incompetence. That Committee has the expertise to make an appropriate determination.

J.
D.B. KONKIN