The Disciplining (Professional Conduct) of Registered Nurses' in British Columbia from 1918 to Present Day: An Historical Inquiry

by

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B.H.S. (N), Open University, 2000
A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

MASTER OF NURSING

in the School of Nursing

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University of Victoria

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ABSTRACT

This thesis is an historical inquiry into the evolution of the disciplinary process of the Registered Nurses Association of British Columbia (RNABC). The idea for the inquiry was born out of the researcher’s personal experience with the disciplinary process, which led her to a desire to unravel “how things came to be the way that they are”. The researcher was particularly interested in the influence of socio-political, economic, moral, ethical, and legal contexts on the evolution of nursing disciplinary processes over time.

The research begins with a brief overview of nursing evolution up to 1975, when the first formal hearings were held by the RNABC. Detailed analysis is undertaken between 1975 and 1996, which is the time period during which the RNABC’s Professional Conduct Committee held formal hearings of nurses charged with misconduct. The analysis ends with a brief discussion of the development of the Consensual Resolution Process, which is an informal negotiated alternative to the formal disciplinary process, introduced by the RNABC in 1997.

The research concludes with a series of recommendations for the future of nursing discipline in British Columbia. These recommendations consider the continuing evolution of the disciplinary context in nursing in B.C. In 2003 the provincial government passed legislation that removed regulatory authority, and hence responsibility for discipline from the RNABC. Instead this power is given to a new body, the College of Nurses, under the Health Professions Act. The recommendations presented in conclusion of the thesis take into account the insight gained into the power struggles over the disciplinary process, the problems associated with procedural fairness and natural justice, as well as the changing regulatory context currently unfolding under the Health Professions Act.
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Acknowledgements:

Many people have supported me and contributed to make this thesis possible. To the British Columbia History of Nursing Professional Practice Group, a big thank you for their scholarship award.

I would like to thank my husband Dave, for his patience, support, encouragement and understanding, not only through the writing of this thesis, but also through the preceding six years while I was involved in the RNABCs disciplinary process. Dave was right when he said that we did not want to be sitting in our rocking chairs when we were 90 years old saying “we wish we had appealed the decision”. Given the fact that we knew I would have to appeal the decision of the Board of Directors of the RNABC to the Supreme Court of British Columbia unrepresented.

To my children Andrea, Bryan and Kevin all assisted in my thesis research in their own special ways. I am grateful to Andrea for her expert computer skills, endless hours of reference formatting and her talent for organizing copious research materials. I am indebted to Bryan for helping keep my spirits up with his keen insight and insane sense of humour, which helped me to laugh at myself and the world when I got too serious. The backrubs p.r.n. were also greatly appreciated. Finally, Kevin provided endless cups of tea and gummy bears, cookies and chocolate, as well as more backrubs (when he wasn’t fighting with his brother!!!), which assisted with my sanity, if not my waistline.

Carol has been a close ally throughout the writing and researching of my thesis, as well as during the years of hearings and appeals. I sometimes wonder whether she knows the material better than I, after reading over edits and re-edits so many times. Her willingness to “be vented at” and remain solidly confident that I would indeed finish was invaluable and helped me to reach the finishing line.

Finally, I turn to the Paddy, Colleen and Mary Ellen, my supervisor and committee members who patiently guided my transformation from a non-writer to a successful graduate student. I have always been a pragmatic and action oriented woman and regarded writing as something that was unnecessarily time consuming – at least for me, as I believed I was not good at it. I am thus grateful at Paddy for her continual
encouragement that I was not such a bad writer and that I could write a thesis and for her guidance along the way. Her patience in reading and re-reading many drafts of a very voluminous thesis and continuing to provide constructive feedback was very much appreciated. Colleen, kept my spirits up with her directness and her sense of humour (I will be framing the doodle of Gumby paragliding!). I very much appreciated her frankness in critiquing and affirming my work. For Mary Ellen, my initial incomprehension of many theoretical issues must have been very challenging and I appreciate that she stayed with my work and continued to address issues that she believed to be important. I am pleased that, in the end, our different viewpoints on history were able to strengthen the final thesis, by forcing me to address issues I might otherwise have omit
Dedication:

I dedicate this thesis to my father, Donald Edward McIntyre, and my mother, Shirley Elizabeth McIntyre, who both died in 1995, at the outset of my disciplinary process with the RNABC. It was their insistence that “the truth will always comes out in the end” that kept me going through the long years of hearings and court processes and helped me to have faith in what I was doing during the “darkest moments”.

There are moments when one is embroiled in such a long and arduous process when it appears that there is no “light at the end of the tunnel”. However, now that all of the court processes are complete I have been able to integrate my experiences and I finally understand what my parents meant by “everything happens for a reason”. From what initially appeared to be a travesty of justice, I was able to create a significant court decision to benefit all nurses and practicing professionals in Canada. My years of Masters research have also enabled me to refine my understanding of the nursing disciplinary process and “how things came to be the way that they are”. From this I believe I have gained powerful tools to teach the nurses of the future the importance of ethics and disciplinary issues. I further believe that by example I teach that we don’t have to simply accept injustice, but rather by standing up for what is right we can produce change for a better tomorrow.

I thank my parents for giving me the strength to make something worthwhile from what initially appeared to be an insurmountable challenge. I have come through the experience a stronger, more capable and wiser woman.
CHAPTER ONE:
BACKGROUND TO THE PROBLEM AND THE PROBLEM STATEMENT

The world stands upon three things:
Upon truth.
Upon peace.
Upon justice.
Speak truth each to the other, establish peace, and render honest justice in your gates (Zechariah 8:16 in Shapiro, 1993, p. 19).

In this thesis I discuss the evolution of the process of disciplining nurses in the Province of British Columbia. I am particularly interested in the period between 1975 and 1996, when formal disciplinary hearings were held in front of the Professional Conduct Committee of the Registered Nurses Association of British Columbia (RNABC). I found that in order to place this period in its proper historical context, I needed to also understand the development of discipline in Canada from the early years of colonial settlement to the present era. I am interested in exploring the history of the disciplinary process because I believe that a better understanding of the forces that have influenced the process can help us to comprehend how things have come to be the way that they are, and to point out potential paths for the future. Past, present, and future knowledge are required to plan how effective change can be enacted (Ashley, 1978; Austin, 1958; McPherson, 1996; Ogren, 1994).

My interest in nursing discipline began in 1994 when I received a notice from the RNABC that my own nursing practice was under investigation. Between 1994 and 1999 a great deal of my life was consumed with a Nursing Professional Conduct Committee Inquiry and subsequent Appeals to the Board of Directors of the RNABC and then to the Supreme Court of British Columbia.\(^1\) During the years that I was involved in the RNABC's

\(^1\) See Appendix I for complete details of my case.
disciplinary process, my focus was on understanding the legal processes and in planning how
to defend my case. This focus made it difficult to comprehend the wider context, including
the related politics and implications of the process in which I was an active participant. It
was not, in fact, until very late in my appeal when the British Columbia Nurses Union
(BCNU) applied for intervener status that the wider context began to become more evident in
my case. Intervener status was requested by the BCNU as they felt that it was important to
show their support for my case, as in the words of the BCNU they “represented some 23,000
nurses” (“Milner v. Registered Nurses Association, Vancouver (unpublished) Registered
Nurses Association, dated August 28," 1997), and thus had a vested interest in the outcome
of my appeal. BCNU’s interest in my case alerted me to the fact that the issues I was arguing
had been ongoing between the two organizations for several years.

Once the guilty verdict had been overturned by the Supreme Court of British Columbia,
my case finished and the costs paid, it seemed that my involvement was complete. However,
because of my experiences I came into contact with a number of other nurses who were
facing disciplinary processes, as I myself had done. These nurses shared their stories and I
began to see that there was a continuation of disciplining nurses that changed with the
prevailing social ideology and current political fashion, but also retained other characteristics
over time. I became interested in understanding the interplay between the different forces that
influenced--and continue to influence-- the nursing disciplinary process. Consequently, my
thesis has been a journey with the expressed goal of gaining insight into how the RNABC’s
disciplinary process has evolved in relationship to the social, moral, ethical, legal, political,
and economic forces which have acted historically on the RNABC.
It is my belief that it is imperative to better understand the past in order to more clearly anticipate future possibilities. This is most important now at a time when the RNABC is undergoing the most dramatic and far reaching metamorphosis since it was founded. This metamorphosis is being caused by the rescinding of the *Nurses (Registered) Act*, and subsequent formation of the College of Nursing (Epstein, 2000; Registered Nurses Association of British Columbia, 1995a, 1995b, 1995c; Seaton, 1999). At the time of writing this thesis, the B.C. provincial legislature has passed first reading to repeal the *Nurses (Registered) Act* and replace it with the *Health Professions Act*. The implementation of the *Health Professions Act* will directly affect the disciplinary process as it now is, as well as numerous other functions of the RNABC (Registered Nurses Association of British Columbia, 2003b).

My involvement in my own case made me acutely aware of inequities in the quasi-judicial process of administrative law tribunals, specifically in relationship to the nursing profession. These inequities occur despite the B.C. court previously stating that, "It is acknowledged that in the case of professional disciplinary proceedings, the courts have held that such tribunals must adhere to a high standard of natural justice" ("Milner v. Registered Nurses Association of British Columbia Vancouver, A972468 (unreported), Vancouver, B.C., December 9," 1999, para 5). While undertaking research to support my own defence, I came across a number of cases similar to my own. It seemed my case was far from the

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2 Quasi-judicial - Refers to decisions made by administrative tribunals or government officials to which the rules of natural justice apply. In judicial decisions, the principles of natural justice always apply. But between routine government policy decisions and the traditional court forums lies a hybrid, sometimes called a "tribunal" or "administrative tribunal" and not necessarily presided by judges. These operate as a government policy-making body at times but also exercise a licensing, certifying, approval or other adjudication authority which is "judicial" because it directly affects the legal rights of a person. Some law teachers suggest that there is no such thing as a "quasi-judicial" decision or body; the body or decision is either judicial or not (Duhaime, 2002 available at www.duhaime.org/lawfirm.htm).
exception. As I investigated further, I became interested in documenting what has happened (and is happening) in administrative tribunals investigating discipline in nursing today. Reflecting on my own case and on the evidence I was accumulating, I became increasingly interested in how nurses are treated in disciplinary processes. My own experiences led me to believe that they were not being treated fairly, though I realise this assessment was coloured by my own experience. I became interested in the whole array of factors that potentially contribute to the way disciplinary processes unfold. I tried to identify where the apparent unfairness was occurring and why. This caused me to step back to look at the evolution, as well as the current state of the disciplinary system. I continue to be interested in how disciplinary actions might be improved for the benefit of individual nurses, the profession, and the public.

I believe that a clearer understanding of how the system works is an important step on the path to improving the way that discipline is handled in nursing, other health care professions, and all other groups' adherent to quasi-judicial processes. It is through the development of a more solid and integrated understanding of the evolution of the Registered Nurses Association of British Columbia’s Professional Conduct Inquiry Process - from its inception to the present - that the existing situation can be understood. Therefore, the inquiry undertaken in this thesis is an exploration of how disciplinary processes came to be

3 Discipline can be defined as:
1. punishment
2. obsolete, instruction
3. a field of study
4. training that corrects, moulds, or perfects the mental faculties or moral character
5a. control gained by enforcing obedience or order
5b. orderly or prescribed conduct or pattern of behaviour, self-control
6a. rule or system of rules governing conduct or activity (Merriam-Websters Dictionary, 2000). My initial understanding of discipline was as per this definition, but broadened through my inquiry. I will return to this discussion regarding the notion of discipline again at the close of my thesis.

4 By evolution, I mean, a process which is non-linear, not always rational, influenced by social and political context, yet still moving forward in time.
conducted the way they are today, and to offer some comments on the implications I see for the future development of disciplinary processes.

A full assessment of disciplinary fairness is beyond the scope of this thesis, although it is an area which should be the subject of future examination. Nonetheless, on the basis of my analysis I believe it will be possible to make tentative recommendations regarding directions for improvement in the professional conduct processes in the future. In addition, the research in this thesis has relevance to the effective future implementation of professional conduct for advanced practice nursing and other self-regulating health professions which are currently being (or have previously been) licensed in the health care system.

Scope and Objectives of the Study

My primary goal in this thesis is to develop a clearer understanding of the historical development of the Professional Nursing Conduct Inquiry Process in British Columbia as it has evolved over time. More specifically, my objectives will be:

1. To survey the evolution of the Professional Conduct Inquiry Process in relationship to relevant social, moral, ethical, legal, political and economic history.

1.1 To sketch out a chronological perspective of the historical development (social, political and economic) of the disciplinary process in nursing in BC.

1.2 To incorporate an overview of the legal system, and the application of administrative law in parallel with the disciplinary processes.

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5 Advanced Practice Nursing (ANP) is an umbrella term. It describes an advanced level of nursing practice that maximizes the use of in-depth nursing knowledge and skill in meeting the health needs of clients. In this way, ANP extends the boundaries of nursing's scope of practice and contributes to nursing knowledge and the development and advancement of the profession (Canadian Nurses Association, 2000, p. 1).
1.3 To highlight the moral/ethical 6 dimensions of the profession and more specifically of the Association in relation to disciplinary processes.

2. To comment on the impact, significance and fairness of the Professional Conduct Inquiry Process as it has evolved over time.

3. To comment on the future, including potential directions for professional disciplining in nursing.

My secondary goal will be to illustrate the application of historical methods to inquiry in nursing. I have found that historical methods have greatly enriched my inquiry in this thesis. Indeed, I have been interested to note that Church (1987) suggests the study of history has the ability to discover one’s identity. Along a similar vein, Ashley (1976) suggests that “…nursing history is women’s history and that…..women and their accomplishments have been virtually invisible”. The invisibility of women in history is further supported specifically in relationship to the invisibility of nurses’ work (Rodney & Varcoe, 2001). Without a clearer understanding of where we have been and the trials and tribulations we have overcome, a number of commentators suggest that, as a profession, we will retread our mistakes (Ashley, 1978; Ogren, 1994). I believe that any such re-treading will prolong a much overdue recognition of our professional status, and thus recognition of our autonomy in nursing.

Historical methods have helped me to appreciate changes in our profession over time. I have learned that the profession has experienced many fluctuations in its social status from the early days when nurses were independent (unlicensed) practitioners (Coburn, 1988; McPherson, 1996). Traditionally, in most cultures, women performed the autonomous role of healer and especially worked in the fields of childbirth and nursing the dying. Under expanding church control of societies the religious orders took on much of this role, and thus

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6 The term moral/ethical is defined in footnote number 26.
the religious orders were initially an attractive vocation for educated women (Canadian Nurses Association, 1968; Gibbon, 1947; Gibbon & Mathewson, 1947; Kerr, 1986). As nursing passed into secular society, it initially retained some of this independence, particularly where it followed directly from the religious nursing tradition. The first trained nurses arrived in Canada in the early 1600s, as a result of a request from the Jesuit missionary fathers. These nurses were from Europe and were nuns (Canadian Nurses Association, 1968; Gibbon, 1947; Gibbon, & Mathewson, 1947; Kerr, 1986). Thus, the first nursing uniform in Canada was the nun's habit (Canadian Museum of Civilization Corporation, 1997). The nuns epitomized the “angel of mercy” image of the nurse, portrayed “as noble, moral, religious, virginal, ritualistic and self-sacrificing” (Kalisch & Kalisch, 1988, p. 7). The first Canadian nursing sisters were therefore heirs to traditions imposed by a strict monastic system (Canadian Nurses Association, 1968; Gibbon, 1947; Gibbon & Mathewson, 1947; Kerr, 1986). The Victorian mores, which accompanied the Nightingale school of nursing, saw the profession become fully subservient to the male-dominated medical profession (Coburn, 1988; Kalisch & Kalisch, 1988; Nightingale, 1911, 1954a, 1954b, 1954c, 1954d, 1954e, 1992). From this juncture onward, there have been continuous waves of struggle for increasing autonomy in nursing practice. The struggle began with the push for registration

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7 The first nurse on record (Canadian Nurses Association, 1968) was Marie Rollet. Although untrained, she was the wife of a surgeon, Louis Herbert, and they arrived in Canada in 1607 (Canadian Nurses Association, 1968; Gibbon, 1947; Gibbon, & Mathewson, 1947; Kerr, 1986).

