IN THE MATTER OF *THE PARAMEDICS ACT* AND BYLAWS AND IN THE MATTER OF A COMPLAINT AGAINST TIM BODNARCHUK

DECISION

Discipline Committee of the Saskatchewan College of Paramedics

Discipline Committee Members:

Jamie Struthers, Q.C., Public Representative, Chair
Cheryl Solonenko, EMT-Paramedic, Member
Mike Van Stone, EMT-Paramedic, Member

Legal Counsel for the Discipline Committee: Merrilee Rasmussen Q.C.
Legal Counsel for the Professional Conduct Committee: Roger Lepage
Legal Counsel for Tim Bodnarchuk, Theodore F. Koskie

INTRODUCTION:

[1] The hearing by the Discipline Committee of the Saskatchewan College of Paramedics (the "College") into the complaints against Tim Bodnarchuk, a Member of the College, was convened in the Travelodge, Saskatoon, Saskatchewan, at 10:00 a.m. on October 3, 2012, being the location, time and date agreed to by the parties.

[2] Theodore Koskie was present at the hearing representing Mr. Bodnarchuk. Roger Lepage was present representing the College's Professional Conduct Committee (the "PCC").

[3] The Discipline Committee heard testimony from [redacted], the patient to whose aid Mr. Bodnarchuk and his partner were dispatched and who lodged a complaint with the College, as well as from [redacted], a colleague of the Member who was on duty with him the day in question, [redacted], the director of [redacted] and [redacted] for the Member's employer, and from the Member, Tim Bodnarchuk. During the course of the hearing the Discipline Committee received the following documents in evidence:

Exhibit P-1: Notice of Hearing with proof of service contained at Tab 1 of the PCC's Exhibit Book
Exhibit P-2: Extract from the College's Register concerning the Member
Exhibit P-3: Patient Care Report relating to the Complainant
Exhibit P-4: Letter of complaint to the College from the Complainant
Exhibit P-5: CP1Protocol for Chest Pain from Tab 7 of the PCC's Exhibit Book
Exhibit P-6: MP2 Protocol for Asthma/COPD from Tab 8 of the PCC's Exhibit Book
Exhibit D-1: Unusual Incident Report to employer from T. Bodnarchuk dated October 30, 2011 at Tab 10 in the Member's Exhibit Book
Exhibit D-2: "Load and go" protocol GP 13 at Tab 12 in the Member's Exhibit Book
Exhibit D-3: ACLS guidelines re patients with heart problems at Tab 7 in the Member's Exhibit Book
Exhibit D-4: MP 14 Protocol re Nausea and Vomiting at Tab 15 in the Member's Exhibit Book
Exhibit D-5: A-46 morphine protocol at Tab 4 in the Member's Exhibit Book
Exhibit D-6: GP 3 Destination and Bypass protocol at Tab 16 in the Member's Exhibit Book
Exhibit D-7: GP 21 IV therapy protocol at Tab 17 in the Member's Exhibit Book
Exhibit D-8: TP 5 Shock protocol at Tab 18 in the Member's Exhibit Book
Exhibit D-9: GP 9 Conflict between health care providers at Tab 19 in the Member's Exhibit Book
Exhibit D-10: GP 8 Use of red lights and sirens at Tab 20 in the Member's Exhibit Book

[4] At the close of the evidence it was agreed that arguments would be submitted in writing by each party on or before October 19, 2012 and a reply by each party by October 26, 2012. These written submissions were duly filed with the Discipline Committee.

THE FORMAL COMPLAINT:

[5] The notice of hearing served on Mr. Bodnarchuk contained the following charge:

Charge Number 1

You, BODNARCHUK, are alleged to be guilty of professional incompetence and/or professional misconduct contrary to sections 24 and 25 of The Paramedics Act, 2007, c. P-0.1, in that on October 29, 2011 at approximately 7:00 pm you attended on [redacted] *at* [redacted] *restaurant in* [redacted]*, Saskatchewan, pursuant to a 911 call after she complained of chest pain and a heart attack. Despite the symptoms, you failed to give priority to administering the 12-lead ECG test as required by Saskatchewan Emergency Treatment Protocol Manual and you failed to*

administer the appropriate medication.

