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IN THE MATTER OF: **The Registered Nurses Act, R.S.M. 2001, c. R40**

AND IN THE MATTER OF: **A Hearing into the Conduct of Shannon Hancock,**

CRNM # 2015-135095-043

DECISION

Important note regarding redactions in this document:

In compliance with Council Policy GP-11, the College of Registered Nurses of Manitoba redacted the names of individuals not directly involved in the hearing and to protect the identity of the Member's family members.

Redacting the name of the doctor and the name of the Director of Health Services was done to further protect the privacy of the family members referred to in the decision.

Other information is redacted to maintain the privacy of the Member's personal information.

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CRNM # 2015-135095-043

DECISION

Discipline Panel Members:	Brian Crawford (Chair)
	Lydia Harris
	Jennifer Colvine
	Doug Simpson
	Quinn Menec
Counsel to the Investigation Committee:	William G. Haight
	Duboff Edwards Haight & Schachter
Counsel to the Member:	Catherine Dunn
	Catherine Dunn Law Office
Counsel to the Panel:	Bill Bowles

Introduction

The Chair of the Discipline Committee of the College of Registered Nurses (the "College") appointed this panel to hold a hearing into the charges against Shannon Hancock (the "Member"), a member of the College, set out in the Notice of Hearing. The hearing was to commence on August 28, 2017. Exhibit 3 is a letter from the Member's counsel to counsel for the Investigation Committee (the "IC") dated August 24, 2017. It records an agreement between counsel that the panel had acquired jurisdiction in these proceedings and could adjourn the hearing date of August 28, 2017 without a fixed date to resume, and without the need for counsel to appear. The panel being made aware of that agreement, agreed to an adjournment on that basis.

The hearing was finally scheduled to resume on January 21, 22 and 23 and February 4, 5 and 6 of 2019. By that time, the Member was no longer represented by counsel.

When the hearing resumed on January 21, the parties advised the panel that there were a number of preliminary motions. They included motions by the Member

- that Mr. Simpson should be removed from the panel;
- that Mr. Haight be removed as counsel for the IC; and
- that the matter be dismissed on a summary basis;

as well as motions by the IC

- that the Member provide an outline of the evidence she expected from the witnesses she intended to call; and
- that the panel refuse to allow some of the Member's witnesses to testify on the basis that their evidence was irrelevant.

Some of the motions were heard, others abandoned. With respect to the motions that were heard, the panel's decisions and reasons were provided on the record. Each of those motions was dismissed.

The motions took up all of the time that had been scheduled for the hearing and new dates had to be set. The hearing next resumed on March 14, 2019, by which time the Member had retained new counsel. The hearing proceeded on March 14, 15, April 4, May 13, 14, 21 and 23, 2019, during which time the Panel heard evidence, and submissions from counsel for the IC and counsel for the Member.

Notice of Hearing

This case arises out of a referral by the IC relating to the conduct of the Member. The matters at issue are set out in the Notice of Hearing as follows:

> . . . that you, Shannon Hancock, a member of the College, are guilty of professional misconduct in that:
>
> 1. Between October 2014 and March 2015, you failed to maintain appropriate professional boundaries by providing Registered Nursing care to, and becoming involved in a therapeutic relationship with [redacted], when provision of the care and involvement in the therapeutic relationship was avoidable.
>
> As a result you have breached: Standard I, including Indicator 5; Standard II, including Indicator 11; Standard III, including Indicators 17, 18 and 19; Standard IV, including Indicators 23 and 24 of The Standards of Practice for Registered Nurses; Primary Value D, including Responsibility 7; Primary Value E, including Responsibility 8; and Primary Value G, including Responsibility 8 of The Code of Ethics for Registered Nurses and the College Nursing Practice Expectation, Professional Boundaries for Therapeutic Relationships.