8 Nuns provided daily medical assistance to all members of the community, including long-term care for the chronically and mentally ill, and help for the poor, the old, the orphaned, and the abandoned (Canadian Museum of Civilization Corporation, 1997).

9 Having, relating to, or characteristic of a monastery. Used often of monks and nuns. Resembling life in a monastery in style, structure, or manner, especially, Secluded and contemplative. Strictly disciplined or regimented. Self-abnegating; austere (Merriam-Webster Dictionary, 2000).
and continued with the endeavour for improved hours and working conditions. This finally resulted in the formation of the nursing unions (Goldstone, 1981).

The current position of nurses as specialists and managers working in collaboration with doctors - and indeed the development of the nurse practitioner professions - represents a trend toward a return to independent (licensed) professionals (Goldstone, 1981; Ogren, 1994; Registered Nurses Association of British Columbia, 2003f, 2003g). I believe that the future holds opportunity and autonomy and thus ‘professionalism’. And with this opportunity comes the responsibility to regulate ourselves in a responsible and professional manner in accordance with the principles of administrative law.

Significance of the Study

So, why is the subject of ‘professional discipline’ important to nursing as a profession? Professionalization is the process by which an association moves towards a specialized form of control (Aydelotte, 1982; Coburn, 1988; Kerr, 1944). With organization as a profession come the responsibility and the legislative grant to regulate or ‘police’ ourselves. It is paramount that nurses and other health professionals begin to understand the historical development of professional disciplining so that we can move forward in terms of transparency and equity. By their very nature, disciplinary actions challenge a nurse’s identity and integrity as a professional. As such, they are highly contestable and inherently difficult to live through. For this reason it is essential that the discipline process be the most equitable and transparent possible. Self-regulating professions have been given limited power and authority to ‘police’ their own members. For example, the RNABC must act within the parameters of the Nurses (Registered) Act. The Association cannot exercise authority which has not been granted to it by law as it would be acting outside its
jurisdiction\textsuperscript{10}. Despite the fact that the \textit{Act} gives the Association legal right to make Rules, these rules cannot be ultra vires \textsuperscript{11} or inconsistent with the \textit{Canadian Charter of Rights and Freedoms}. These constitutional rights, which must be afforded to all, provide the framework for the democratic process in Canada (Gibson, Murphy, Jarman & Grant, 2003).

The disciplinary process in nursing has been, throughout its history, initiated by way of written complaint, although it is not required to be so (Registered Nurses Association of British Columbia 2003a, 2003d). The complaint generally concerns the conduct, ethics or practice of an individual nurse. Resolution is obtained by following the procedures established by the Association. If a complaint is substantiated, common outcomes include rehabilitation mechanisms, temporary or permanent restrictions on registration, and termination of registration and thus rights to practice. The severity of the sanctions to individual nurses and the balancing of this with the responsibility of the Association to protect the public have presented the RNABC with considerable challenges in developing a functioning discipline process. These are described in more detail in the following chapters.

It is my firm belief that this area of study is of significant importance to our professional conduct and, by extrapolation, to the profession itself. Confidence in professionals is an important issue in 21st century society. The public must be able to trust those who are trained to exercise their professional judgement both ethically and competently, and must be assured that those who do not practice within standards of practice will be sanctioned.

\footnotesize
\textsuperscript{10} The consequence of acting outside their jurisdiction can be serious and the RNABC could lose their right to act, if they proceeded. See Milner v. RNABC, Decisions and Reasons dated February 14, 1996, p. 2.

\textsuperscript{11} Ultra vires - Without authority or inconsistent with the over riding legislation. An \textit{Act}, which is beyond the powers or authority of the person or organization. See Bishop v. College of Physicians and Surgeons, (1995) 65 B.C.L.R. 315 and (1996) 26 D.L.R (4th) 15 (B.C.C.A.).
Presently, the health care professions suffer from a high incidence of litigation (Black, 1996; Hurlburt, 2000; Keatings, 2000). Increasing caseloads and patient acuity, and worldwide recruitment issues (i.e. a shortage of skilled professionals), all increase pressure on health care professionals and the health care system (Registered Nurses Association of British Columbia, 1999a, 2000e; Rodney & Street, 2004; Voelker, 2001). An unfair disciplinary process can only exacerbate these pressures and negatively affect the morale of nurses. Furthermore, every trained nurse who leaves the profession or is banned from practising incurs a huge financial loss to our society. Of course, nursing’s commitment to the public means that incompetent nurses should be sanctioned, disciplined, or re-educated to protect the public, but I believe this must be carried out in a way that rehabilitates as many nurses as possible. Thus, changes to the disciplinary process must be carefully designed, carried out and evaluated with the need for rehabilitation in mind.

**Relationship to Previous Research and Literature**

Nursing discipline, and in particular the history of nursing discipline, is an area of study that seems to have received surprisingly little academic attention (Abdellah & Levine, 1986; Christy, 1975; Glass, 1989). This may be due to the complexity of the issues or the general stigma attached to them. Thus, the subjects of professional misconduct, unethical behaviour, or fitness to practice remain “behind closed doors” (Le Duke, 2000). Indeed, in an extensive bibliographical search, I have found little material directly related to the application of nursing discipline in British Columbia or elsewhere. Furthermore, my literature review has uncovered no research in Canada that has focussed on this area. There is some limited research in the United Kingdom, Australia and in the United States of America on nursing discipline, but this research relates to legal concepts that have some fundamental differences with the Canadian system. Moreover, this other research does not employ historical
methodologies and frameworks. In my discussions with nursing professionals who have an interest in nursing history, it has been suggested that the lack of historical analysis of nursing discipline is related to the difficulty in obtaining many of the documents necessary to undertake research in this area. Problems in accessing data more generally are also discussed in the nursing literature (Austin, 1958; Christy, 1975; Firby, 1993; Lusk, 1997; Matejski, 1986; Newton, 1965; Ogren, 1994; Sarnecky, 1990; Sorensen, 1988; Thompson, Mahwah & Erlbaum, 1998).

A scarcity of previous research in the primary area of professional disciplining has been a concern for me as I have conducted this thesis, and I have consequently been forced to expand my search to indirectly related literature. This indirectly related literature has included administrative law, professional disciplining in other healthcare professions, legislative history, general nursing history, nursing administration, and ethics. This expansion has, for one, provided me with insight into disciplinary trends in other professions. Because they are related through a common legal system, other professions tend to parallel trends in nursing discipline. Secondly, the literature concerning nursing administration and ethics has allowed me to access the prioritization of ethical and logistical strategies used to address disciplinary-related issues in the past. Thirdly, I have noted that the issue of professional and organisational ethics as it relates to professional disciplining and quasi-judicial hearings are untouched in B.C. nursing history. The most probable explanation for this is the difficulty in obtaining documentation. Another possibility could include nurses’ reluctance to come forward and speak about their experiences, as the matter of misconduct is largely taboo (Le Duke, 2000). While, as I have argued, there is a dearth of literature addressing the specific area of professional nursing discipline history in B.C. and Canada, our colleagues in the
United States and Great Britain have begun to look at disciplinary issues more extensively. Their examinations include the balance of power between the professional nursing association and the nurses it represents, as well as the emotional, financial and legal struggles of the individuals involved.12

Many of the international authors have focused their research within their own geographical jurisdiction. These findings are not always applicable to the Canadian context because of significantly different legal systems. As well, most studies concentrate on the present, as opposed to looking at the historical development of the disciplinary process. Fortunately, there are nurse historians in Canada and elsewhere who have done work in the general area of nursing development and regulation (Beardwood, 1999; Bryant, 1999; Du Gas, 1999; McPherson, 1996; Nelson, 1999b, 2002a; Rankin, 1997; Stinson, 1992; Stuart, 2002), and who have compiled historical narratives of nursing in British Columbia and Canada. These narratives provide much of the background for the more focussed history of nursing discipline presented in this thesis.

The work of other authors, who have focussed on areas more tangentially related to my research, will be woven into the narratives in Chapter Three. For instance, these authors write about schools of nursing (Zilm, 1996; Zilm & Warbinek, 1994), educational growth (Registered Nurses Association of British Columbia, 2000b, 2000c, 2000e; Warbinek & Fitzpatrick, 1997, Zilm & Warbinek, 1994), community health (Registered Nurses Association of British Columbia, 2000d, Warbinek & Fitzpatrick, 1997) and psychiatric care (Registered Nurses Association of British Columbia, 1990a, 2000c, 2000h). The contributions of all these authors are important in gaining insight into the development of

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nursing, and more specifically nursing disciplining, in British Columbia. I also located another body of historical nursing research focused on specific time periods, such as the Boer War (Blais, 2001), or bibliographical work honouring the pioneers of nursing (Registered Nurses Association of British Columbia, 1990a, 2000b, 2000c, 2000i, 200k). These latter accounts, however, say nothing specific about nursing discipline and were only used to provide contextual data for the narrative in this thesis.

The research proposed for this thesis will therefore encompass literature from Canadian legal history, history of the Canadian health care system, administrative law, nursing (organizational and administrative ethics), the history of the British Columbia Nurses Union, and the written works of several nurse historians worldwide. This will allow me to articulate the evolution of disciplining nurses in B.C. as it unfolded over time. Because it draws on detailed primary data from the RNABC disciplinary hearings, I believe that the primary data uncovered will provide an adequate research base for my endeavour to gain an understanding of previously uncharted territory.

**Profile of the Study**

The main focus of the thesis is the development of the disciplinary process between 1975 and 1996. However, I begin the narrative in Chapter 3 by describing the process by which nurses became a recognized professional body in 1918 to provide some context for my study. Some initial context concerning the pioneer nurses in Canada and British Columbia has also been included earlier as a prelude, which give supporting background to the narrative. In the remainder of Chapter 3 and in Chapters, 4, and 5, I continue with my more focussed inquiry. This includes a review of the first formal Professional Conduct Inquiry in 1975. I then explore a subset of subsequent hearings in the period up to the last hearing in 1996 for the purpose of gaining an insight into the evolution of the disciplinary process (see Appendix II
for a table summarising the important highlights in each chapter). Altogether, throughout the chapters my narrative addresses the first thesis objective of surveying the evolution of the Professional Conduct Inquiry Process in relationship to social, moral, ethical, legal, political and economic history. The analysis I have included in my narrative provides information about the impact, significance, and fairness of the Professional Conduct Inquiry Process as it has evolved. My narrative also provides a foundation for later comments on the potential future for professional disciplining in nursing. The thesis is presented as six distinct, yet cohesive chapters. More specifically, in this first Chapter, I have presented an introduction to the study and an explanation for its focus. I have included a discussion of the purpose, justification, significance, data, methodology and literature. In Chapter 2 I will discuss the epistemology and application of the historical method of inquiry to nursing. Further discussion will elaborate on the process of historiography and its application and importance to nursing as a profession. In structuring the subsequent chapters for this thesis, I have learned that for any historical analysis, one of the first steps must be to determine the historical scope of the study. The availability of written material concerning both Canadian history and nursing becomes more prolific at the beginning of the Twentieth Century (Zilm, 1994). Thus, the narrative (in Chapter 3 through 5) is able to focus more specifically on nursing and nursing discipline from this point on. A more in-depth analysis of the disciplinary process of the RNABC’s Professional Conduct Inquiry Committee from 1975-1996 is provided in a Chapters 3 through 5. The era between 1975 and 1996 was a time in which the formal disciplinary process became transparent. With this transparency considerable amounts of documentary material regarding disciplinary hearings during this period were available as public record. This has provided me with a rich foundation for an
in-depth analysis. Chapter 3 is comprised of a narrative and analysis of the early RNABC disciplinary process, commencing in 1975 when the first formal professional inquiry process was held. Chapter 4 follows the format of the previous chapter, presenting the information I obtained from the period 1980 to 1989. Chapter 5 contains a fairly detailed exploration of the time period from 1990 through to 1996, when the last formal hearing was undertaken and a Consensual Resolution Process was initiated. The more detailed exploration I have undertaken in Chapter 5 has allowed me to gain insight into the challenges associated with the completion of the formal hearing process and the development of the Consensual Resolution Process as it stands today.

In Chapter 6, I pull together my understanding of the historical events and influences I have explored in Chapters 3 to 5. This closing Chapter incorporates a summary of key historical points, as well as an analysis of major trends throughout the history of nursing and nursing discipline within the province. I then present a look towards the possible future of the disciplining process. Specifically, I suggest options for an equitable, procedurally fair and legally sound alternative to the disciplinary process currently in use by the RNABC. I lay out these options in consideration of the imminent implementation of the Health Professions Act in BC. Chapter 6 ends with suggestions for further research and a series of recommendations for the development of a future nursing disciplinary process—a future process that could integrate the insights gained from this research.

13 The Consensual Resolution Process is a mediated in camera process developed in 1997, whereby nurses come to an “agreement” with the Association regarding remediation of practice concerns (Registered Nurses Association of British Columbia, 1999b).
CHAPTER TWO:
HISTORICAL METHODOLOGY

Those engaged in historical research and research of other types, all need to develop a degree of historical mindedness. This habit of reflecting the present against the background of the past cultivates a perspective, tends to delay hasty conclusions, and often injects appropriate humility into those involved in current undertakings (Newton, 1965, p.23).

Introduction: Looking for a Methodology

In this Chapter I explore the conceptual framework and practical application of a methodology appropriate to gaining an understanding of the evolution of the professional disciplinary (professional conduct) process as it has been applied to nurses in British Columbia. This exploration revolves around the research questions, which determine the requirements of the methodology chosen. My initial study aims were:

1. To understand the development of the RNABC disciplinary process from its inception to its present format and;

2. To piece together a picture of the legal, ethical and societal implications of the current process for nurses in British Columbia.

These aims led me to explore historical inquiry as a possible methodology.

In order to locate my research within the canon of methodological paradigms, it was first necessary to reflect on the purposes of my research and the assumptions underpinning my understanding of history. My research sought to gain insights into how the nursing disciplinary process came to be the way that it is. My interest in the nursing disciplinary process originated in my own experience of the process as biased, and thus an implicit aim was to critique the process with a view to transformation. Another aim was to develop an
integrated understanding of the forces which act upon the disciplinary process and to share this understanding with academic colleagues, students, and practicing nurses so that they might better be able to protect themselves from disciplinary complaints. In this way I was acting as a "transformative intellectual" in the role of an advocate or activist. All of these items appear to align my work with critical theorists as described by Lincoln and Guba (2000). From an ontological perspective, I view history as a process which is shaped by the social, political and economic contexts of events. My work is informed by Lamb’s (2004) assertion that an examination of the past allows us to "gain a deeper understanding of how our profession has influenced and been influenced by the social, political, and economic context of our practice. An historical perspective allows us to learn from the past and to connect our past to our future ..." (p. 20). I see reality as only comprehensible in a partial way. I believe it is possible to assert probable causes and relationships in many situations. From an epistemological viewpoint I see my findings as one of many possible constructions, but, nonetheless, as still useful.

My vision of history is progressive in that I see history as an evolutionary process, where an understanding of the past and the present can provide insight into probable future actions - a view that is implicit in my research questioning. However, I do not see this historical unfolding as a simple progression of facts, which in themselves provide predictable future directions. Rather, in order to produce useful extrapolations, I am interested in a scholarly understanding of human behaviour as determined by the totality of the historical reality: the social, political, cultural, economic, ethical and gender values of the time and the specific context in which they operate. The aim of my research is to provide a sufficient understanding of the dynamics which have caused the nursing disciplinary process to unfold
in the way that it has. From this understanding, I hope to gain insight into how the disciplinary process may be transformed in the future. There is an intrinsic moral (values based) stance involved in my approach which places it within the critical paradigm of methodologies (Denzin & Lincoln, 2000).

In reflecting on how nursing has approached historical inquiry, Newton (1965) makes a point that I believe is important to consider; “History stands ready to act as creator of the future” (p.24 – my emphasis). A quote from Adelaide Nutting makes a similar point at an earlier time: “I have but one lamp by which my feet are guided and that is the lamp of experience. I know no way of judging the future but by the past” (Nutting, 1931, p.1389). I have considered these historical views of nursing history and suggest that it is important to consider these quotes, while taking into consideration a more critical perspective supported by Lamb (2004) in the preceding quote and by Nelson (1999a, 1999b, 1999c, 2002a, 2002b). In other words, progress in society is achieved through a critical analysis of historical trends in their context and its application to the current (different) context. Based on these premises, I hope to shed light on the development of nursing disciplining and the historical development of procedural fairness and natural justice which took place within the RNABC Professional Conduct Inquiry Process. Throughout, I will be interested in the implications for procedural fairness and natural justice. These implications are, I believe, relevant for the past, present and future evolution of nursing as a self-regulatory profession.