Particulars of the professional misconduct are as follows:

1. The patient reported a history of ongoing chest pain during the day and having taken five sprays of nitroglycerine prior to calling 911. The patient reported being a smoker and having taken three sips of beer at The [redacted] and no food intake.

2. After receiving the call at 19:07, Bodnarchuk attended via ambulance with his partner, [redacted] ICP ("[redacted]"), and arriving on scene at 19:12.

3. Despite the continuing symptoms, Bodnarcuk decided not to administer ASA, morphine or nitro.

4. Bodnarchuk attempted to secure an IV line rather than do the 12-lead ECG test.

5. Bodnarchuk gave priority to investigating a possible asthma attack rather than a myocardial infarct despite prompting from his partner to do the 12-lead ECG test.

6. Bodnarchuk's partner, [redacted], before leaving [redacted] restaurant, asked if he wanted a 12-lead ECG test done. Bodnarchuk replied "let's just go". On route, [redacted] reported to ACP [redacted] who requested the results from the 12-lead ECG test. He reported that Bodnarchuk was working on it. When the ambulance arrived at the [redacted] Hospital in [redacted], Bodnarchuk insisted that [redacted] come back into the ambulance and give the patient a neb of Ventolin. When [redacted] opened the back doors to the ambulance, Bodnarchuk was still trying to get an IV access and had not done the 12-lead ECG test. Despite being at the hospital, Bodnarchuk again insisted that [redacted] give the patient 2.5 milligrams of Ventolin with 8 litres per minute of oxygen. [redacted] tried to take the patient to the resuscitation unit, but because Bodnarchuk had not done a 12-lead ECG test, the patient's admission was stalled and eventually sent her to the active end. [redacted] immediately expressed frustration that Bodnarchuk had not done the 12-lead ECG test. Bodnarchuk had not given any ASA, bur rather, treated for a slight wheeze. [redacted] complained to the supervisor about these issues and a further complaint was received from the patient.

7. Bodnarchuk failed to respect cardiac protocol CP1 when there is a presentation of chest pain and projectile vomiting. He failed to have the patient chew and swallow 160-325 milligrams of uncoated ASA. He had been trained to obtain a 12-lead ECG test. He had been trained to assist the patient to take nitroglycerine as per the patient's own prescription using the patient's nitroglycerine. The patient was not hypotensive and did not have a heart rate below 50 BPM.

FACTS:

[6] While there were some differences in points of detail in the evidence provided by the witnesses, there is no dispute as to the central facts.

[7] On October 29, 2011, [redacted] was taken by a group of her friends for dinner at [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. The other paramedic then started treating her for asthma and she said she told him that's not what it is. She said she didn't think the EMT believed that she was having a heart attack. 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]. Mr. [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 Mr. [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 Mr. [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] Mr. [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] Mr. [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 Mr. [redacted] to administer a

nebulizer [redacted], while she was still in the ambulance, because of her wheezing. Mr. [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.

[13] The next day Mr. [redacted] submitted an Unusual Incident Report to his employer because he felt that the 12-lead should have been done immediately, aspirin should have been administered, and they should not have stopped in the hospital garage to give the patient a nebulizer.

[14] [redacted] was not sure how he became aware of this situation, but when he did become aware he reviewed it and was concerned that the patient was complaining of chest pain and was not properly treated. He said the employer's standard was that when a patient complained of chest pain a 12-lead should be administered within the first five minutes. This will determine whether or not the patient can be bypassed directly to [redacted] and saves crucial time when the patient arrives at the hospital.