Further particulars were provided to the Member by letter dated April 9, 2018 (Exhibit 2) from the counsel for the IC to the then counsel for the Member. Those particulars were:

- The Member was employed at [redacted] in an outreach position from May 2014 to April 2015. Her employment began in January of 2014 and the Member assumed the duties of an outreach nurse approximately 4 months later.
- After commencing her employment with [redacted], the Member had discussions with [redacted] management regarding her [redacted]. The Member was concerned about [redacted] health and believed she would benefit from services provided by [redacted]. She therefore made efforts to have [redacted] become a [redacted] client. [redacted] management advised the Member that if [redacted] was to be accepted as a client the Member could not be involved in her case.
- [redacted] was accepted as a [redacted] client in early October 2014.
- Shortly after [redacted] was accepted as a [redacted] client the Member accessed [redacted] electronic medical chart. Thereafter she accessed the chart on at least fourteen different occasions. The Member viewed [redacted] medical summary and chart on at least three occasions, updated an appointment for [redacted] and printed a document or documents from the chart.
- The Member accessed [redacted] chart on the following dates:
    - October 14, 15 and16, 2014
    - November 19, 24 and 26, 2014
    - December 17, 2014
    - January 6, 12 (5 access' that day) and 27, 2015
    - February 2 and 18, 2015
    - March 11 and 17, 2015
- The Member rescheduled an appointment for [redacted] through [redacted] medical records and was cautioned by a [redacted] physician regarding this conduct
- [redacted] had a health care proxy being her daughter [redacted]. [redacted].

The letter also provided that "the Indicators and Primary Values referenced in the Notice of Hearing are the only Indicators and Primary Values upon which the IC will rely"

Facts

The IC led evidence from six witnesses: Tracey Legary, Robert Marshall, Nancy McPherson, Michelle Cherepak, [redacted] and Dr. [redacted].

Tracey Legary is the Manager of Professional Conduct with the College. She provides support to the IC. She provided background evidence about how the IC's investigation had proceeded.

Robert Marshall is an ex-homicide detective who now works as an investigator for the IC. He testified about his investigation in this case, including his interviews with the Member.

Nancy McPherson was called and accepted as an expert witness, with expertise in the professional boundaries of nurses in their dealings with family members. She testified about circumstances in which a nurse is able to provide nursing care for a family member and a nurse's professional responsibilities when therapeutic boundaries are crossed.

Michelle Cherepak is an [redacted]. She testified about homecare availability for [redacted].

[redacted] was the Director of Health Services at [redacted] and testified about the Member's employment there, how the Member's [redacted] became a patient and the circumstances under which the Member was terminated.

[redacted] was [redacted] doctor at [redacted]. [redacted] testified about the care provided to [redacted] and the interactions [redacted] had with the Member.

The Member testified on her own behalf and called one other witness: Dr. Kristen Jones-Bonofiglio.

Dr. Kristen Jones-Bonofiglio, PhD, RN, is an Assistant Professor in the School of Nursing and the Director of the Centre for Health Care Ethics at Lakehead University. She was called and accepted as an expert witness with an expertise on nursing ethics and moral distress in a variety of nursing settings.

Events at [redacted]

[redacted] is a community health center operating in the [redacted].

The Member is an experienced registered nurse who worked at [redacted] between the time she was hired in January of 2014 and the time she was terminated in March of 2015. No allegations have been raised in this hearing that call into question the Member's nursing skills. In fact, a performance review filed in these proceedings shows that [redacted] felt her job performance was meeting, and in a number of cases exceeding, expectations.

In January of 2014, the Member was hired by [redacted] to work on a part time basis, as an STI nurse. In May of 2014 the Member moved to a full time position as the Outreach Nurse for [redacted]. This involved making home visits to vulnerable and elderly [redacted] patients living in the community.

In August of 2014, the Member met her [redacted] walking on the street. The Member and [redacted] were not particularly close and the Member had not seen [redacted] for approximately two years. The Member was concerned that her [redacted] looked unwell. She thought [redacted] color was unusual and suspected [redacted] may be jaundiced. She noticed [redacted] had lost considerable weight since she had last seen [redacted].