My vision of human behaviour also appears to be aligned with Lewin’s field theory due to the importance I give to psychosocial understanding as a vehicle for change (Smith, 2001). It is my hope that the finished historical narrative will be both “descriptive - answering who, what, when, where and how questions - and...interpretive, answering the why” (Sarnecky,
1990 p. 6). Thus, probable future trends can be tentatively put forward based on an understanding of human behaviour in its societal context. My research is also informed by the observation of Matejski (1979) that “The historian often begins with the observation of a current event, and gradually unwinds the spool of time toward when the event originally occurred” (p.81). I began from an observation of the nursing disciplinary process in the 1990s and worked backwards in time in an attempt to understand how things came to be the way that they are, thus attempting to unravel Matejski’s “spool of time”. In consideration of more specific methodological concerns, my goals were to better understand the reasons behind the evolution of the disciplinary process and hence to access moral and ethical implications. Both of these aims suggested the use of qualitative methodologies because these have the potential to provide data on the rationale supporting an action. However, my closeness to the material presented a challenge in terms of my need to overcome potential criticisms of subjective bias in my research. As I set out to conduct my study, I realized that my study would require combining both quantitative with the qualitative data. The strategy that I selected was the use of a descriptive methodology structured to provide a step-by-step method for the research, which I will elaborate on later in this chapter. The descriptive step-by-step process I chose aided me in providing a clear decision trail for replicability of the study. It also demanded the justification of decisions, and, hence, an explicit focus on the historical researcher’s (my) decision-making process, which I believed would limit bias in my explorations. However, operating from the critical paradigm my findings are intrinsically ‘value mediated’ and bias could thus be conceptualised as a clear positioning of self, thus strengthening the research.

While my methodological decisions were dictated by the research questions to be investigated, there was also a reciprocal clarification process that occurred through my
examination of methods. As I assessed different methodological potentials for their suitability to the research questions and the type of data they would produce, the research questions underwent an iterative evolution. My initial idea was to focus directly on the formal disciplinary process from 1975 onwards. I assessed the suitability of several methods, including case study, historical and autobiographical methodologies. Of the three methods, an historical methodology to study an historical development in the context of a wider historical framework presented the closest fit to the questions that I sought to gain insight into. An historical methodology also presented the closest fit to my belief that the historical and social context of a phenomenon are key to understanding how things came to be as they are and how they are likely to develop in the future. The choice of the historical methodology led me to explicitly consider the chronological scope of the study, which resulted in my review of the time frame for the study backwards in time. This expansion allowed me to better trace the relationships between the historical development (nursing discipline) and the historical context (society and nursing). When I eventually settled on a specific historical methodology, I honed the research questions to their final form to produce the optimum set of available data for my final analysis.

The final form of the research questions were:

1) To gain insight into the development of the nursing disciplinary process, in context with the social, moral, ethical, legal, political and economic history of British Columbia.

1.1) To sketch out a chronological perspective of the historical development of the disciplinary process in nursing in B.C.

1.2) To incorporate an overview of the legal system, and the application of administrative law in parallel with the disciplinary processes.
1.3) To highlight the moral and ethical dimensions of the profession, and more specifically, the Association actions in disciplinary proceedings, by providing an in-depth analysis of the RNABC’s Professional Conduct Inquiry Committee from 1975-1996.

2) To comment on the impact, significance, and fairness of the Professional Conduct Inquiry Process as it has evolved over time and to look at potential directions for professional disciplining in the future.

In the next section I will articulate in more detail my reasons for selecting historical methodology as being most appropriate to the study undertaken. In this chapter I will also include sections discussing the importance of the research to the profession of nursing and ethical issues in the research. I will elaborate on my implementation of an historical methodology further on in this chapter.

**Historical Methodology**

Historical methodology is sometimes referred to as historical inquiry or documentary research (Glass, 1989). I chose an historical methodology because it provided me with a way of combining the rich variety of data concerning societal norms, nursing practice, ethics and discipline in the early years of colonial nursing. It also provided me with a way to access to detailed data on formal disciplinary hearings from the end of the twentieth century, and allowed me to view the evolution of the disciplinary process. I recognized at the outset, though, that because historical methodology is seeking knowledge about the past, primary sources (those that are the accounts of actors and direct witnesses to events) are frequently not available. The inclusion of secondary data sources (which report an event rather than witness it) can address this limitation. However, secondary sources introduce potential problems in validity and reliability of data. Fortunately, an historical methodology includes explicit steps to assess the secondary data. Another key reason that I selected the historical
methodology was because it enabled me to access data about the wider historical context of
the rise and fall of ideologies, social mores and values. This latter inclusion is, I believe,
critical to the understanding of the evolution of the disciplinary process I was studying. I will
say more about this as I proceed.

An historical approach has not yet been used to investigate the development of nursing
discipline so far as I am able to determine. I believe it is a productive method for the
investigation of these issues because it most clearly accesses understanding of the societal
changes that parallel the evolution of the disciplinary process. Authors of nursing history support the use of historical inquiry in nursing. For instance, Ogren (1994) believes that
studying nursing history allows nurses to fully understand problems currently affecting the
profession—such as pay, regulation, shortages, education, definitions of practice, autonomy,
and unity. Ogren claims that present day nurses cannot effectively “address these important
issues without the foundation of historical knowledge…” (p.8).

Despite its value, historical methodological research designs itself have created some
debate amongst authors (Nelson, 2002b) for over 40 years (Austin, 1958; Nelson, 2002b).
This debate centres on the design, firstly, as either a method or a methodology, and secondly,
as belonging to qualitative or quantitative modes of research.

**Historical Methodology: Debates and Decisions.**

**Truth and Meaning**

And truth and meaning “haunt every methodological discussion” in historical inquiry
(Nelson, 2002b, p.1). Thus, in using historical methodology for studying the development of
the Professional Conduct Inquiry Processes in nursing, it has been necessary for me to

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consider at least some of the debates within historical methodologies. Nelson (2002b) outlines these debates as those touching on truth, constructivism, social practice, technologies and power (p.30).

According to Notter (1972), “Historical research is not merely a collection of incidents, facts, dates, or figures; it is a study of the relationship of facts and incidents, of themes or currents of social and professional issues that have influenced past events and continue to influence the present and future” (p. 483). Similarly, according to Rafferty (1997), “…nursing cannot be understood in its own terms but against the background of the social, political, economic and cultural context in which it subsists” (p. 4). Rafferty’s position parallels my own ontological stance that the historical reality is shaped by the social, political and economic context of the period. Matejski, (1979), suggests “...life and spirit differ with each age. Thus, an historical event must be seen and interpreted in its own moment in time” (p. 81). My approach, which is supported by a number of scholars (e.g., Christy, 1975, 1981; Church, 1987; Hockett, 1955; Nelson, 2002b), is that the concept of time and place in relationship to events is a significant aspect of historical inquiry. By understanding the relationship between historical context and change, it is possible to suggest probable future directions which are consistent with a critical theory approach which aims to critique, transform and emancipate (Lincoln & Guba, 2000).

All of this means that the specific socio-economic context of an event plays an important role in interpreting what can otherwise seem to be “facts”. The context provides a changing external framework where different tools and technologies can be engaged to reproduce familiar patterns of human interaction and may also provide opportunities for change through changing societal ideologies. For nursing discipline, this approach entails an examination of
the main social forces influencing how and why nurses were and are disciplined, and the
trends (or lack thereof), in both society and the disciplinary process. This approach then
illuminates trends in nursing discipline and parallel trends in the societal forces behind the
trends and signals possibilities for future change. Thus, in studying the regulation of nursing
from an historical perspective I believe it is necessary to study its evolution within the
dynamic social context and ideologies that have created it, rather than concentrating on the
evolution of nursing practice in isolation.

A particularly vivid example of this kind of contextual historical approach comes from
Rafferty (1996), who examines the change in nursing paradigms from the Dickensian,
independent Mrs. Gamp of late 1800s, who was accused of drinking too much gin15 (Rafferty,
1996, 1997), to the increasing hospitalisation, separation of nursing and medicine and proper
subservient conduct16 (McPherson, 1996) espoused by Florence Nightingale. While the link
to discipline is not obvious at first glance, the changes in ideology are related to changes in
disciplinary practices. An ideology of nurses as handmaidens to doctors leads to disobedience
being perceived as a disciplinary infraction, while an ideology of advocating for patients can
lead to ethical dilemmas over bringing doctors’ errors into question. There are always links
between the perceived problems and the use of disciplinary systems to control and protect the
system from the perceived evils of the times. Throughout history this discipline has been
enacted by the matriarchal leaders, religious sisters, and matrons of the nursing profession.
These trends were paralleled in Britain, Canada and the United States with considerable

15 "...let it cease to be a disgrace to be called a nurse; let the terms of nurse and gin-drinker no longer be
convertible; let us banish the Mrs Gamps to the utmost of our power; and substitute for them clean,
intelligent, well spoken, Christian attendants upon the sick" (Rafferty, 1996, p. 211).

16 According the McPherson (1996), subservient conduct included standing when the doctor or senior matron
entered the room, not questioning the doctor and protecting the doctor or covering up his mistakes, not
speaking or fraternizing with male patients, doctors or staff.
coordination through international meetings (Coburn, 1988; McPherson, 1996, 1994). The inclusion of the societal context within historical inquiry illuminates the societal mores and an influence of the time period such as those described above, and, is therefore, ideally suited to unravel what seemed to take place in the development of nursing disciplining in B.C.

**Legitimacy**

Debate has also centred on attempts to legitimize historical inquiry, and its application, reliability and acceptance, as a method of inquiry into nursing issues. According to various authors (e.g. Austin, 1957-1958; Christy, 1972, 1975, 1981; Church, 1987, 1998; Firby, 1993; Nelson, 2002b; Newton, 1965; Ogren, 1994; Sarnecky, 1990), this quasi-qualitative methodology has yet to achieve full credibility or acceptance within the nursing profession because it allows different voices to narrate different perspectives of the past. The methodology has been seen as inferior to the more prestigious quantitative or scientific approaches to understanding truth (Abdellah & Levine, 1986; Brink & Wood, 1998; Sarnecky, 1990), which posits facts as concrete and measurable. However, according to a number of authors, there has been resurgence in the use of historical inquiry, as scholars recognize that the study of the past is valuable and provides useful information for the present (Abdellah & Levine, 1986; Brink & Wood, 1998; Sarnecky, 1990). The resurgence of the historical methodology echoes Newton (1965) who “envisions historical research as the curator of tradition, the model for the present, the creative innovator of the future, and the inspiration of the discipline” (p. 24).

Polit and Hungler (2001) define historical research as “the systematic collection and critical evaluation of the data relating to past occurrences” (p. 248). This is similar to Tosh's, (2000) view of history as “an inventory of possibilities, all the richer if research is not conducted with half an eye to our immediate situation” (p. 20). What I believe Tosh is
referring to is that that historical research is stronger if the researcher endeavours to immerse themselves in the historical material and its context. Another popular research methodology text by Lobiondo -Wood and Haber (2002) describes the methodology as a straightforward approach to “establishing facts, probability and possibility with historical method” (p. 234). My view of history is not found in the simple, unbiased search for answers described by Polit and Hungler (2001) or Lobiondo - Wood and Haber (2002). Rather, I envisage historians assessing the evidence (data) as best they can in an attempt to determine how events unfold, and the events’ interrelationships and surrounding circumstances.

In terms of my research, I wanted to produce an historical narrative with enough contextual data to explain pertinent trends in Canadian healthcare that impacted the development of nursing and the nursing disciplinary process. In my account I was able to triangulate data and posit a sequence of events that were chronicled at the time as ‘fact’. I have then combines these facts with an attempt to understand the various standpoints of the authors of the sources to illuminate the power struggles that have occurred and which continue to occur in the interpretation of these ‘facts’. This analysis could be seen as creating a “thick description” (Beck, 1993; Geertz, 1973; Seale, 2000) of the history of nursing discipline. I have presented my historical methodological analysis in the form of a narrative.

**Qualitative/Quantitative Categorization**

Historical methodology has traditionally been viewed as a qualitative methodology (Austin, 1958; Christy, 1975, 1981; Church, 1987; Hockett, 1955; Spieseke, 1953). This has led “...others in the [nursing] profession to perceive this methodology as an effortless exercise whose product is merely a chronology of facts, events and ideas” (Sarnecky, 1990, p.6). This misconception has forced researchers using historical methods of inquiry to spend much time justifying its use. Theorist Christy (1975, 1981), the pioneer of historical inquiry
in nursing, has fought the battle to legitimize her work by setting out a clear step by step process which is to be followed when undertaking historical inquiry. Christy (1975, 1981) claims that in this manner the validity or truth of the research can be supported and therefore, must be accepted as academically rigorous. The struggles by theorists such as Christy to establish historical inquiry as a valid methodology parallels the longstanding historical fight between quantitative and qualitative methodologies (Sandelowski, 1986), where qualitative methodologies are seen as non-rigorous by proponents of positivist research (Sarnecky, 1990).

In nursing research there has been a move to qualitative methodological paradigms (Beck, 1993), as these methodologies have gained acceptance for their ability to access different types of data than their quantitative counterparts. However, Nelson (2002b), points out that historical methodology is not a ‘qualitative methodology’. Rather, historical methodology is viewed as a method of inquiry unique unto itself. It involves both quantitative and qualitative elements that combine to provide a more complete overall description from the data. For instance, historical methodology can incorporate data regarding numbers of practising nurses, percentages of practising nurses disciplined, and rate of increase or decrease in hearings. Historical methodology can then combine this type of data with qualitative narrative accounts from Matrons (Head Nurses) expressing their philosophy of practice and reasons for suspending nursing students, along with accounts from disciplined nurses of their experiences of the process.

In summary, historical inquiry is much more than memorizing dates, places, and events, or merely offering a prima facie description of events. It is a process that seeks to uncover

17 Guba and Lincoln (1981) purport that credibility is the proposed criterion against that which the value of truth in qualitative research is based.
and gain an understanding of the underlying causes, meanings, and basic factors or principles, which then help to explain past actions, events, and societal influences. History examines the people, their culture and society, their individual choices and their values. It is concerned with the flow of events and with placing them within their socio-political context.

**Application of Historical Methodology**

In any study, a series of decisions regarding which methods to follow and which to ignore determines the final shape of the research and the eventual analysis that is possible from the methodology. Issues such as definition of scope (temporal and substantive), level of detail, sources of data chosen, and presentation format are discussed. My aim here is to provide the reader with a map of the 'decision tree' used in my study--one that would enable subsequent researchers to follow the same methodological path to validate the research findings, as well as to provide some justification for the specific form of the methodology eventually utilized. Sections follow outlining the importance of the study to nursing, ethical considerations, and the dissemination of knowledge. A final section provides a summary of the key points in historical methodology in relation to its application to the study.

**Time Frame**

Within this thesis, one of the areas at which I looked was the history of the legislation which granted regulatory power to the RNABC, its subsequent amendments; and the regulations, rules, bylaws and the constitution of the Association through which these powers were (and are) enacted. This legislative development occurred in parallel with changes in nursing ethics and changes to the Canadian legal system. Thus the evolution of regulation in nursing must be seen in the context of the developing legal system and expectations for nursing practice. My research focus was therefore on an analysis of the historical development of RNABC procedures for disciplinary cases, paying special attention to
changes in that system and their relationships to landmark court decisions in nursing discipline.

The main adaptation of the historical methodology undertaken in the study is the organization of the data into two major temporal divisions. The first period spans the inception of nursing in the Province of British Columbia, officially from 1912 to 1975. The selection of 1975 as an end date for this period is based on the implementation of a clearly documented Professional Conduct Process at that time. The second period begins in 1975 and continues to 1996, when the Professional Conduct Hearing Process metamorphosed into the Consensual Resolution Process. The period from 1996 to the present is addressed in the discussion on implications, although I have not done an historical analysis of this more recent period because there have been no formal hearings since 1996 and no records exist on the public record of Consensual Resolution Processes. For clarity, the research periods, the relevant chapter and key themes are shown in Appendix II.