15] Tim Bodnarchuk said that when he first saw [redacted] at the [redacted] she was sitting on a bench and swaying from side to side. He assumed she was in a lot of pain. He said she looked like she was in respiratory distress and he thought they should follow the "load and go" protocol rather than stay on the scene and perform a 12-lead as Mr. [redacted] suggested. Mr. Bodnarchuk said that the patient had told Mr. [redacted] that she had a cardiac history and had asthma. Mr. Bodnarchuk asked her a few more questions and found she was a smoker, that she had had a little bit to drink and that she used puffers for her asthma and was allergic to codeine. He said the patient had told Mr. [redacted] that she had taken three sprays of nitro at the restaurant and two during the day (although [redacted] testified that she had said she had taken

only two at the restaurant). Mr. Bodnarchuk observed that her 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.

[16] Mr. Bodnarchuk testified that he initiated the Asthma/COPD protocol because [redacted] wheezing was getting worse and her sentences were getting shorter, which led him to think that her respiratory condition might be deteriorating. That protocol calls for the initiation of an IV (after administering oxygen and ventolin), which he completed on his second attempt as they were nearing [redacted]. He said it was his decision to divert to [redacted] because of her chest pain. He acknowledges that he did not administer ASA or morphine, but said they were contraindicated because of her vomiting and her allergy to codeine. He says he did not dismiss her concerns, he acknowledged them. He said he told her he understood she was having chest pain but that he had to first of all deal with her breathing problems.

THE LEGISLATION:

[17] 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.

[18] 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.

[19] The Act also contains a provision guiding the use of protocols by an EMT:

> 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.

SUBMISSIONS OF THE PARTIES:

[20] Counsel for the PCC argues that Mr. Bodnarchuk ought to have followed the CP1 protocol for chest pain. If Mr. Bodnarchuk had followed that protocol he would have performed a 12-lead immediately before leaving the [redacted] parking lot, and would have administered ASA and nitro as well as morphine for pain. Instead, he chose to treat a minor wheezing problem with

the result that appropriate treatment for the patient was delayed and her health and life put at risk. This conduct constitutes professional incompetence, because it displays a lack of knowledge, skill or judgment or a disregard for the welfare of the patient to such an extent that it demonstrates that Mr. Bodnarchuk is not fit to perform this aspect of the practice of a paramedic. It also constitutes professional misconduct because it is conduct that is harmful to the best interests of the public.

[21] Counsel for Mr. Bodnarchuk argues that Mr. Bodnarchuk acted properly in following all of the applicable protocols, including the protocols for chest pain and asthma, and that they all had to be balanced and prioritized. His assessment was that he must first ensure the ABCs – airway, breathing, circulation – and that these precede the performance of the 12-lead. He did take into account the patient's complaints of chest pain by routing the ambulance directly to [redacted]. When the patient's breathing got worse, he started to initiate an IV as required by ACLS 2005. By this time they had reached the hospital and he didn't have time to perform the 12-lead. He did not administer ASA, nitro or morphine because the patient was asthmatic, was vomiting and had low blood pressure. He did not want the patient to have a respiratory collapse and thus complicate a myocardial infarct.

[22] In relation to the allegation of professional incompetence, counsel for Mr. Bodnarchuk argues that there is no evidence that Mr. Bodnarchuk is not fit to perform some or all of the duties of a paramedic. He points out that the employer did not discipline Mr. Bodnarchuk or restrict him in any way from the performance of all of aspects of the practice of the profession, nor did the PCC. Counsel for Mr. Bodnarchuk argued that the PCC had not proven that Mr. Bodnarchuk had acted outside of the approved protocols in failing to administer the 12-lead ECG test, ASA and nitroglycerine.