[redacted] lived alone in a house within the [redacted] catchment area and the Member thought that [redacted] would benefit from the many services [redacted] provided to its patients. The Member therefore spoke with her immediate supervisor at [redacted], [redacted], and asked [redacted] if her [redacted] could become a patient at [redacted]. [redacted] first response was to say no, as there was a policy at [redacted] against family members of staff being accepted as patients. Later on, [redacted] [redacted] approached the Member and told her that [redacted] had reconsidered. [redacted] believed there might be exceptions made to the policy against family members and said [redacted] would take the matter up with the intake committee. [redacted] did so and [redacted] was accepted as a patient, although there were apparently some people at [redacted] that did not agree this was appropriate.

When [redacted] was admitted to [redacted], [redacted] cautioned the Member about becoming involved in [redacted] care. [redacted] said [redacted] told the Member she would have to remove herself completely from her [redacted] care. The Member said [redacted] told her not to be involved and to "stay at arm's length". [redacted] daughter, [redacted], [redacted] and was [redacted] health care proxy.

[redacted] doctor at [redacted] was Dr. [redacted] There was a difference in the evidence about the extent to which the Member and Dr. [redacted] spoke about [redacted] Dr. [redacted] said that [redacted] never conveyed any medical information about [redacted] to the Member but that [redacted] listened to information the Member gave to [redacted] about [redacted]. The Member agreed that she had given information about [redacted] to Dr. [redacted] but said that Dr. [redacted] had also shared information about [redacted] with her. For example, the Member said that Dr. [redacted] told her about the results of a "mini mental" exam that Dr. [redacted] gave [redacted]. The panel believes that both Dr. [redacted] and the Member testified honestly, but on a balance of probabilities prefers the evidence of the Member on this point. [redacted] was only one of many patients that Dr. [redacted] was managing at that time and [redacted] evidence appeared to be based, understandably, on what [redacted] general practice would be, rather than on a recollection of specific facts. In addition, the Member recalls not only being told about the results of the mini mental exam but also reporting those results to [redacted], [redacted] health care proxy. Finally, Dr. [redacted] was being asked to testify to a negative – what [redacted] didn't do. All [redacted] could fairly say is that [redacted] didn't recall providing information, and that [redacted] didn't think it was the type of thing [redacted] would do. The Member, however, purported to have a specific recollection of a specific event.

The Member said that she felt Dr. [redacted] was inviting her into what the Member referred to as "the circle of care". Although the panel accepts that the Member may have believed that, it does not find that Dr. [redacted] did so invite her. Any information about [redacted] that Dr. [redacted] shared with the Member was in all likelihood because [redacted] was the Member's [redacted] and not because [redacted] was inviting the Member to become involved in her [redacted] care at [redacted].

[redacted] keeps its medical charts in electronic form managed by a program called ACCURO. The Member testified that between October of 2014 and March of 2015, she accessed [redacted] medical chart on ACCURO on several occasions. For example, on one occasion, she accessed the chart to reschedule an appointment for [redacted]. On another occasion, she accessed the chart to print out an ultrasound requisition. On several other occasions, she accessed the chart to find out the results of tests and relay those results to [redacted] health proxy, [redacted].

[redacted] testified that in or before March of 2015, [redacted] decided to have an audit done of the Member's ACCURO accesses, to ensure that she was not becoming involved in her [redacted] care. That audit suggested that not only had the Member accessed her [redacted] chart but that she had accessed several other charts as well, including the charts of some of her colleagues at [redacted].

[redacted] decided to meet with the Member to discuss the audit. The Member was not given any notice of the meeting or any prior indication of its purpose. On the day of the meeting, the Member arrived at work to find she was unable to log in. [redacted] came to her desk and asked her to come to a meeting in the basement. The Member and [redacted] went downstairs and the Member was introduced to [redacted], who she was told was her union representative. At the hearing, the Member alleged that [redacted] was not entitled to represent her as [redacted] was a member of CUPE and CUPE was not entitled to represent nurses. The panel makes no finding about whether or not that is correct. It is possible, although there is little evidence on the point, that had the Member had another union representative events might have been different. Nevertheless, the fact and the propriety of the Member's chart accesses would remain, and that is the issue before this panel.