These temporal divisions are analysed at significantly different levels of detail in order to produce a workable volume of data. The earlier period (up until 1975), is analysed at an overview level, with the aim of providing a general understanding of the evolution of disciplining nurses in its historical context. The later period (from 1975 to present day, with specific concentration on the disciplinary hearings held from 1975 to 1996) is analysed in greater detail due to the shorter time span, the greater abundance of data, and the social changes impacting nursing and nursing discipline during this time period. My decision to sample the data set at a more detailed level for the period 1975-1996 is consistent with what is recommended by Brink and Wood (1998) when an investigator discovers a massive data set. Thus, during the period from 1975 to 1996, data is presented demonstrating trends in
disciplinary charges and struggles between the RNABC and BCNU. In addition, I present the socio-economic context, descriptions of nursing practice, and tracing of ethical and legal trends in more detail for this latter time period.

Sources of Data

As a basic design, historical research involves locating and examining data from primary and secondary sources (including documents), interpreting the evidence, and analysing, synthesising and interpreting the findings. The quality of the research is dependent on the primary and secondary data sources uncovered. For this study, archival material, correspondence, reports and legislative drafts and memoranda were available through the RNABC, the B.C. Hospital Association, and the BCNU. Several nurse historians (too many to list here), have done an impeccable job of retaining and writing about the background information that will be used to support my work (for example, Du Gas, 1969; McPherson, 1996, McPherson & Stuart, 1994; Rankin, 1997; Strong-Boag, 1990, 1991; Warbinek & Fitzpatrick, 1997; Zerr, 1997a, 1997b; Zilm, 1997). Data in this study will include public documents such as the legislative acts, legal documents, RNABC archives, current educational materials, British Columbia Nurses Union articles, other archival sources, private data, and local and community newspaper articles. Much of this data is secondary with respect to nursing discipline. However, I have also included findings from disciplinary hearings and appeals as well as some writing by lawyers who were directly involved in disciplinary hearings, which I consider to be primary sources. In addition, I have also incorporated considerable data from other sources that provide first hand accounts of nursing practice and developments in different time periods.

The strength of historical inquiry methodology revolves around critical examination of the data. Lack of access may inhibit the completeness of the data and its integrity (and thus
the accuracy of the study), as archived material may be in the control of an association such
as the RNABC. Generally this can be overcome by seeking permission to review data. An
interesting piece of legislation which indirectly supports historical research is the Freedom of
Information and Protection of Privacy Act, (FOI Act).18 Up until 1996, public bodies such as
the RNABC have been legally able to withhold documentation from public viewing at their
discretion. In 1996 the FOI Act was added to the amended Nurses (Registered) Act. The FOI
Act set in place a process which in many circumstances required the RNABC to disclosure
archival and personal records to the public, and more specifically, to the research community.

I believed it was important to consider the standpoints of many different stakeholders in
my final recommendations, including the public, patients, RNABC, Nurses, BCNU, other
health professionals and health care institutions. In order to define stakeholders, I drew upon
the Health Professions Council requested submissions from ‘Stakeholders’ in Nursing in the
mid-1990s for a review of the future role of the RNABC in Nursing (British Columbia Health
Professions Act, R.S.B.C. 1996, Chapter 183, 1996; Epstein, 2000, 2003; Ministry of Health

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18 Freedom of Information and Protection of Privacy Act, RSBC 1996, Chapter 165 s. 35
Disclosure for research or statistical purposes
35 A public body may disclose personal information for a research purpose, including statistical research,
only if
(a) the research purpose cannot reasonably be accomplished unless that information is provided in
individually identifiable form or the research purpose has been approved by the commissioner,
(b) any record linkage is not harmful to the individuals that information is about and the benefits to be derived
from the record linkage are clearly in the public interest,
(c) the head of the public body concerned has approved conditions relating to the following,
(i) security and confidentiality;
(ii) the removal or destruction of individual identifiers at the earliest reasonable time;
(iii) the prohibition of any subsequent use or disclosure of that information in individually identifiable form
without the express authorization of that public body, and d) the person to whom that information is disclosed
has signed an agreement to comply with the approved conditions, this Act and any of the public body's
policies and procedures relating to the confidentiality of personal information.
Disclosure for archival or historical purposes
36 The British Columbia Archives and Record Service, or the archives of a public body, may disclose
personal information for archival or historical purposes if
(a) the disclosure would not be an unreasonable invasion of personal privacy under section 22,
(b) the disclosure is for historical research and is in accordance with section 35,
(c) the information is about someone who has been dead for 20 or more years, or
(d) the information is in a record that has been in existence for 100 or more years.
Planning, 2003; Ministry of Health Services, 2003; Registered Nurses Association of British Columbia, 2001a, 2003c, 2003f; Seaton et al. 1999). The ‘Stakeholders’ were defined for this purpose as, the RNABC, BCNU, other healthcare professions and ‘the general public’.

Reports from the Health Professions Council review were the main data sources used for my recommendations; however, other contemporary documents produced by the stakeholders were used to supplement the findings. The inclusion of many stakeholders’ perspectives will enable me to include different perspectives in my recommendations. For example BCNU, Health Professions Association (HPA) and the RNABC, the College of Physicians and Surgeons and the College of Pharmacists entered into a discussion, in early 2000, regarding whether registered nurses should be able to prescribe drugs 19 (British Columbia Nurses Union, 2000). If it is decided that registered nurses will be allowed to prescribe drugs, careful consideration will have to be given to what, if any, impact this decision will have on the professional Conduct Inquiry Process of the RNABC. I suspect that nurses who abuse their prescribing privileges might be sanctioned outside of the RNABC’s process, due to a jurisdictional overlap with both pharmacists and physicians.

Step-by-Step Process

Research that describes data as merely facts or quotations, without scholarly interpretation contributes little to understanding (Lusk, 1997, p. 359).

Among historical researchers 20 there is considerable consensus on the process appropriate to support historical inquiry as a methodology. Among these researchers, Christy (1975, 1978, Austin, 1958; Christy, 1975, 1978, 1981; Church, 1987; Coburn, 1988; Collingwood, 1946; Firby, 1993; Glass, 1998; Lusk, 1997; McPherson & Stuart 1994; McPherson, 1996; Maggs, 1996; Matejski, 1996).

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19 “administer by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act” (British Columbia Nurses Union, 2000, p.4).

1989) was one of the earliest to develop the methodology in a clearly structured format and articulate much of the groundbreaking discussion regarding its efficacy. For this reason I have chosen to base my discussion of the process of historical inquiry on Christy’s work, and refer to the approaches of other researchers where they are pertinent. Christy seems to me to embody a paradigmatic approach which is aligned with postpositivism (Lincoln & Guba, 2000). Although Christy is not operating from a critical paradigm, her approach provides useful direction for the methods I employed. As I will explain shortly, I added a step to incorporate a critical perspective to Christy’s approach.

Christy (1975) suggests that historical research be undertaken in the following sequence, “gathering of the data, the criticism of the data and the presentation of the facts” (p. 189). She explains that initially “the question” in historical research is broad and poorly defined but, as the researcher begins to sift through the large volumes of data, clarity and focus is achieved. Christy (1989) describes the process of historical inquiry in seven steps (A-G) in more specific terms. These seven steps (with minor variations), form the process implemented by the majority of the authors listed above, and will be used in this research. They are:

A. Defining a question.

B. Identifying the secondary sources.

C. Locating and reviewing the materials.

D. Framing and focusing the question.

E. Identifying and locating primary sources.


21 Postpositivism — support critical realism—“real” reality but only imperfectly and probabilistically apprehendable, they are said to be modified dualists/objectivists’ critical traditional/community; findings probably true. The methodological paradigms are modified experimental/manipulative; critical multivs; falsification of hypotheses; and may include qualitative methods (p.165).
F. Utilization of the primary sources.

G. Conducting analysis, synthesis and exposition.

A. Defining a question

The initial definition of the question enables the researcher to define the subject matter and interest area of the research. The definition is usually broad and not stated in a concise manner. My initial area of interest centred on understanding the evolution of what is now the Professional Conduct Inquiry Process of the RNABC. This interest was derived from my own personal involvement in the Inquiry Process, when I was charged under the *Nurses (Registered) Act*, 1979. My quest was to gain an understanding as to ‘how’ the Professional inquiry process was developed in order to better understand the rapidly changing Professional Disciplinary Process. Further details of the Disciplinary Process appear in Chapter 3 through 5 of this thesis.

B. Identifying the secondary sources

Secondary document sources are defined as material written by others about a given subject or related area of study. This contrasts with ‘primary sources’, which are first hand sources, written by direct witnesses of, or participants in, the activities being studied (See step E) (Brink & Wood, 1998). Both primary and secondary sources may include books, journal entries, newspaper articles, films, pictures and videos. In historical inquiry, the method begins with secondary sources and later incorporates primary sources, because the focus of the method is on understanding the context of events first and then building an understanding of the dynamics of the events themselves. The following section describes the process of locating secondary source materials for the study. In a later section, using secondary sources to find primary materials will be explained.
Most secondary source documents for this study were uncovered in the RNABC library using the databases *Cumulative Index to Nursing & Allied Health Literature (CINAHL)*, and *Nursing and Allied Health* full-text databases. The two RNABC databases contained information from *Nursing BC/RNABC News* back to 1984, in addition to nursing journals. A search using the subject words 'conduct' resulted in 13 citations and an additional six citations were found when I searched the word 'discipline'. According to other researchers (Young Consulting Group, 1999), a search using the RNABC library database, with the subject word 'conduct' resulted in 29 citations. Thus, I recognised a need to carry out further data searches, because too few relevant data had been unearthed. For the period of 1948 to 1984, a manual review was undertaken, which resulted in an additional 54 references related to 'conduct' and 'discipline' in the *Nursing BC/RNABC News*.

A second search, which located all journals containing the hit words 'professional discipline', resulted in 757 articles. The hit word 'professional conduct' produced a further 231 articles and 'professional misconduct' 1006 articles. All of these articles were reviewed for duplications and unrelated articles (which were discarded) by undertaking a search of the combined words 'professional discipline,' 'professional misconduct,' and 'professional conduct'. The result was 228 journal articles. This final search produced those articles which were relevant to my research topic. A review of these 228 articles produced a majority of articles from the United States and United Kingdom. These articles produced some useful contextual material. The Canadian articles, however, were limited to reviews of the disciplinary process, as well as articles providing information on *Act* changes and advice to nurses charged. There was very little information specific to the research topic.
The RNABC’s journal was another important source of data for the research. The RNABC News commenced in 1948; the title of the journal was changed in 1990 to Nursing BC. The CINAHL, the index referencing system used by the RNABC, began in 1982, thus, articles for the period 1948 to 1982 were not included in the previous database search. Therefore, a search by hand, involving flipping page by page, was required for articles pertaining to ‘professional conduct’ and ‘professional disciplining’ from 1948 to 1982. Once again secondary information was discovered to be very limited. There were only a few articles written about nursing discipline (professional conduct), and most of these were educational articles.

There was only one set of newspaper articles uncovered. These articles written in 1995-1996 were discovered in the Vancouver Public library. They concerned a specific disciplinary case - my own - before the RNABC Professional Conduct Inquiry Committee ("Milner v. Registered Nurses' Association of British Columbia Vancouver (unpublished) Registered Nurses Association, dated February 14, 1996,"; "Milner v. Registered Nurses' Association of British Columbia Vancouver, A972468 (unreported), Vancouver, B.C., December 9, 1999,"; "Milner v. Registered Nurses' Association of British Columbia, Vancouver (unpublished) Registered Nurses Association, dated August 28, 1997,"). There were no films, pictures, or videos identified.

The dearth of literature in the area of nursing discipline (professional conduct) in B.C. necessitated a broadening of my search through indexes and library catalogues in other Canadian provinces, the United States, and the United Kingdom. The literature found through this search identified more active research in the area of nursing discipline in the United States and in United Kingdom. None of this expanded historical research produced
leads to further Canadian research or useful secondary data sources. There were, however, interesting examples of applied research addressing the implications of discipline on future practice (e.g., Le Duke, 2000, 2001), as well as research addressing important ethical issues regarding nursing discipline (e.g., Johnson, 1997; Salvage, 2000).

C. Locating and reviewing the materials

Obtaining and locating the secondary materials identified in step B. proved to be difficult, as many databases are updated sporadically and frequently are 5-10 years out of date. Most medical and nursing reference material, including journals and archived documents, is housed at the Beth Israel Library in the U.S.A. Other secondary source documents were accessed in the RNABC and the BCNU library, the B.C. History of Nursing archives, as well as, at University libraries in Canada, the United Kingdom, Australia, and the United States. Accessing data therefore required using interlibrary loans and became both time consuming and costly. This aspect has been noted as a draw back to historical inquiry (Brink & Wood, 1998).

Once located, I reviewed all of the secondary source materials which I had identified in step B. Difficulties can arise with revision of secondary document sources. For instance, language and word usage can change over time; and, there is a lack of availability of data in different data formats (Brink & Wood, 1998). In my research there were frequent examples of this, such as the terms 'charwomen', 'poultice', and 'shake building', which required careful attention to meaning. At this point, data sources were referenced and collated with preliminary colour coding. Time frames and themes were the major review protocols used at this phase of the research (Brink & Wood, 1998; Christy, 1975, 1981). Some of the

22 Charwomen, defined as a female custodians or janitors. Poultice—a soft heated and sometimes medicated mass spread on a cloth and applied to wounds and lesions. Shake building—the entire building is made from cedar shakes (now commonly used for roofing materials) definitions available at (Merriam-Dictionary, 2003).
secondary source materials contained primary source material, and so documents were first categorized as primary and secondary sources. Major themes for each source were colour coded and then summarized onto index cards. For example, many documents from the early 1900s concerned the theme ‘Legislation of Nursing as a Profession’, and thus were coded. This thematic coding enabled cross-referencing of themes between different sources.

D. Framing and focusing the question

In this phase, the number of questions asked, the time frames and the level of detail of the analysis, determine the depth and breadth of the research. It also provides theme areas for further analysis (Brink & Wood, 1998; Christy, 1975, 1981).

The primary framework to be researched was determined to be:

1.1 To sketch out a chronology of the historical development (social, political and economic) of the disciplinary process in nursing in B.C.

1.2 To highlight the moral and ethical dimensions of Professional Conduct Inquiries.

1.3 To provide a more in-depth analysis of the disciplinary process of the RNABC’s Professional Conduct Inquiry Committee from 1975-1996.

A secondary framework (which it is hoped will be illuminated by the primary framework), is:

2.1 To comment on current and future potential directions for professional disciplining of nursing.

E. Identifying and locating primary sources

Primary sources are those documents that contain a witness to the event in question, or are first hand accounts of the event (Brink & Wood, 1998; Christy, 1975, 1981). Identification of primary sources may involve published indexes, manuscripts, and archival minutes. Primary sources may also include meetings or communications with persons who
were present, either in person or through written sources, such as diaries or letters. Due to the problems associated with personal communication (confidentiality, consent, the reliability of respondents due to advanced age, and time and sampling constraints), I made a decision not to conduct personal interviews, but to rely only on data in print. In addition there is an absence of data identifying nurses who were involved in disciplinary processes prior to 1975. There is only outdated or incomplete contact information for nurses disciplined after 1975 to the present, so contacting the nurses presented logistical difficulties.

Finally, I placed two advertisements in the B.C. History of Nursing Professional Practice Newsletter, requesting any information on the history of the Professional Disciplining of Nurses and received only one response. I hoped, as this newsletter was read by nurses with an interest in nursing history and professional practice, I might receive replies from nurses who had practiced in several time periods. The poor response rate convinced me that I would encounter insurmountable difficulties if I elected to base my research on interview data. Because of all of these reasons, I elected not to conduct any interviews. This created a limitation on my research. However, interviews would provide interesting and valuable auxiliary data for future research in this area.

Other problems that are common at this stage of the research are incomplete data, or 'gaps' in the data (Christy, 1975). Missing information is sometimes due to the filing system or language categories used. As well, historical documents may contain unrecognizable shorthand or abbreviations. A final limitation may be posed by inaccessibility of the data; documents may be sealed, or have restrictions placed on their reproduction and usage. This

23 Query 'Unethical and Unprofessional Nurses' in B.C. History-A Master's student at the University of Victoria is seeking nurses and others able to provide information about the 'Professional Conduct and Disciplining of Nurses' between 1918 and the present. Please contact Cindy @ cindymilner@home.com.
can be overcome with application under the Freedom of Information and Protection of Privacy Act, research agreements and contracts regarding usage and reproduction rights.