ANALYSIS:

[23] The Discipline Committee observes that the outcome of this case does not turn on credibility, but on interpretation and assessment. As stated from the outset, while there are some

differences in the details of the testimony of each of the witnesses, there really is very little dispute about the facts. The Discipline Committee finds all of the witnesses to be credible. [redacted] presented as a patient with severe chest pain who also had some breathing problems. Mr. Bodnarchuk recognized the fact that she was having chest pain and this is substantiated objectively by the Patient Care Report that he completed at the time, which indicates "chest pain - unstable" and shows her breathing issues as "minor". He says he also decided to divert to [redacted] because of her chest pain (although it would appear that he did not have the documentation necessary to override the normal allocation of their destination through the dispatch system according to Protocol GP 3) [redacted] said that he believed they had both assumed they were going to [redacted] because the patient had chest pain. 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.

[24] 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 a 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?

[25] Mr. Bodnarchuk and his partner were dispatched on the 911 call to the [redacted] to assist an older woman who was complaining of severe chest pain. The Patient Care Report Form (PCR) that he completed indicates that he assessed her chest pain as "unstable" and her asthma as "minor". There is no mention on the PCR of the audible wheezes about which Mr. Bodnarchuk testified. This again indicates that at the time he assessed this aspect of the patient's condition as

minor. The vital signs recorded on the PCR indicate that the patient was stable. Nor does the information reported on the PCR support the application of the "Load and Go" protocol, which applies in a situation of immediate life threat. Mr. Bodnarchuk also testified that he decided to divert directly to [redacted] because of the patient's chest pain. This statement also indicates that the patient's chest pain was her most serious problem and therefore should have led to the application of the CP1 protocol, which calls for the administration of the 12-lead ECG test, ASA and nitroglycerine.

[26] In these circumstances Mr. Bodnarchuk should have followed the protocol for chest pain, CP1. He did not, and he acknowledges that he did not. His argument is 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 addresses 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. He failed to follow the CP1 protocol by failing to administer the 12-lead ECG, failing to administer ASA, and failing to assist the patient to take her own nitroglycerin.

[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.

[28] Counsel for Mr. Bodnarchuk argues that no evidence has been provided upon which the Committee can conclude that this failure was of such a nature or to such an extent that demonstrates that Mr. Bodnarchuk is unable to continue in the profession or to perform one or more of the services ordinarily provided by the profession. In this regard, he pointed to the lack of discipline taken by the employer against Mr. Bodnarchuk and the failure of the PCC to restrict his practice in any way.

[29] The Committee notes that whether or not an employer disciplines an employee who is a member has no relevance to the issue of whether that member is guilty of a discipline offence under the Act. Workplace discipline is defined differently from professional discipline. Nor is the assessment an employer may make of a situation in the workplace binding in any way on the decision that the Discipline Committee has to make pursuant to the authority provided to it under *The Paramedics Act*. As a result, whatever the employer did or didn't do has no necessary relevance to the question to be decided by the Committee. Similarly, the PCC has no power under the Act to restrict the practice of a member except by consent or through the discipline hearing process out of which a discipline order may be imposed on the member by this Committee. Therefore, there is nothing to be read into the PCC's failure to restrict the member's practice, since it has no ability to do that. While section 28 of the Act allows the PCC to apply to a judge for a temporary suspension order, this provision is rarely if ever resorted to by any of the self-regulated professions other than medicine and then only in the most serious situations. The Act does not require that a temporary suspension be obtained under section 28 before a finding of professional incompetence can be made.

[30] 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.

[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. 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, 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.

ORDER:

[32] Having found Tim Bodnarchuk to be guilty of professional misconduct, as outlined above, the Discipline Committee of the Saskatchewan College of Paramedics hereby Orders that the hearing of the matter by reconvened on a date and at a time and place to be determined by the Chair of the Committee, after consultation with the parties, for the purpose of hearing evidence, if, any, and submissions in relation to the issue of what orders should be made by the Committee pursuant to section 31 of *The Paramedics Act*.

DATED at Regina, Saskatchewan, this 17 day of December, 2012.

Jamie Struthers, Chair
Discipline Committee
Saskatchewan College of Paramedics