[redacted] met with the Member and told the Member that she was being accused of privacy breaches. The two of them then met with [redacted] and one other [redacted] administrator. The Member was confronted with the results of the audit. She admitted that she had accessed her [redacted] chart but denied she had accessed any other charts. [redacted] had the audit with [redacted] and the Member asked to see it. [redacted] said [redacted] could not show it to her as that would be a breach of PHIA.

The Member recalls that the first meeting focused primarily on the alleged chart accesses of patients other than [redacted] She testified that she felt "ambushed".

At a second meeting, the Member was allowed to examine the audit but was not allowed to take a copy from the meeting. She noted that one of the patients whose chart she was accused of accessing had a name similar to one of the Member's own patients. The Member pointed this out to [redacted] and said that it would have been easy to select the wrong patient name from the dropdown list of patients in ACCURO.

At this meeting [redacted] told the Member that [redacted] had proof that the accesses were intentional as there was a two-step process required to access a chart. The Member disputed this and asked for a walk through on ACCURO with a fictional patient so they all could see and agree on how easy or difficult it would be to access a chart in error. The Member's request was denied.

Once again, the Member's recollection was that the emphasis at the second meeting was on accesses of charts of patients other than [redacted].

There was a third meeting. At the advice of [redacted], the Member had obtained a letter from her [redacted], [redacted], saying that she had [redacted] and [redacted] consent to access [redacted] chart. At the third meeting the Member was advised that she was terminated.

On April 9, 2015, [redacted] wrote a letter to the College advising that the Member had been terminated as the result of a number of PHIA breaches, including accesses to [redacted] chart, the chart of a [redacted] doctor, the charts of two [redacted] nurses and the charts of other [redacted] patients.

The Member admits, and has always admitted, that she accessed [redacted] chart, but there is a conflict in the evidence about the number of times this occurred. The IC alleges there were 19 separate accesses. The Member estimates that there were half a dozen accesses, although acknowledged at one point in her evidence that there may have been a few more. In the panel's view, that conflict is not significant.

What is significant, however, is the usefulness of the audit information generally. There was evidence that someone can access ACCURO records using someone else's computer that has not been properly logged out; there was evidence from the Member, unchallenged by the IC, of a bug in ACCURO that permitted a user to gain access to medical records under another user's ID if the other user had used a certain feature to hide or blur the screen contents; there was evidence that it is easy to mistakenly access the wrong medical records when working with ACCURO. We also note that though the audit showed a number of accesses by the Member to a number of different charts and that the Member was originally accused of a number of PHIA breaches arising from those accesses, those accusations have all since been abandoned and the IC has proceeded only on a charge of boundary violations as outlined above. [redacted] testified in [redacted] direct examination that [redacted] itself had removed a number of names from the audit list as [redacted] accepted the Member's explanations. The actual audit obtained by [redacted] was not produced at the hearing and no one with a technical background was called to testify as to the reliability of the audit.

In these circumstances, the panel is unable to find that information in the ACCURO audit about who accessed what medical records, and when and for how long they did so, is a reliable indicator of intentional chart accesses by the Member. With no other evidence to the contrary, the panel therefore accepts the Member's evidence that she did not intentionally access any medical records other than those of her [redacted] and that she likely intentionally accessed that record approximately six times.

The Investigation

In response to [redacted] letter of April 9, 2015, the matter was referred to the IC.

The IC records its considerations and decisions in a document called a "Notice of Decision and Reasons" ("NDR"). The evidence is that an NDR is a "living document", by which is meant that additions are made to it after each relevant meeting of the IC. Presumably, a single complaint normally results in a single NDR. In this case there were three NDRs. The primary NDR is at Tab F of Exhibit 15. It considers the allegations made in [redacted] letter and recommends the matter be sent to the discipline committee. A second NDR is at Tab E of Exhibit 15 and concerns the Member's [redacted]. The third NDR is at tab G of Exhibit 15 and concerns the Member's unwillingness to pay for either the [redacted] ordered by the IC or the cost of a court reporter who recorded the interviews of the Member by the IC's investigator.