In the interest of conducting ethical research and the potential for wide dissemination of my research findings, I decided to rely on both primary and secondary documents that currently form part of the public record. This has the advantage of avoiding lengthy application procedures, meetings, and confidentiality agreements, which would limit the ability to widely disseminate the research. Primary documents were located at the RNABC library, BCNU library, the B.C. Hospital Societies public archives, and the B.C. Supreme Court and Court of Appeal. As well, primary documents were selected from an estimated 50,000 court documents and direct correspondence from my personal involvement with the Professional Conduct Committee and the Board of Directors of the RNABC ("Milner v. Registered Nurses' Association of British Columbia Vancouver (unpublished) Registered Nurses Association, dated February 14, 1996;"; "Milner v. Registered Nurses' Association of British Columbia Vancouver, A972468 (unreported), Vancouver, B.C., December 9, 1999;"; "Milner v. Registered Nurses' Association of British Columbia, Vancouver (unpublished) Registered Nurses Association, dated August 28, 1997;") All of this material is in the public domain as it has been presented to the Board of Directors (BOD) of the RNABC, or to the Supreme Court of British Columbia. However, it also provides a unique insight into the disciplinary process, as normally this documentation would not be accessible to a researcher.

**F. Utilization of primary sources**

Gathering of information from primary sources is considered to be data collection. Volumes of data are gathered in an attempt to answer the research question, and to provide the supporting context. This phase therefore aims to define relationships and construct the ‘whole picture’. Data is categorized in relationship to the requisite question. Some authors
suggest colour-coding themes (Christy, 1975, 1981), while others make use of index cards, as a filing system (Brink & Wood, 1998). As previously described, once sources had been categorized as primary or secondary, they were organized using a combing method. Firstly the data were coloured coded on index cards as suggested by Christy (1975, 1981) and Brink and Wood (1998). This method of data organization was especially important for the large quantities of primary material from professional conduct hearings in the period 1975 to 1996. Finally, the themes were summarized into a computer index system.

It is also necessary at this point to judge each document for its authenticity and credibility. External criticism questions the authenticity, that is, is the document really what it appears to be? This step answers the when, where, why and whom, according to Christy (1975). This is based on a judgement by the researcher derived from his or her knowledge of the times. Criteria such as handwriting and ink and paper efficacy may be judged when original documents are available. Other factors evaluated include the language used and triangulating the data between multiple sources. Some of these processes may require an expert to validate the data (Brink & Wood, 1998; Christy, 1975). This process combines the qualitative method of assessing credibility, fittingness, and audit-ability with the quantitative determination of internal and external validity and reliability. It determines both the internal consistency and validity of a data source and its vividness and faithfulness in describing the phenomenon, (e.g. Did it sound real?) and comparing the data between this and other independent data sources (external validity), and showing. “How well the working hypothesis or propositions fit into a context other than the one from which they were generated” (Beck, 1993, p.264). This addresses issues such as typicality and representativeness of informants and/or data sources.
Triangulation was the most frequently used technique for validation in my study. A good example of this was the documents relating to the establishing of the Graduate Nurses Association of B.C. (GNABC), where newspaper articles and editorials, reports from the legislature, reports from the GNABC, personal accounts and minutes from Annual General Meetings all corroborated different perspectives of the event. Many of these accounts refer to the same people, a fact which provides auditability between sources.

Legislative and GNABC minutes were observed on original parchment in handwritten form. These were cross-referenced with documents from the B.C. Hospital Society. This provided considerable security of the credibility of the documents. Handwriting and signatures were compared for consistency. The tone of articles was assessed for fittingness with other information regarding the mores of the time with emphasis on women's roles in particular time periods. A few journal articles were located which referred to persons who were not mentioned in any other sources. These articles also conflicted with information found in sources which had been judged to be valid, credible, and auditable. These articles were therefore discarded because they did not meet the criteria that I was using.

Using a combination of quantitative and qualitative criteria for determining consistency, validity and reliability of data helped me to avoid a preoccupation with fact and bias. Such a preoccupation is sometimes caused by attempts to legitimate qualitative methodologies by providing triangulation with subjective criteria for determining authenticity (Christy, 1975). In other words, different independent sources recording an event were individually assessed for authenticity and validity and then included in the narrative. The different perspectives on nursing and nursing discipline from the various sources illuminated the societal dynamics
which contributed to the evolutionary trends within nursing discipline in the GNABC, and later the RNABC.

G. Conducting analysis, synthesis and exposition

The final stage, which occurs through a process called synthesis, involves interpretation of the data. This largely intellectual task involves categorization or thematic analysis and a reconstruction of the results into a response that answers the research question (Brink & Wood, 1998). The when, where, why and whom of events is established through categorization and the interpretation of data into a response to the question (Fox, 1982).

Supplementary data on events, organizations, and people are sought to further explain situations (Brink & Wood, 1998). And the researcher must weigh the importance and meaning of the data in order to determine which material should be omitted and which included (Christy, 1975). The strength of the research argument lies in solid, supporting data (or lack thereof), and in the skill with which the researcher assembles “the myriad of fragments of information recorded in his [sic] research notes and put[s] them together in a logical sequence with clarity, flow and no gaps” (Christy, 1975, p. 192). Finally the research is presented, usually as a descriptive narrative, utilizing footnotes to “document sources, explain statements, or provide verification and make possible additional research by an interested reader” (Brink & Wood, 1998, p.185). This format, which forms the results’ narratives for the periods before and after 1975, is used in Chapters 3 and 4 respectively.

Nelson (2002) suggests an eighth step not outlined by Christy (1972, 1975,1981), which is that of explicitly placing the data in its historical context. Nelson states, “There is no mention in these method guides to the connection between historical methodology and the social context – the very task of history” (p. 8). While I agree it is important to address this aspect explicitly, my interpretation is that this aspect is implicitly addressed within Christy’s
(1975) description of historical methodology. Thus, when I carried out a preliminary search for data sources, my search was not limited to those which referred directly to nursing or nursing discipline. Rather, it also included sources relating to the founding of Canada and of British Columbia, as well as documents outlining trends in medicine and the changing role of women. Again this links back to the critical paradigm with the inclusion of contextual information in the search.

Once the step-by-step method had been clearly conceptualised (as per Christy, 1975) it became necessary for me to attend to ethical issues raised by the method. Before I discuss ethical issues I provide a discussion of the importance of research into the history of nursing discipline to the profession of nursing. This discussion highlights the importance of the dissemination of the research findings, which is a key issue in the discussion of ethics which follows.

The Importance to Nursing

As a predominantly female profession, nursing fought--and continues to fight--a battle for respect and power (Nelson, 2002b). This reality colours much of the documentary evidence written by and about nurses. Because of the continuing struggle for recognition, the authorship, audiences, and contexts of historical sources about nursing must be carefully analysed; it is important that researchers who are sensitive to these dynamics are involved in the study of nursing history. In addition to issues of power, the impact of changing technologies and changing social paradigms is omnipresent in the development of nursing discourse over time (Maggs, 1987; McPherson & Stuart, 1994; Nelson, 1997, 1999a, 1999b, 1999c, 2002a, 2002b; Reverby, 1987; Strong-Boag, 1991; Whittaker, 1984). This overriding impact must also be examined to provide a clearer understanding in the changing foci of the nursing disciplinary process. Many areas of concern can be identified in this cause and effect
context. For example, health administrators opt to spend health dollars on expensive diagnostic technologies, leaving insufficient monies to pay an adequate nursing staff. And then nurses may provide less than adequate care due to understaffing. Additionally, decisions to change or replace head nurses and assistant head nurses with administrators leave new nurses without mentors. Lastly, decisions over staffing levels are often placed in the hands of people with no nursing training (Rodney, Varcoe, Storch, McPherson, Mahoney, Brown, Pauly, Hartrick, & Starzomski, 2002). I found that my nursing training and experience, in varied care settings allowed me to analyse disciplinary citations and charges from an understanding of the expected abilities and conduct of nurses at different levels. This experience would not be available to a non-nurse researcher. My position is echoed by the American Nursing Association (ANA), which has “realized that research is a professional responsibility and that without such activity the professional status of the group is open to question” (p. 20). This builds on Newton’s (1965) assertion the nursing profession reached an understanding in the 15 years between 1950 and 1965 that “research is the word of the decade” (p.20).

It is my conviction that historical research is particularly important to nursing at the present time due to the rapid changes that the past twenty years have seen in the nursing profession (Firby, 1993; Lusk, 1997; Matejski, 1979; McPherson, 1996). This is especially critical in light of the current crises in many health care systems worldwide. These crises are characterized by inadequate staffing levels, strikes by nurses and allied health care professionals and disputes regarding job descriptions (British Columbia Nurses Union, 2002; Rodney, et al., 2002). These conditions make it essential to plan for the future of nursing. Indeed, Maggs (1996) suggests, “knowledge of nursing history creates occupational cohesion
and exclusivity... the hallmarks of an emerging profession” (p.623) and Lynaugh (1996) calls nursing history “Our source of identity, our cultural DNA” (p.1). I concur that research into nursing history provides the necessary understanding for us to plan for, and control, the direction of our own future, rather than passively following the dictates of the wider society. Hence, it is essential that nurses are active as researchers of the profession. It is my wish that my work will contribute to this from my own position (that of a nurse who has undergone the discipline process). I will follow the threads of the disciplinary process and its dynamics back through the historical record to the inception of the nursing disciplinary process in its historical context. My hope is that this will inform future changes to the disciplinary process by making available an analysis of the forces that shape it.

**Ethical Considerations**

Ethical considerations in research are of the utmost importance, ranking alongside issues of the dissemination and utilization of nursing knowledge. In this thesis, all documents that will be sourced in the research are public documents. Therefore, it is unlikely that I will face any of the traditionally-considered ethical concerns, which relate to confidentiality, voluntary participation and informed consent (Jonsen, 1998; Keatings, 2000; Williams, 1986).

However, the scope of issues considered under ethical behaviour has been expanding in recent years and non-traditional issues are increasingly considered (Cipriano, 1998; Hoffmaster, 2001; Ludwick, 1999). Several issues arose that warrant discussion, the first of these is a consideration related to the empowerment of nurses. A second is my belief that I have an ethical obligation to disseminate the findings of my research. Further sections will consider ethical considerations in document selection and finally professional ethics in relation to organization ethics.
Empowerment and Ethics

Nursing discipline is intimately related to issues of empowerment, as discipline is a key factor in determining the degree to which nurses feel free to exercise their clinical autonomy without facing undesirable consequences. Thus, I believe the ability of a nurse to challenge a doctor’s decision and thus protect a patient from a clinical mistake may be impeded by a fear of retribution through losing his or her license to practice. The mandate to obey the doctor and the responsibility to perform an advocacy role have been dynamic through history thus looking at the evolution of nursing, there are continual struggles for autonomy and recognition, which are ongoing today. This condition is a powerful justification for the use of historical methodology as it allows an exploration of the past, an understanding of the present, and a vision for the future, which was woven together with nursing and societal mores. The relationship of autonomy to these mores also suggests the need for care in extrapolating backwards and forwards in time, because of the delicate interplay between a nurse’s autonomy (or lack thereof), and his or her level of professional responsibility. Thus nurses who were at the forefront of leading change in earlier eras could be seen to be empowered, even though through the lens of contemporary mores their actions appear conservative.

Dissemination of Knowledge

Another ethically-related concern that arises from my own personal experience is the dearth of directly relevant Canadian literature (as I explained earlier in this chapter) that provides independent information on how to understand and work through the disciplinary process. Access to information about professional practice issues is key to empowering nurses to know their rights and to be able to stand up and protect themselves. I therefore feel

24 Professional and organizational ethics, law, self-regulation, past precedents, union rights.
that I have an ethical obligation to disseminate the findings of my research. My intention is
to accomplish this through presentations to nursing schools, conferences and nursing interest
groups (including the RNABC and BCNU), as well as through journal submissions.

**Ethical Considerations in Document Source Selection**

A waiver of Ethical Review of Human Research was obtained from the University of
Victoria in regard to this research. Throughout this study, I have been aware of
confidentiality issues and adhered rigidly to a policy of utilizing data from archival and
public documents. Particular attention has been given to the data relating to the sampled data
set for 1975-1996, which I indexed by registration number as opposed to name in an attempt
to limit the exposure of nurses who have experienced professional disciplinary procedures by
the RNABC. This method of indexing prevents the reader from locating nurses directly from
the thesis, although it provides enough locator information to follow cases from the
RNABC’s professional conduct inquiry, and if necessary, to appeal before the Board of
Directors of the RNABC and to the Supreme Court of British Columbia.

**Professional Ethics**

In examining disciplinary processes, numerous moral-ethical considerations are raised.
Whereas ethics usually focus on the individual responsibility of nurses, the focus of this
study is on the ethical responsibilities of nursing associations to provide a fair and equitable
process regarding disciplinary matters. Those ethical and moral obligations include
accountability to the public and procedural fairness for nurse members. Such obligations

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25 This research is limited to the use of materials that are in the public domain and for which all applicable
copyrights, patents of other legal requirement and approvals have been either fulfilled or received (p.2).
Application for Waiver for Ethical Review of Human Research-University of Victoria, Nov. 23, 1999.

26 Moral-ethical refers to ethics: The explicit, philosophical reflection on moral beliefs and practices. The
difference between ethics and morality is similar to the difference between musicology and music. Ethics is a
conscious stepping back and reflecting on morality, just as musicology is a conscious reflection on music
raise questions about the definition of what constitutes an ethical violation or an ethical dilemma. "Violations involve neglect of moral obligation. Ethical dilemmas arise when ethical reasons exist for and against a particular course of action" (Registered Nurses Association of British Columbia, 1997b, p.2). The practical application of ethics in the real world of frontline nursing in 21st century Canadian hospitals provides a challenging context for examining applied ethics in general. Examination of the ethics of the conduct of nursing professional associations in particular is an important and poorly understood area of study (Cipriano, 1998; Ludwick, 1999). I believe that it is of paramount importance that nurses understand ethics and its somewhat grey inter-twining with the Canadian legal system (Black, 1996; Jones, 1999). I believe that nurses also need to consider the goals of the RNABC, which have been enshrined in nursing since the formation of the GNABC in 1912 (Registered Nurses’ Association of British Columbia, 1997b; Whittaker, 1984). The primary goal is to serve and protect the public and not to compromise the public interest. To gain insight and an understanding of this goal, I have chosen to look at the development of the RNABC from its inception.

Here, I think, a little digression is needed on the relationship between professional and nursing ethics, and administrative codes and the law, due to the complex nature of the issues they entail. The literature in these areas indicates a transition occurring between an ‘old vision’ of nursing ethics, where nurses were expected to obey orders from doctors, and a modern ethic, where nurses are expected to uphold the patients right to informed consent and to promote advocacy (Catalano, 1995; Curran, 1989; Davis, Aroskar, Liaschenko, & Drought, 1997; Dawson & Wilson, 1983; Lamb, 1979). These shifting ethical frameworks provide a context for the changing legal regulations applied to nursing. Societal pressure is
the driving force behind regulation change and legal precedents (Bay, 1998; Johnson, 1993, 1996, 1997; Zlotkowski, 1999). This has been the case since nursing was first regulated in 1918, in the context with the regulation of the medical profession, lawyers and engineers. Later examples include the move to consensual processes, which mirrors a trend for increasing mediation in legal processes generally (Beer, 1997).

Although law often embodies ethical principles, law and ethics are far from co-extensive (Johnson, 1997). For example, it is possible to imagine situations where completely legal courses of action are unethical. The contrary is also true. Hall (1996) writes, “Law is the minimum ethic and, therefore, legal behaviour is not necessarily the highest ethic” (p. 12). In studying ethics, a common set of issues are usually investigated, such as truth-telling, consent, capacity, substitute decision-making, confidentiality, conflict of interest, end-of-life issues, resource allocation and research behaviour. In contrast, my interest lies with the less traditional issues of ethics and focuses on the related ethical and moral obligations of the Association to its members.

Much of the ethical and moral work of the Association is directed by the code of ethics. Professional codes reflect our common morality and the circumstances of practice in a particular society (Bryant, 1999; Cipriano, 1998; Johnson, 1996, 1997; Taff, 2000; Zlotkowski, 1999). As circumstances change, professional organizations (e.g., those of doctors, lawyers, nurses and engineers) respond to pressures from outside and from within the world of practice and requisite revision follows. Most professions have highly-detailed and enforceable membership codes (Bay, 1998; Bonang, 2000; Rafferty, 1997). In some cases these are spoken of as ‘professional ethics’, or in the case of law ‘legal ethics’. Generally, failure to comply with a code of professional ethics may result in expulsion from
the profession or some lesser sanction. The kind and degree of moral accountability between parties clearly depends on the relationship they have. Accountability in the professional context is about answering to clients, professional colleagues and other relevant professionals. The demand to give an account of one's judgements, acts and omissions, arises from the nature of the professional-client and the professional-professional relationships. In professional ethics accountability has a central place. It is the preparedness to give an account of one's professional judgements, acts and omissions. Historically, the responsibility for discipline, and thus an accounting of actions or inactions, has been with the Association as legislated by the Act. One of the areas I will discuss in this thesis includes my thoughts about whether the RNABC has promoted procedural fairness, natural justice, and an ethically sustainable disciplinary process, supported by the tenets of self-regulation.

In summary, professional ethics is becoming an increasingly complicated field. It overlaps with a number of previously distinct areas of study including economics, business administration, nursing, medicine, philosophy and law. Each of these fields has developed to become increasing complex and thus we must rely on experts in many areas of our lives. However, an understanding of professional ethics in nursing requires an interdisciplinary approach, which has a broad understanding of each of the contributing subject areas.

Many factors combine to create the need for protection of the public by professional associations. These may include the anonymity of big cities, the creeping individualism of society, and the increasing litigiousness of society. Disconnectedness brings (Berger, 2002). As nursing does not act in a vacuum, it cannot help but be affected by the larger societal trends. Thus, in the health care context, the relative power of nurses and the dynamic and
changing environment they work in are the key issues in the developing field of nursing
ethics and the regulations it may mandate (Cipriano, 1998; Coburn, 1988; Ludwick, 1999).

Summary
In this Chapter I outlined my choice of methodology for the research and provided a
justification for this choice. I discussed the debates within the historical inquiry literature and
provided a description of the steps of historical inquiry process. In addition I provided an
explanation of how the process was applied to this study. Further, I presented a discussion
regarding the interface between ethical issues and the study. Whereas most studies of ethics
and nursing focus exclusively on the actions of individual, practising nurses within
institutional and private practice settings, this study focuses on the ethics of the Nursing
Association as it attempts to balance the dual mandates of public protection and professional
regulation. In other words, while the Association must fulfil its legislated mandate to protect
the public from unethical and incompetent nursing practice, it is also bound by the legal
precedents to carry out this function according to the rules of due process. Thus the
Association must sometimes navigate a fine line between abuse of process on the one hand
and allowing nurses to get away with unethical and incompetent practice on the other. I wove
this ethical thread into the narratives found in the following three Chapters, in which I lay out
the results of the research.
CHAPTER THREE:
AN HISTORICAL NARRATIVE OF NURSING DISCIPLINE
IN THE PERIOD 1975 TO 1979

History begins with the handing down of traditions; and tradition means the carrying of habits and lessons of the past into the future (Carr, 1987, p.1).

Introduction

In this Chapter I describe the chronological development of the Professional Conduct Inquiry Processes, the overriding ethical, legal and administrative law issues, and, in keeping with the methodology of historical inquiry, a parallel narrative of nursing within the social, political and economic context of the times. In this chapter and in the following chapters (4, and 5) the concentration of the focus shifts to British Columbia, and more specifically the disciplinary process undertaken by the RNABC. This shift is due to a significantly large and detailed set of data uncovered, which is specifically related to the disciplinary process of the RNABC. Due to the rich and detailed literature available during this period on the nursing disciplinary process, the contextual data form a background overview, while the disciplinary data and cases form the foreground. For ease of organization, each section presents a narrative about social, political and economic nursing history. These main areas are interwoven with three subsections that focus on nursing ethics, legal issues, and developments in discipline. Because of the large amounts of data for this period regarding discipline, these subsections are further divided. The subdivisions focus on major events in the development of the disciplinary process, such as changes in the rules governing the
process, legal precedent setting cases, and examples of the types of conduct cited in disciplinary cases.

Prelude: The Foundations of Nursing in the Colony and in British Columbia

Nursing in Canada is an important healthcare occupation with a rich and vibrant history commencing with the arrival of the first nurses in Canada some 400 years ago. The early period from the 1600s to the 1970s can be summarized into three major time periods: the emergence of nursing up until the time of organized associations; incorporating the transition from the private arena to private duty hospital-based care (1600-1918); the move to hospital-based nursing; and unionization and the modern healthcare system (1950-1975) (Coburn, 1988; Davis, 1997; Paulson, 1976).

In terms of the account of the evolution of nursing ideology, nursing began from Monastic roots. Under this religious philosophy, nurses were called to the vocation of nursing, which provided an opportunity for service to the poor in the name of God. Paradoxically, nursing concurrently provided an opportunity for women of the upper classes to achieve a level of self-actualisation which was not available in the narrowly prescribed societal roles of the time. During this period, the trend was to dedicate one’s life to the care of the poor; however, the lady’s servants performed the majority of the physical nursing care to patients during this early period because it was seen as improper for a lady to “dirty her hands” (Davis et al., 1997; Domville, 1891; Gibbon, 1947; Kerr, 1944).

As nursing developed under the Catholic orders in New France, the religious service aspect of nursing continued to dominate. However, nursing moved from a charitable occupation for ladies to a vocation for mainly middle-class women led by ‘saintly’ ladies who had renounced their material possessions. These women devoted their lives to the service of the poor and performed the physical care personally, as well as all the other
services (e.g., cleaning, cooking, and even fuelling the fire), necessary for the functioning of the hospital. There were no accounts specific to discipline within this early time period that I was able to locate. It is inferred that the sisterhoods provided a hierarchical internal disciplinary structure, and thus nursing sisters were indoctrinated to obey the strict religious rules (Domville, 1891; Gibbon, 1947; Mc Pherson, 1996; Rafferty, 1996; 1997).

In the British Colony, the absence of the Catholic Church led to an initially disordered and disorganized approach to nursing care. Nursing was an activity associated with drunken women of the lowest class and was given no social status (Rafferty, 1996). Then the Nightingale model of nursing developed during the Crimean War in Eastern Europe. Nightingale created an acceptable face of nursing for British middle-class women. Her "respectable hand maiden to the doctor" image, accompanied by education in many aspects of public health and hygiene, was rapidly exported to the New World. It became entrenched in what is now Canada, when loyalists fleeing the American Civil War moved north, changing the demographics of the new nation to a predominantly British colony (Canadian Nurses Association, 1926, 1968; Coburn 1988; Gibbon, 1947; Kerr, 1944; Murphy, 1957).

Both the religious sisterhoods and the Nightingale model left their hallmarks on early nursing on the West Coast. Initially the land that would become British Columbia was only accessible by boat from Europe or overland from the South. Thus, many early nurses were sisters from American orders. When the railway connected Vancouver to Eastern Canada in 1896, West Coast nursing became joined to the Nightingale and Catholic traditions, which flourished in the Dominion of Canada in the East (Cranny & Mole, 2000).

As the colony of New Caledonia (British Columbia) developed, hospitals were developed into apprenticeship-based schools of nursing. Under the strict guidance of Matrons and
Mother Superiors (depending on the religious affiliation of the institution), young, single middle-class women were shaped into obedient handmaidens (to doctors) who were required to behave with proper decorum and manners (Lamb, 2004). It was during this period that the first glimpses of the informal disciplinary attempts were visible, which punished breaches of etiquette as defined somewhat arbitrarily by each individual Matron. The idealized service and hospital-based apprenticeship training continued for many years, with the students running hospitals under the sharp eye of the matron until they were able to graduate into the relative freedom of private-duty nursing care (Coburn, 1988).

The Victorian era saw the development of universal suffrage and a developing institutional structure within the Province (Coburn, 1988). These forces combined to join the almost inevitable development of the movement for recognition of nursing as a profession. This movement also coincided with societal forces for rights for women of a certain class and thus the creation of an ‘elite’ of trained graduate nurses. Despite this allegiance with powerful groups in society, there were considerable struggles with the doctors who wanted nursing to remain under the control of the medical profession (Kalisch & Kalisch, 1982; McPherson, 1996; Paulson 1976). The nascent women’s movement and nurses’ experiences of wider roles in the First World War both aided the nurses in their determination to achieve self-regulation rather than a subservient doctor-controlled model. A more detailed description of the struggle for and meaning of self regulation is included after the current section summarizing the history of nursing discipline.

In the early years of the GNABC, nursing education and discipline remained under the control of Matrons in the hospital-based schools. This was despite the inclusion of distinct clauses in the Nurses Act defining the GNABC as a self-regulating body (Canadian Nurses
Association, 1912, 1913, 1914; Goldstone, 1981; Registered Nurses Association of British Columbia, 1987a, 1987b; Whittaker, 1984). Self-regulation includes the disciplinary function, although there are no records of any formal disciplinary actions or processes established for disciplining by the Association. After an initial backlash with the popularisation of the ‘Girl Friday’ image of nursing (Lamb, 2004), the GNABC devoted considerable resources to issues of education to ensure that nursing maintained a ‘good name’. As well, the GNABC resources were a response to severe nursing shortages. Nurses gradually gained respect for providing intelligent cooperation as trained professionals, rather than for providing blind obedience in the name of service to the doctors (or God) (Coburn, 1988, Kalisch & Kalish 1982; Paulson, 1976).

The Depression of the Thirties led to much hardship for nurses as they struggled to find the resources to feed and clothe themselves along with most others in the society. Private care almost ceased to exist and opportunities to serve the growing numbers of destitute people were only available to those who could afford a proper nursing uniform (Kelly, 1973; Kerr, 1996; Paulson, 1976). Despite the hard times, 1935 also saw the further developments in registration for nurses with the enactment of the Nurses (Registered) Act. The Act heralded the change in the 1940s from the apprenticeship “learn-by-doing” model to the baccalaureate model. Membership remained voluntary, which was considered to be a significant weakness in the Act (Weir, 1932).

Between 1950 and 1975 nursing underwent a number of changes. Medicine evolved to incorporate a stream of technological innovations with which nurses were expected to keep pace Registered Nurses Association of British Columbia, 1957; Goldstone, 1981; Kerr, 1944). This led to a demand for specialization of nurses and formal codes of ethics were
developed. The empirical training model shifted toward a college-based approach. Throughout society there was a focus on organizing for rights and the role of nurses became one of advocating for patient’s rights (Curtin, 1978a; Tate, 1977; Walsh, 1978; Whittaker, 1984). However, the labour rights movement was eventually to lead to conflicts within the nursing Associations as they struggled with the dual mandate of public protection and advocacy of nurses’ rights. As the functions became more clearly separated within the Association, committees were formed regarding ethics and review of practice. Significantly, there are no documented accounts of any nurses being disciplined by the Association throughout this period, and it appears that the disciplinary function continued to be deferred to nursing administrators in the hospitals and in the educational programs, much as it had been since the early days of the colony.

According to Coburn (1988), the most significant incident that occurred in regards to Collective Bargaining in nursing was a Supreme Court of Canada decision in 1973 ("Saskatchewan Nurses Association v. The Service Employee's International Union (SEIU)," 1973). This was to have a direct impact on the structure and functioning of the RNABC. The court ruled that the provincial nursing associations could not function as a bargaining agent for their members. This created a need for a restructuring of all Canadian nursing associations because of the concern over the possibility that a conflict of interest may arise as "...one group cannot at the same time act as a regulatory body, bargaining authority and a professional association (Registered Nurses Association of British Columbia, 1973, p.12).

When the RNABC was required to separate the governance and advocacy functions within its structure, this led to the introduction of a formal disciplinary process. Lay public involvement had been legislated into the association, consolidating the “public protection”
mandate of the Association. Also, the labour movement had matured providing greater powers for disgruntled workers. These two roles increasingly provided the dynamic for conflict of interest issues for the Association.

Overall the historical flow of nursing can be seen as an upward struggle for occupational autonomy, struggles for fair treatment, and the struggle to self-regulate and thus self-police. According to Coburn (1988), “Nursing is now using theory, organizational changes in health care, and credentialism to help make nursing separate from, but equal to, medicine and to gain control over the day to day work of nurses” (p.437).

The Movement for Registration in Nursing

Before embarking on a discussion of the formal disciplinary process commencing in 1975, I believe that it is important to provide some details regarding the legal recognition of nursing as a profession in 1918. These details provide important contextual background to the formal disciplinary process described in this chapter and the following two chapters. In addition these details also provide a particularly vivid example of the struggles of nurses throughout their history.

As the concepts of nursing care and who should be a nurse became more clearly defined by nursing leaders in British Columbia, interest in distinguishing the trained nurse from the un-trained nurse grew. Registration Acts were thought to be the only legal means by which nurses could meet standards of care and of admission to the profession. The registration process was aimed to promote a good name for “nursing” and control nursing education and thus discipline. It was argued that this would, in turn, facilitate the protection of the public from unsafe practice (Canadian Nurses Association, 1926, 1968; Mussallem, 1992; Rafferty, 1996, 1997; Russo, 1982; Whittaker, 1984).
The struggle for professional status in B.C. began in 1909 with the informal organization of practicing nurses. In 1910, the Graduate Nurses’ Association of Vancouver attempted to organize all British Columbia nurses (Whittaker, 1984). Their executive committee met to draft an *Act of Registration*. At the same time, they planned the formation of a Provincial nurses’ association. The bill, which was not presented to the legislature (Canadian Nurses Association, 1911), included a provision for an Examining Board consisting of two doctors and four nurses, to ensure that registered nurses had attained certain standards of nursing education in theory and practical experience (Canadian Nurses Association, 1911). It is noted by Lamb (1979) that it was not until after the first two decades of the 1900s that articles began to focus on ethics in nursing; thus, there was no formal analysis of these issues for the first 20 years of registration. It is therefore not possible to comment on ethics at this time because of the lack of documentary evidence.

In order to present an act to the legislature, the nurses thought it necessary to be united. The Victoria nurses arranged for a meeting in September 1912, which attracted sixty-eight nurses from Victoria, Vancouver, New Westminster and Kamloops. They formed the Graduate Nurses Association of British Columbia (GNABC) and immediately struck a committee to draft another bill for registration (Canadian Nurses Association, 1912). The proposed bill would have incorporated the GNABC, which was to be governed by a 12-member council elected from the membership. The GNABC would have had the power to examine nurses, to approve training schools, to keep a current register and to set the standards for applicants to be registered (Canadian Nurses Association, 1913). The GNABC had assured the membership of the support of the medical profession for passage of their bill.
Yet the bill was not presented to the Legislature in 1914. The GNABC bill had been “thrown overboard” (Canadian Nurses Association, 1914, p.224). What this meant was that it had really been withdrawn as a government measure. Dr. Young, a medical doctor and the Minister of Education, was to have presented the bill to the Legislature. However, Dr. Young advised the GNABC that “it was not a convenient season” to bring the bill forward (Canadian Nurses Association, 1914, p. 328). supposedly because the First World War was imminent and nurses were going to be involved. A different account of the struggle to pass the nursing Act was described in another primary source by the president of the GNABC at the Canadian National Association of Trained Nurses (CNATN) convention in 1917 (Whittaker, 1984). Although this account conflicts with Dr. Young’s account, both accounts were included here as I considered the accounts to be authentic. Indeed the conflict between the accounts illuminated an important power struggles between the doctors and nurses at this time.

This doctor... was our Provincial Secretary and also Minister of Education, and the nurses introduced the bill and we took it up to him and asked him to do something with it. We never knew what happened. We went away feeling that our bill was being taken care of, but it had not even been touched. The next year he said he was going to help us. We found that he was working against us. Our bill last year, as many of you may have known, got up to its Third reading. If it had ever gone through, the nurses in British Columbia would be five times worse off than they are today (Canadian Nurses Association, 1917, p.437-438).