It appears from the primary NDR that the IC first met and considered the allegations against the Member on June 23, of 2015. The NDR says that the IC reviewed [redacted]'s letter of April 9, 2015, the Member's response to the letter, and "the investigation report". An entry on this NDR for September 22, 2015, however, explains that the reference to the investigation report was in error and that what the IC had reviewed was just a document summarizing the issues raised by the [redacted] allegations.

At the June 23 meeting, the IC accepted the allegations made in [redacted]'s letter and did not accept the version of the facts set out in the Member's response. The IC decided that the matter did not require a formal discipline hearing but could be dealt with by way of a censure. The Member, had she accepted the censure, would have had to appear before the IC to be censured and would have had her name published together with the allegations that she had accessed multiple charts of people who were not her patients. She would also have been required to pay costs of $1000.00

The Member did not accept the censure. If the Member did not access multiple charts, but only the chart of her [redacted], that is understandable.

When the Member did not accept a censure, the IC continued with a more thorough investigation. In the course of the investigation, the Member was interviewed on several occasions by Mr. Marshall. She testified that she felt intimidated.

The Member wanted a record of what was said and asked that the interviews be tape recorded. Mr. Marshall, in consultation with the IC, denied this request. At a subsequent interview, Mr. Marshall advised the Member that the IC had hired a court reporter to record the remaining meetings, but that it would be done at her expense. The Member testified that she did not agree to paying that expense but felt that if she refused to continue the interview, the IC would find her uncooperative.

The final interview by Mr. Marshall took place in May of 2016. His report was completed and forwarded to the IC in time for its meeting on July 14th. Mr. Marshall's report was marked as an exhibit for identification in this hearing and some parts were later marked as exhibits.

At its July 14th meeting the IC reviewed Mr. Marshall's report and a number of other documents listed in the NDR at Tab F. Up to this point the NDRs at Tab F and Tab E are identical. But now they diverge. The NDR at Tab E continues with a separate issue. That NDR reports on the following decision taken by the IC on July 14th:

[redacted]

That letter of guidance was not filed in this hearing.

Once the [redacted] was resolved, the IC returned to a consideration of Mr. Marshall's report and the allegations made in [redacted] letter of April 9, 2015. At its meeting on October 18, 2016 the IC had directed Ms. Legary to obtain from the Member a copy of an arbitration award the Member had received as the result of a grievance relating to her dismissal from [redacted]. The IC did not receive a copy of that award until June 13, 2017.

The IC met on July 20, 2017 and reviewed a large number of documents that by that point had been collected in its investigation. The record in the NDR for July 20, 2017 notes that the committee had earlier decided only to proceed with respect to the allegations of unauthorized logins against [redacted] and two other individuals, AB and MD. At this meeting, the committee found insufficient evidence to proceed with the allegations concerning either of AB and MD. It also decided not to proceed with an allegation of a PHIA violation concerning the accesses of [redacted] chart. It did find, however, that those accesses of [redacted] chart constituted a boundary violation, contrary to the College guidelines. The IC no longer felt that a censure was sufficient and referred the matter to the discipline committee.

The third NDR is at Tab G of Exhibit 15. That NDR involves the Member's refusal to pay for either the court reporter hired by the IC to record Mr. Marshall's interviews or the [redacted]. In a

meeting held on December 14, 2017, the IC determined that both costs were to be paid by the Member and so advised the Member's counsel.

Issues

The essence of the charge against the Member is that she committed a boundary violation when she accessed her [redacted] chart.

The College has published a policy document entitled "Professional Boundaries for Therapeutic Relationships" that sets out certain expectations for all registered nurses when involved in, and when becoming involved in, a therapeutic relationship. The policy provides that it is inappropriate for a nurse to enter into a therapeutic relationship with a family member unless the nurse first satisfies himself or herself that there are no other options or that all attempts at exercising other options have been exhausted. The policy in effect at the relevant time was marked as Exhibit 17. A copy is attached to these reasons.

The Member admits that she did access the chart, but argues that she was faced with an extremely difficult ethical situation and had no other reasonable alternative in the circumstances. The IC's position is that alternatives were available but the Member did not take sufficient steps to identify and pursue them.