This account suggests professional rivalries between doctors and nurses, and also suggests that gender power struggles may have been present, as well. The doctors wanted the profession of nursing to be under the direct control and management of the College of
Physicians and Surgeons, as opposed to a self-regulating profession. In an article in the Canadian Nurse, Ethel Morrison, a graduate of the Vancouver General Hospital, outlined the perceived benefits of registration.

In what way will registration advance the profession of nursing? First, if the law requires a higher standard, our training schools for nurses will have to train and pass only nurses of that standard. Second, for the working together of all graduate nurses for a thorough registration, and equal exam, if ever necessary, the expelling of unworthy members. Third, to receive from the medical association the same respect for our registration bill that they have to their own (Morrison, 1911, p.6-7).

The nurses were clear that self-regulation was a critical issue within the registration process, and they were not inclined to cede this issue. However, significant progress in the matter of registration was not to be achieved until after World War One, which dominated the decade of 1910.

On March 23, 1916, Bill 11, An Act Respecting the Profession of Registered Nurses (British Columbia Legislative Assembly (BCLA), 1916, p.27) was read. However, the struggle for registration of nurses was not yet over. On the second reading, the Nelson MLA opposed the bill, stating:

Graduate nurses are fairly well treated now and need no more protection. Some of our grandmothers... were better than any graduate nurse who ever got papers in British Columbia, especially in maternity nursing and children's diseases (Victoria Daily Times, 1916, p.11).

This MLA saw the legislation as offering protection to nurses, whereas the nurses stated purpose was the protection of the public. These two viewpoints continue to be evident in discourse concerning organizations and professional status today. That is, many people view
professional organizations as protecting their members rather than protecting the public (Bryce, 1993a, 1994).

At the Committee of the Whole Assembly, on April 6, 1916, Sir A. Macdonald (Vancouver) offered the GNABC the right to set the qualifications of an applicant and the right to refuse the admission of a “qualified” candidate, though he did not define the term “qualified”. Dr. Young countered with an amendment to place the bylaws and regulations of the GNABC under the control of doctors, as he felt it was not sufficient to have two doctors on the Examining Board (Whittaker, 1984). Young was accused of being “out of practice”; his retort was that “it was not necessary to be in practice to hear stories of the actions of irresponsible nurses” (Victoria Daily Times, 1916, p.11). A supporter of the amendment “contended that nurses were adjunct to the medical profession and the doctors should have a word in the framing of their rules and standards” (Victoria Daily Times, 1916, p.11).

There was also great controversy over maternity care and the practice of midwifery. Many doctors, including Young, proposed that midwifery and obstetrical nursing be included under the Nursing Act (Victoria Daily Times, 1916). The nurses opposed this intent, probably because of the poor image of midwifery at the time.

On May 17, 1916, Bill 11 was approved with Young’s amendments, but the Legislature prorogued 27 before the final reading of the bill. The nurses were relieved. The president of the GNABC, stated, “That is just how near we came to having midwives in British Columbia” (Canadian Nurses Association, 1917, p.438). The practice of midwifery would remain unregulated, and thus was practiced legally only by members of the College of Physicians and Surgeons. One of Young’s proposals at this time was to include a course on “ethics” in nursing training which concentrated largely on nurses’ required obedience to

27 A legal term for postponed.
doctors, as the doctors had expressed concerns about the nurses’ independence (Whittaker, 1984).

In 1916, the Conservative government, which had successfully opposed the vote for women, was in its final year. Women had supported the opposition Liberals to help defeat Bowser and to pass the enfranchisement referendum (Buckley, 1979). The new government granted the women of British Columbia the franchise and the right to be elected to the legislature on April 5, 1917 (Cleverdon, 1974). The first female member of the B.C. Legislature was Mary Ellen Smith in 1918. In the new political atmosphere of 1918, the GNABC decided it was time to present another Registration Act to the legislature. Bill 68 was introduced on April 10, 1918 (Goldstone, 1981; Whittaker, 1984). In order to get some advance publicity on the new bill, President Helen Randal stressed that the bill did not refer to those who nursed friends or relatives “nor to any person nursing the sick for hire who does not in any way assume to be a registered nurse” (Whittaker, 1984, p.318). Dr. Barrett, president of the Victoria Medical Association, assured the nurses that their bill had the Association’s “whole-hearted approval” (Whittaker, 1984, p.318). Dr. Sutherland (Revelstoke) introduced An Act Respecting the Profession of Nursing (British Columbia Legislative Assembly (BCLA), 1918) in order to formalize the doctor’s support.

The provisions for control of non-graduate nurses and for midwives were omitted in the new bill. Added to the new bill was the requirement that nurses obtain experience in the nursing of contagious diseases (“British Columbia Bills - An Act Representing the Practice of Nursing, Victoria, B.C.,” 1918). Nurses now had much more control over their own group. The standards for admission to a school of nursing did not require a definite number of years of schooling, or an age limit. However, the Council had the right to approve a school of
nursing. This vague clause was ultimately very important, as the Association began to close schools of nursing and restrict entry based on age and educational background. The rational was to ensure that professional nurses were distinguished from their untrained counterparts.

Bill 68 passed quickly through the Legislature and was given Royal Assent on April 23, 1918 (British Columbia Legislative Assembly (BCLA), 1918). The *Registered Nurses Act*, SBC. 28 1918, Chapter 65, was now law and Helen Randal was appointed the President. A Miss Breeze was appointed the Registrar, in name only, for the sole purpose of signing the registration certificate with the President (Goldstone, 1981; Kerr, 1944). According to Kerr (1944), the first council of the GNABC which was appointed by the College of Physicians and Surgeons, named Ms. Randall as the Registrar of the College, until her retirement in 1944. Miss Breeze was appointed the Secretary and Treasurer.

The purpose of the Association was to set the standards of nursing education and practice in the province, and to uphold the integrity of the nursing profession (Registered Nurses Association of British Columbia, 1998). However, I have been unable to locate any documentation discussing the specific standards of practice at this juncture. The Association drew up a constitution and bylaws, which were amended almost annually, and provided the Association with the ability to function as a public body. The “Constitution” provided the Association with the ability to set out the “… general purpose of the Association and establish the process to make amendments to the constitution and bylaws. The Constitution must conform to the objects and purpose of the *Nurses (Registered) Act*” (Registered Nurses Association of British Columbia, 1998 p. 4). The bylaws “stipulate[d] the corporate governance” of the RNABC, as well as, setting out the authority for decision-making within

28 SBC – Statutes of British Columbia.
also established the classes of membership and the voting powers within the Association. In
1918, the constitution and bylaws set out the rules of the Association, in accordance with the
*Act* (*Constitution and Bylaws, 1918*), although there was nothing specifically laid out in
regards to disciplinary procedure.

Thus, from the beginning, the interpretation of natural justice lay in the hands of people
who may or may not have had an understanding of the legal principles of natural justice.
Legally speaking, this legislation gave the Association the power to self-regulate the practice
of registered nursing in the Province of British Columbia.

**Self-Regulation**

The legislation of nursing as a profession in British Columbia introduced the important
construct of self-regulation. Self-regulation is a crucial element of the nursing profession in
British Columbia, and as such warrants further discussion as I close this Chapter. The two
ways in which a body can be regulated are by the government or by the profession itself. The
first *Act* of 1918 granted nurses in British Columbia the right and responsibility to regulate
their professional body. Regulation refers to the framework and process in which order,
consistency and control are brought to policy or practice. Self-regulation, according to the
*Canadian Nurse* (2001), is “based on the belief that the profession has the special knowledge
required to set standards of practice and assess the conduct of its members through peer
review” (p. 6). This concept is further supported in the courts and is referred to as curial
deferece:

Curial deference should be given to the opinion of an
administrative tribunal, which enjoys the requisite quality of
specialized expertise on issues that fall squarely within its area
of expertise. In such cases, the court should not interfere
unless the tribunal’s decision is not reasonable or is clearly
Thus self-regulation is based on the belief that professions have a unique and specialized body of knowledge, and only members of the profession have the ability to set standards of practice in accordance with this knowledge (Bonang, 2000; Mawani, 1999; Registered Nurses Association of British Columbia, 1999a, 1999b, 1999d). A number of writers (such as the ones I have just cited) believe that members of professional associations are more capable of assessing the conduct of fellow members through peer review. Under curial deference, judges in the courts regard members of the association as more capable of assessing the appropriateness of conduct of other members of the association, than a court of law, in regards to professional practice.

Nursing in Canada has been delegated by the provincial government the rights and responsibilities of self-regulation. The primary purpose of self-regulation is to protect the public from unqualified, incompetent, or unethical professionals (Bay, 1998; Mawani, 1999; Registered Nurses Association of British Columbia, 1998a, 1998b, 1999a, 1999b, 1999d, 1999e, 1999f, 2000a, 2000f, 2001). Historically, this was done by the development of educational programs and other established requirements for entry into the profession. In recent years, the context of regulation has changed. Social, political, economic and technological factors are influencing nursing practice and its regulation, and thus, the development of self-regulation has taken on a much broader role, incorporating professional practice standards, strengthening leadership through education and providing support strategies (Canadian Nurses Association, 2001).

Although from the onset of professional nursing in British Columbia there is a strong suggestion that hearings were to be carried out in cases of nursing discipline, there is no
record of any such hearings taking place. One is left to wonder if this is due to secrecy to protect the accused, or because no hearings were ever actually held. I favour the latter theory, because there is also no reference to any procedure or process being set up which would have enabled the Association to effectively undertake hearings into the conduct of their members until 1975. There is also a provision in the Act that the name of any nurse who was removed from the registry would be recorded. I was unable to locate any record of such an occurrence.

The extent to which self-regulation has evolved is one thread I continue to weave into the narratives in the remainder of Chapter 3 and Chapters 4, and 5. A question arose for me as I pursue this thread, ‘is this the process of self-regulation (and naturally flowing from it, self-discipline), true self-regulation, or is it regulation by a few elite and powerful leaders?’ (Coburn, 1988; McPherson, 1996). In this study I hope to shed light on this and related questions as I proceed.

Nursing in the Period 1975-1979

The year 1975 is significant in the development of nursing disciplinary processes in British Columbia. It is marked by the first documentary records of formal disciplinary cases undertaken by the RNABC, arising from complaints regarding the conduct of nurses. There are no clear causal links that I have been able to uncover which lead to the development of the formal disciplinary process. Thus the process seems to have arisen as a result of changes in mores and ideologies in the wider society at this juncture and not the legislative requirement for a process that had existed since 1918.

The late 1970s saw the continued consolidation of Vancouver as a thriving metropolitan city. It was an era of growth for the city (at the Federal level, the economy floundered) and the development of infrastructure aimed at a flourishing tourism industry. After the tumult of the 1960s, life in the 1970s seemed duller with the beat of a disco generation setting the tone,
then to be replaced with the snarl of punk music as the decade closed (Cranny & Moles, 2002; The Province, 2000). Generally, the 1970s seemed to be marked by a series of scandals and other events which forced the general public to question the institutions upon which they had come to rely. Although the Vietnam War, the Watergate scandal and Love Canal were all United States-based concerns, the proximity most likely influenced Canadians. These events all demonstrated a greater access to information, which in previous years would probably have been suppressed. Perhaps the RNABC’s development of a formal disciplinary process at this time, after 57 years of legal standing, could be understood as an effort to respond to perceived public demand for accountability, professional responsibility, and transparent leadership.

One of the important shifts in the 1970s was a change in patterns of nursing service delivery. In nursing practice, primary care nursing was introduced in the early 1970s and began to be implemented in full force in 1975 (Kerr, 1996). Primary care nursing replaced the team nursing care model. Team care nursing had been criticized as leading to a fragmentation of patient care among different RNs and their associated practical nurse teams. Because each patient was under the direct care of only one RN, in primary care accountability for each patient was clearly defined. This made it easier to identify professional accountability, which likely facilitated the role of the disciplinary process in protecting the public (Kerr & MacPhail, 1996a). Under team care, it can be hypothesised that as accountability was spread over a group of RNs, it would have been less obvious which individual nurse was responsible for the patient as a whole. I have not, however, been able to ascertain a link between regulatory issues and discipline. The primary care model was seen as
a solution to the multiple problems associated with the organization of staff to provide quality nursing care (Corpuz, 1977; Dawson, 1983).

A second major change in the 1970s was in specialization. Since the mid 1970s, there had been an increasing "necessity for every nurse to specialize in an area of practice after completing a program of basic nursing education" (Kerr & MacPhail, 1996, p.374). The main reason for this need for specialization was the exponential growth of diagnostic and treatment regimes. In addition, the 1970s marked the beginning of the information era and the birth of grass roots health organizations, such as the Women's Health Collective and the Midwifery Task Force in B.C. The impact of grass roots health organizations is seen in the example of the relaxation of the abortion laws in 1970 (Womenspace, 2003). The RNABC released a paper in 1971 in response to the change in the abortion laws stating that abortion should not be preferred to other methods of birth control, and that the decision should be between the doctor and the woman. At this time the Association also called for more education, research and improved access to birth control information (Womenspace, 2003). Nurses working in reproductive health required specialized education in the new procedures of abortion, but also had to be able to respond to women's requests for information regarding contraceptive choices. These choices had to be understood through the lens of the complex ethical issues surrounding abortion. These issues included the balancing the rights of nurse to a moral position on abortion, and the rights of women and unborn children to life and liberty. Only though grappling with these issues could nurses begin to effectively advocate for a patient's informed consent within a health care system. The women's movement continued to gain ground. In addition to the abortion issue, the Royal Commission on the Status of Women (RCSW) presented 167 recommendations, which became the blueprint for mainstream
feminist activism during the 1970s (Womenspace, 2003). Education, employment, and family life were major concerns for the women and groups who made presentations to the RCSW.

Nursing was still a largely female occupation, and hence, benefited from the recommendations of the RCSW and the associated increased autonomy, benefits, and power that women were beginning to derive in Canadian society (Womenspace, 2003). At the same time, within the Association the changing societal values and laws led to the development of more ordered and formal rules, to ensure that the legal obligations of the Association were fulfilled “to serve and protect the public” (Registered Nurses Association of British Columbia, 2003e, p.1). It seemed from a review of the literature during this time period that every new development required a rule in which the Association would follow. By 1978, it was clear that nurses needed practical guidance in the application of ethics to the plethora of new ethical issues they were facing. This was to provide impetus for the adoption of a new Code of Ethics for the Association to replace the previous code which had an international focus and was 25 years out of date (Canadian Nurses Association, 1986a).

**Nursing Developments - Specialization and Ethical Concerns**

Because of the increase in nursing specialization, concerns arose when graduate nurses were deemed 'incompetent' to practice in speciality areas without further post-basic education (Canadian Nurses Association, 1986b). This safety concern prompted many tertiary care facilities to offer intensive courses and orientation programs to nurses wishing to work in speciality areas, such as the operating room, post anaesthetic recovery, the intensive and coronary care units, and labour and delivery (Canadian Nurses Association, 1986b; Erickson, 1979). This increased specialization had changed the scope of nursing practice and led to a broadening of responsibilities and ethical issues affecting nursing practice. Examples
can be seen in the transfer of functions from physicians to nurses, such as the ability of a nurse to administer anaesthetic gas (nitrous oxide) in the labour and deliver area, and the ability of a nurse to remove epidural catheters and pronounce a patient's death (Grace Hospital, 1987; Registered Nurses Association of British Columbia, 1995c).

In 1978, at the CNA annual general meeting, the CNA voted to make the development of a new Code of Ethics a national priority. Up until this point, nurses had been guided by the International Council of Nurses (ICN) Code for Nurses - Ethical Concepts Applied to Nursing. This code had been adopted in 1953 by the Canadian Nurses Association from the 1953 International Council of Nurses (ICN) (Kerr & MacPhail, 1996a), and had not been updated since.

**Changing Roles in Labour Negotiations**

The expansion of areas of practice for nurses brought them into conflict with job descriptions of other members of the healthcare team - thus, specialization also influenced issues of labour relations. The issues arising from increased specialization included wider standards of practice for specialized nurses and the difference between what could reasonably be expected of a newly graduate nurse and a nurse working in a specialized area, (such as critical care, emergency, or labour and delivery). These in turn affected staffing considerations, education, and hence labour issues. In 1975, the responsibility of negotiating contracts for hospitals moved from the Committee of the British Columbia Hospital Association (BCHA) to the newly formed Health Labour Relations Association (HLRA) (British Columbia Nurses Union, 1992; Goldstone, 1981; Registered Nurses Association of British Columbia, 1978; Russo, 1982). The HLRA was an independent organization whose sole purpose was to represent the interests of public and private hospitals in bargaining. The
following year, the Government Employee Relations Bureau was legislated into existence. Its role was to take over all direct bargaining on behalf of the government (Russo, 1982).