The primary issue in the case, therefore, is whether the Member made a sufficient effort to consider the alternatives before accessing [redacted] chart. During argument, however, other issues concerning the wording of the policy were addressed by the parties. The issues to be determined, therefore, are these:

1. Can entering into a therapeutic relationship be a boundary violation within the meaning of the policy?
2. If so, can entering into a therapeutic relationship be a boundary violation within the meaning of the policy even if the client's needs are the focus of the relationship?
3. Did the Member become involved in a therapeutic relationship with [redacted]
4. If so, was it avoidable?

Decision

Is entering into a therapeutic relationship a boundary violation within the meaning of the policy?

The boundaries to which the policy refers are the boundaries that are appropriate in a therapeutic relationship. Is it appropriate, therefore, to speak of a "boundary violation" when someone enters into an inappropriate therapeutic relationship. Arguably, the problem is not that a boundary of that relationship has been crossed, but that the relationship should not have been entered into at all.

Despite the grammatical appeal of such an argument, the policy lists certain specific acts that may amount to boundary violations. One of them is "Entering a Therapeutic Relationship with Family, Friends or Acquaintances". It is clear, therefore, that entering into such a relationship can amount to a boundary violation as that phrase is used in the policy.

Can entering into a therapeutic relationship be a boundary violation within the meaning of the policy if the client's needs are the focus of the relationship?

The policy does not say that *all* therapeutic relationships with a family member are boundary violations. The question still remains, therefore, as to whether, if the Member had a therapeutic relationship with [redacted] in this case, it amounted to a boundary violation. It would not be a boundary violation, of course, if it was unavoidable. That is a separate issue that is discussed below. There is another issue, however, that needs to be considered first.

The policy has a section headed "Boundary Violations". The first sentence of that section reads: "A boundary violation occurs when the client's needs are no longer the focus of the therapeutic relationship." The section then goes on to list examples of potential boundary violations, including entering into a therapeutic relationship with a family member. When the section is read as a whole, are we to conclude that a therapeutic relationship with a family member can only be a boundary violation if the client's (family member's) needs are not the focus?

The panel has considered this issue and does not believe a lack of focus on the needs of the family member is a necessary condition for a boundary violation. The section lists three other possible boundary violations: accepting gifts from clients, disclosing irrelevant personal information to a client, or commencing a social relationship with a former client. In each of these instances a nurse client relationship already exists or has existed. In those cases, it may be that a loss of focus on the interests of the client is a necessary component of a boundary violation. But it would not, in the panel's view, be a sensible interpretation of the policy to find that a therapeutic relationship with a family member is not a boundary violation unless the nurse does not have the client's best interests in mind. It is a boundary violation to enter into *any* therapeutic relationship where the interests of the client are not the focus. That being so, there would be no need to have a separate category of boundary violation for entering into a therapeutic relationship with a family member, if that also required that the interests of the client were not the focus.

In the panel's view, the policy makes it clear that entering into a therapeutic relationship with a family member is fraught with potential conflicts of interest, and that is so even when a nurse enters the relationship only with the best of intentions and only thinking of the best interests of the client.

Did the Member become involved in a therapeutic relationship with [redacted]?

The policy appears to define a "therapeutic relationship" as "a planned, goal-directed and contractual connection between a registered nurse and a client for the purpose of providing care to the client in order to meet the client's therapeutic needs." An issue was raised in argument as to whether accessing [redacted] medical chart falls within this definition.

Upon consideration, the panel does not believe that this statement is intended to be a definition of "therapeutic relationship". Instead, it appears to be a statement of what the goal of a therapeutic relationship should be, or perhaps of what an ideal therapeutic relationship is. If it were otherwise, a nurse whose actions were not intended to meet a client's therapeutic needs could claim that she therefore wasn't in a therapeutic relationship and therefore couldn't be guilty of a boundary violation. But as we have already seen, failing to focus on a client's therapeutic needs is often the very essence of a boundary violation.

The panel has also considered the use of the word "contractual" in the policy. Even if the statement in which the word occurs is not intended as a definition, does the use of the word nevertheless suggest that a contract between nurse and patient is a necessary element of a therapeutic relationship? First, the panel does not interpret "contractual" in this

context to refer to a relationship that satisfies all of the legal formalities for a binding, legally enforceable agreement. Instead, the panel understands the word to refer to a consensual relationship, where both parties understand that the nurse has agreed to provide care and the patient has consented. That would include the relationship between the Member and [redacted] and [redacted]. Secondly, the panel is of the view that even this limited type of contract is not a necessary condition for a therapeutic relationship. If it were, it would be a defence to a boundary violation that the patient hadn't consented to the nurse providing care. Lack of patient consent ought not to be a defence to a charge of nursing impropriety.

The panel is of the view that a "therapeutic relationship" as that phrase is used in the policy is simply a nursing relationship – one in which a nurse provides nursing care or has agreed to provide nursing care to a patient. In this case, the Member agreed with [redacted] and [redacted] to reschedule an appointment and to review the chart and advise them of certain test results. Ms. McPherson, called as an expert witness by the IC, testified that activities such as scheduling an appointment and reviewing and reporting on tests did constitute the provision of care. The panel agrees with that conclusion. In the panel's view, the notion of providing care must be given a broad interpretation in the policy in order that it achieve its stated goal of ensuring "that the public receives safe, competent and ethical nursing care". The Member accessed [redacted]s chart in her capacity as a nurse. She only had access to the chart as the result of her being a nurse. In the panel's view that is sufficient to create a therapeutic relationship.

Was the therapeutic relationship avoidable?

As noted above, this was the primary issue raised in argument. The Member argues that, although she accessed [redacted] chart and although she knew that in most circumstances doing so would be improper, the situation she faced in this case was an exceptional one that justified her actions.

The Member believed that her [redacted] was "falling through the cracks". She believed that [redacted] should have provided her with outreach nursing care but didn't do so because the Member was the only outreach nurse on staff. She explained that she acted as she did because she felt doing so was in the best interests of [redacted] and that acting in the best interests of every patient at [redacted] outweighed any duty she had to respect therapeutic boundaries.

The Member called Dr. Jones-Bonofiglio as an expert witness, with expertise in nursing ethics. Dr. Jones-Bonofiglio testified that given there were no practical alternatives, the Member's actions were required in order to safeguard [redacted] interests and were therefore permissible.

The IC acknowledges that a nurse can enter into a therapeutic relationship with a family member if there is no alternative. It submitted in argument, however, that the Member did have alternatives in this case but failed to pursue them.

The panel agrees with the IC that the member had alternatives that she failed to pursue.

When the Member asked to have her [redacted] admitted to [redacted], she should have been aware of the potential for conflicts and should, at the very least, have considered how she would handle them. When the Member was warned by [redacted]. [redacted] to keep at arm's length, she again should have considered how she would respond if circumstances tempted her to intervene in [redacted] care.

When the Member did become concerned that [redacted] was "falling through the cracks" she had a number of options available to her, as testified to by witnesses called by the IC:

- There were other nurses at [redacted] whom [redacted] testified would have been able to do outreach nursing for [redacted] When asked why she did not speak to another nurse, the Member said she did not think it was appropriate for her to do so. The panel does not agree.
- When nurses have an ethical or practice dilemma there are resources at the College the nurse can access. The Member testified that she had consulted with the College about other issues in the past. She could have done so in this case, but chose not to do so.
- Home Care services could have been requested, but this was not pursued.
- Finally, before becoming involved in [redacted] care, the Member, at the very least, ought to have spoken with [redacted], her immediate supervisor. In fact, on cross-examination, the Member admitted that that was something she ought to have done.

In these circumstances the panel is satisfied that the Member had a number of possible alternatives to becoming directly involved in [redacted] care. We find, therefore, that by accessing [redacted] chart the Member committed a boundary violation.

"Professional Misconduct", as that phrase is used by the College is explained in the College's bulletin titled "Discipline Definitions":

> "Misconduct" is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standards of propriety may be found by reference to rules or to standards ordinarily required to be followed by a RN in the particular circumstances. "Misconduct" is qualified by the word "professional" which links the misconduct to the practice of registered nursing.

The panel is satisfied that the boundary violations of the Member satisfy these criteria. The panel therefore finds that the charge of professional misconduct has been proven.

Disposition

Both the Member and the IC have provided written argument concerning the appropriate disposition, including what would be an appropriate award of costs. The IC asks for a three month suspension and costs of $75,000. The Member argues that past cases of nurses accessing medical records without authorization have resulted in a censure and costs of $1000. In the panel's view, these positions represent the extremes and the correct disposition lies somewhere between them.

Penalty

The panel agrees with the IC that the boundary violation in this case requires some form of denunciation. The panel also agrees with the Member, however, that there are a number of mitigating factors that must be considered.

- The Member has no prior disciplinary record
- The Member has a 25 year history of good character and nursing excellence
- [redacted]
- The Member was never motivated by anything other than her [redacted] best interests

- The Member's [redacted] and health services proxy both consented to the Member's conduct in writing, albeit after the fact.
- There is no evidence of any harm to her [redacted] as the result of the Member's actions.

The Member has also argued that she has always accepted responsibility for her chart accesses. But with this submission, the panel does not entirely agree. It is true that the Member has always admitted to the chart accesses proven in this hearing, and that is a consideration in her favour. However, the panel received the distinct impression that, despite admitting to the breaches, the Member has never accepted or understood that she did anything wrong. In addition, the panel notes that the Member was cautioned by her supervisor not to become involved in her [redacted] care and was specifically cautioned by Dr. [redacted] after [redacted] found out the Member had accessed her [redacted] chart. Yet, despite these warnings, the Member's conduct continued. All of this, in the panel's opinion, demonstrates a significant lack of insight that calls for more than just a censure or reprimand.

The parties submitted copies of other decisions on the question of an appropriate penalty. The panel found the cases helpful but all of them involved different circumstances. *College of Nurses of Ontario and Manpreet Dhaliwal* is a report of a decision of the Discipline Committee of that college that involved a nurse improperly accessing medical records. That case, however, appears to have involved PHIA breaches and the people whose records were accessed had not provided their consent.

The member has provided three authorities – all of them records of censures by the College. Those cases, in the panel's view must be distinguished as censures involve a nurse taking responsibility for her actions and the panel has found the Member has not done so in this case.

Having considered the parties submissions, it is the panel's decision that the Member should be suspended for two months, effective immediately, and that she should successfully complete a remedial course of at least eight hours on appropriate boundaries in a medical context. The course should be one approved by the College, taken at the Member's expense, and be completed by the end of 2019.

Costs

The IC seeks reimbursement of $75,000 in costs. It has advised the panel that its total costs were approximately $250,000. This figure includes the fees charged by counsel to the IC for the hearing but apparently does not include costs, not directly attributable to the IC, that were paid by the College for the hearing, such as the cost of renting hearing space, the cost of the panel's legal counsel, and so on. The panel does not dispute that costs in that amount were incurred. Nonetheless, it is of the view that an award of $75,000 for costs would be excessive.

In this case, the panel notes the following:

- Although the Member was offered a censure at an early stage, the censure that was offered required her to admit to facts that the IC has not proven. She was never offered a censure for the matters to which she admitted and that were proven at the hearing.
- The IC argues that the Member's conduct has been inappropriate and has resulted in much of the delay in resolving this matter. The panel accepts that the Member's conduct was responsible for some of the delays but notes that [redacted]

[redacted]

- The Member has already spent over $50,000 on legal fees and other related expenses. She lost her job and had been without work for a period of time. An award of $75,000 would likely be an extraordinary burden on her. If the panel were to award costs of $75,000 in this case, nurses in future cases who do not agree with a position taken by the IC, might be afraid to have their matter decided by the discipline committee. In the panel's view, that would not be in the public interest.

In the circumstances, the panel awards the IC costs in the amount of $15,000. The Member is given two years, from August 1, 2019 to pay.

DATED at Winnipeg, Manitoba, the 9thth day of July, 2019.

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Brian Crawford, RN, Chair

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Lydia Harris, RN

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Jennifer Colvine, RN

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Doug Simpson, Public Representative

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Quinn Menec, Public Representative