Within the RNABC, in 1976 a Labour Relations Division separated from the Registered Nurses Association in order to comply with the B.C. labour laws, which prohibited management personnel from influencing negotiations on nurses’ collective agreements (British Columbia Nurses’ Union, 1992; Goldstone, 1981; Registered Nurses Association of British Columbia, 1977; Russo, 1982). In 1977, the by-laws of the Association changed to reflect this division. Under the new by-laws the RNABC’s Labour Relations Division had its own governing body and council, a separate staff to deliver union business, and a entirely separate funding source (Russo, 1982). This separation echoed the Supreme Court of Canada decision of 1973, and paralleled legal precedents across the country. However, in B.C., the new organization “shared the name of the RNABC and was mandated by RNABC by-laws” (Russo 1982, p.32). The Supreme Court of Canada decision mandating the separation of governance and advocacy functions of professional associations had been clarified within the RNABC by clearly delimiting roles and responsibilities. Possibly this separation of function brought to light issues of disciplinary concern, which promoted the development of the formal disciplinary process, although I have not been able to locate this idea explicitly in the data I retrieved.

In summary, it can be seen that the major trends in B.C. nursing in the late 1970s meant increasing specialization, leading to an expanded field of ethical concerns for nurses. Wider ethical considerations led to the development of a new code of ethics. The trend in specialization also impacted labour negotiations, and, on an administrative level, the period saw the beginning of the process of separation of functions within the RNABC. The process

of separation of functions continued, arguably to the present day, as I have explained in Chapters 6 and 7. However, in the 1970s, the process manifested as the separation within the RNABC of bargaining and governance functions.

Nursing Disciplinary Processes 1975-1979: The First Formal Hearings

The first formal hearings of the RNABC were held in August, 1975 (British Columbia Nurses’ Union, 1992; Goldstone, 1981; Registered Nurses Association of British Columbia, 1975). For the first time in the history of nursing in B.C., the topic of nursing disciplining appeared in an editorial in the RNABC News (Registered Nurses Association of British Columbia, 1975b). The published article indicated that nurses had been sanctioned before the Board of Directors of the RNABC.

By the time the article appeared, the RNABC Board had disciplined three nurses. Formal hearings against three members of the Association were conducted in mid-September under the authority of the Registered Nurses Act (Registered Nurses Association of British Columbia, 1975b, p.13). In the editorial, the nurses who had been disciplined were identified by name and registration number. A very brief description of the charges and penalty followed, which I have provided below. Following this description, I have given specific examples drawn from cases, to provide insight into the evolution of disciplinary process within each individual time period. I have elected to define the time periods using the same chronological divisions that appear in the Summaries of Professional Conduct Inquires of the RNABC.

Of the first three nurses charged, one nurse had her membership revoked following complaints charging her with “conducting herself in a manner contrary to the ethical standards of the profession… exhibited a habit or illness rendering her unfit or unsafe to be entrusted with the care of the sick…” ("Registered Nurses Association of British Columbia,
Decisions and Reasons, 1975, #342975, p. 2.

The complaint initiated by the employing agency alleges that a 27-year old nurse, educated in another province, who was currently employed in a large acute care hospital:

1. Demerol 100 mg signed for in Nurse’s Notes and narcotic record - no physicians order.
2. Signed for Demerol on narcotic Record - not recorded in Nurse’s Notes.
3. Gave injection of Demerol to patient, signed narcotic record - not in Nurse’s notes. Unable to find empty Demerol vial.
4. Demerol recorded on Physician’s Order Sheet, as verbal order-physician did not give order.
5. Patient states nurse had offered her injections (already drawn up) x 2, which were refused. Also states when nurse did give injection did not experience usual effect.

(Registered Nurses Association of British Columbia, 1975, #342975, p. 1).

The finding of the BOD was unanimous and the member’s registration was revoked in January, 1976. The following June, the member requested reinstatement. The Referral and Review Committee requested written evidence the “she had overcome her [substance use] problem” (p.2 my addition). In October, 1976, some 10 months after the initial complaint was lodged, the BOD reinstated the membership under the conditions that “... she finds employment in nursing in a setting where her supervisors are aware of the problem and where she is evaluated consistently for freedom from drug dependency” (p.2). The Referral

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30 Identification or Data Indexing-The identification of the nurses involved in hearing prior to 1977, have been indexed numerically (but not chronologically, according to the RNABC) “Code numbers were assigned for editing purposes and do not relate to the time periods or subject matter ...”. The author notes that indexing numbers could only be crossed referenced by searching the cases, when they were reported in the RNABC News. For hearings after 1977, indexing is by registration number, and crossed referenced numerically in the “Summaries of Professional Review Files, Volume I. Disciplinary Actions by the RNABC”, dated 1975 to 1979, compiled by the RNABC in 1984 and 1985.

31 The Referral and Review Committee was the Committee of Ethics and is now known as the Professional Conduct Committee.
and Review Committee monitored the member’s progress, and following 16 months of performance evaluation, in February, 1978, the committee was satisfied with the reports and ordered no further follow up. The matter was closed.

The other two nurses, referred to in the editorial, were also charged with “… conducting themselves in a manner contrary to the ethical standards of the profession…” These cases concerned mental illness and the abuse of alcohol ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1975 #9114;", "Registered Nurses Association of British Columbia, Decisions and Reasons, 1975, #32993."). Both members were suspended indefinitely.

Members of the Association responded to the reporting of the three nurses disciplined by the RNABC Board of Directors. In the RNABC News (Registered Nurses Association British Columbia, 1975, p. 18) nurses who wrote to the editor of the RNABC News replied with the following comments:

“Disgusting article”

We are writing to express our disgust regarding the article entitled ‘Board disciplines three nurses’ .... We do not question the revocation or suspensions...or the fact that this information was published... necessary for the protection of these nurses, the nursing profession and the public in general. But we are alarmed at the manner in which this was presented. After all, drug addiction, mental illness and alcoholism are illnesses. ... of all organizations to publicly condemn individuals for being ill (Registered Nurses Association British Columbia, 1975, p.18).

From reading the reply, I suggest that some members of the Association did not support the manner in which the Association presented the details regarding fellow members. There were no letters published that supported the article. Yet the following quote from the
RNABC Committee on Social and Economic Welfare indicates that this new process of reviewing the behaviour of fellow members had not been an easy one.

I would like to assure you that the hearings have been very hard on all concerned. This is the first time that board members have had to face such a situation, assessment of peers. It is not an easy thing for any of us, "Who am I to be judging another nurse? Do I understand all the facts?" The decisions were not taken lightly (Registered Nurses Association of British Columbia, 1975a, p.9).

In 1975, the Committee on Social and Economic Welfare was renamed the Committee of Referral and Review and the committee referred 11 cases for hearings before the Board of Directors; these hearings were conducted under the authority of the Registered Nurses Act, 1973, Section 29. A further 10 cases were recommended for follow up consideration. Of the 11 referred for hearings, the BOD decided not to hold a hearing in one case (#41), suspended seven nurses (#24, #40, #26, #4, #10, #37, #35), and revoked three members’ registration numbers (#342975, #32993 and #9114). It should also be noted here that nurse’s names did not appear in the Summaries of Professional Review or in the Decisions and Reasons of the Committee of Referral and Review, although the nurse’s names and registration numbers did appear in the RNABC News. I speculate that this may have been

32 The numbers cited represent the case numbers listed by the RNABC, in the RNABC, Summary of Professional Review Files, and 1975-1979. In early 1975 cases were assigned a number, in late 1975 onward cases were cited by registration number, hence a different numbering system.

because of a lack of clarity over the nurses right to be protected and the public's right to
know.

Much of the data I was able to retrieve concerning nursing disciplinary hearings during
this period are found in a two-part document published by Margaret Dolan (1980) in response
to internal concerns in the RNABC over the disciplinary process. I consider Dolan's report to
consist of both primary and secondary sources because in parts it provides narrative in the
first person of events and in other parts it reports on events as described by others. Dolan's
Action Process of the Registered Nurses Association of British Columbia". This study
reviewed 58 cases heard by the RNABC between August, 1975 and January, 1980. The
hearings were divided into two groups by Dolan. Between August, 1975 and September,
1977, 28 cases were heard before the full, 24-member Board of Directors of the RNABC (11
cases in 1975 and the remaining 17 cases from 1976 to August, 1977). In the summer of
1977, the disciplinary process was revamped. The changes were specific to the way
disciplinary cases were presided over, and it involved replacing the 24-member BOD with a
three-person disciplinary panel. Commencing in September 1977, the remaining 30 cases
reported in the Dolan study were heard before the three-member panel of nurses appointed by
the Committee of Referral and Review, under the authority of the Registered Nurses Act,
1977, Section 29 and 29 A-N inclusive (Registered Nurses Association of British Columbia,
1977).

The reasons cited for a change in the method of hearing professional disciplinary matters
was that the process was "...very time consuming..." (Registered Nurses Association British
Columbia, 1975a, p. 9) and "... unwieldy, expensive in both time and money" (Registered
Nurses Association British Columbia, 1977b, p. 4). Young Consulting Group (1999) reports that the change in the way hearings would be handled “...address[ed] not only the concern with logistics, but also the concerns regarding fairness” (p.10). I might speculate that the reference to fairness related to the cost to a nurse of undergoing a lengthy disciplinary process, as well as the power imbalance introduced by a hearing in front of the entire BOD.

Carmacks, the Director of Employment and Referral Services, further described the 1973 Act (which mandated hearings in front of the entire BOD) as, “not expedient either for the RNABC, for the member or for the protection of the public, ...” (Registered Nurses Association British Columbia, 1977b, p.4). In other words, changing the hearings by forming a three-member committee to preside over complaints was seen to be more economical and time efficient.

This change was reflected in the Registered Nurses’ Association of British Columbia (1977b) publication which explained several alterations to the disciplinary process under the Registered Nurses Act (1977). The 1973 Act, Section 29, had been repealed and replaced with a new Section 29. The new Section 29 had been expanded from “half a typed page to six and a half pages” (p. 4). The changes can be summarized in general terms as making the disciplinary process more formal and judicial. The panel was able to take evidence under oath and request affidavits, and witnesses could be examined and cross-examined by the parties (the member or member’s counsel, the committee and the Association or its counsel). Disciplinary hearing would now be heard by a three-member panel appointed by the 10-person Disciplinary Committee (Registered Nurses Association of British Columbia, 1977b, p.5). The three-member panel, as opposed to the full 24-member Board of Directors, would now hold formal quasi-judicial hearings into the alleged complaints against the member.
The amended Act also laid out the rights and responsibilities of members and the Association during disciplinary hearings. For example, members were entitled to be represented by counsel, witnesses could be called, and the hearing was to be recorded by a court reporter. With regard to penalties, the panel now had considerably more latitude. Members could be reprimanded or censured, or her or his membership could be suspended or revoked. As well, conditions could be placed on the member’s registration, such as limiting the place of work, or requiring supervision of practice (Registered Nurses Act, R.S.B.C., 1977, c. 335). This process now allowed the panel considerably more autonomy, which would become particularly beneficial in addressing situations involving addictions (elaborated on below).

In addition to procedural changes, the publication of a ‘members sanctioned’ section of the Act became more specific. If the member was found guilty, the member’s name, registration number and summary of the charges and findings would be publicized in the RNABC News, the B.C. Gazette,33 and, where appropriate, the local news for “lay media” release. The Act also required that all Decisions and Reasons be in writing. The appeal process 35 was described in two steps. Firstly, the member was entitled to appeal the decision of the disciplinary panel to the BOD, which could choose to re-hear the matter either with a new hearing, or by reviewing the transcripts of the original hearing. The second step, if needed be, was the right to appeal to the Supreme Court of British Columbia ("Registered Nurses

33 The "British Columbia Gazette Part I", produced under the authority of the Queen’s Printer Act, is published once per week, and includes legal notices, such as Notices to Creditors; Notices of Restorations, Incorporations, and Dissolutions; Public Tenders; and Order-In-Council Notices.

34 This would include the newspaper in the community where the nurse resided as well as the provincial newspaper.

35 The appeal process is the avenue that can be followed if any party is dissatisfied with the results of the decisions of the disciplinary committee (Registered Nurses Act, RSBC, 1977, c. 335).
Act, R.S.B.C., 1977, c. 335; Registered Nurses Association of British Columbia, 1977). The appeal process, to the Supreme Court of British Columbia retains in a very similar format to the present day.

Of the 30 cases reviewed in the Dolan study (Dolan, 1980) between 1977 and 1979, five of 30 cases were appealed to the BOD, one nurse was exonerated, one nurse’s findings were reversed, and two nurses had their conditions of registration amended, I was unable to determine the results of the fifth matter. This indicates to me that the BOD, in the early years, was inclined to overrule the decisions of the newly formed disciplinary panel. Interestingly Dolan’s study does not comment as to why the BOD chose to amend the decisions of the panel.

"Nursing Discipline Involving Substance Use Issues"

As indicated above, one of the key issues that the Disciplinary Committee grappled with at this time was the issue of addictions. Prior to the 1980s, the resources available for the treatment of addictions were very limited. However, the late 1970s saw the introduction of “...mandatory attendance at AA/NA, counselling and drug testing...” (Young Consulting Group, 1999, p. 10) as a condition for the continuation of registration for nurses with alcohol and drug addiction issues. Wedge (1991b) pointed out in her report titled Submissions to BCNU Council, Natural Justice and the RNABC Professional Conduct Committee, dated 1991, that BCNU found that in respect to Section 22.1 of the Act, members’ constitutional rights may have been (and are currently) in jeopardy. Section 22.1 of the Act states that:

36 From my experience in attempting to track cases and appeals (internal and external) before the RNABC, its various committee, panels, and to the Supreme Court of British Columbia I have at times had difficulty. Cases seem to be dropped with no apparent explanation, as in the example provided.

37 Alcoholics Anonymous / Narcotics Anonymous are twelve step peer support groups for people with addictions based on the twelve step philosophy.

38 Wedge’s reports play a significant role in this thesis and will be discussed in detail in Chapter 5.
22.1(1) Where there are reasonable grounds to believe that a member is incompetent, or suffering from a physical or mental condition or an addiction to alcohol or drugs that impairs her ability to practice nursing, the chairman of the Professional Conduct Committee may direct the member to undergo a physical, mental, clinical or other assessment as the chairman determines is required.

(2) Following an assessment under subsection (1), the person making the assessment shall deliver a report of his [sic] opinion, in writing to the member who was the subject of the assessment, and the chairman of the Professional Conduct Committee.

(3) A report prepared under subsection (2) may be used in evidence at an inquiry under this Act, subject to sections 11 and 12 of the Evidence Act, except that “14 days” is substituted for “30 days” in each place that it appears.

According to Wedge, Section 22.1 of the Act, pursuant to which the RNABC could order a medical or psychological assessment of a nurse by a physician of the Association's choice, was of grave concern, and had been a concern for many years. The powers given to the Association under this Section represented a significant incursion into a nurse's constitutional right to security of the person and due process of law. "BCNU may wish to consider alerting its members to the insidious nature of Section 22.1(1) and the constitutional right to resist such an order" (Wedge, 1991b, p.2). The argument here was that the RNABC needed to defer these matters to an appropriate court rather than dealing with the issues themselves within the disciplinary process. This was also true for matters of alleged theft of controlled drugs, which Wedge claimed should have been dealt with by the criminal courts system Wedge, 1991a, 1991b).

Although it was a number of years before this issue of nurses' rights was addressed formally, RNABC's approach to addictions can be seen as one where the Association may have over stepped its legislative authority. At this point, however, the error could still be
seen as one related to the relative inexperience of the RNABC in disciplinary matters. This inexperience may well have been a contributing factor in the first Supreme Court Appeal arising from a disciplinary hearing, which I will turn to next. At this point I would like to note it is my view that the RNABC could be commended for trying to treat substance use issues separately from other disciplinary issues at this time because the understanding of substance abuse as an illness was in its infancy.

Appeal to the Supreme Court

In 1977, the first appeal to the Supreme Court of British Columbia was undertaken, although dropped that same year for undisclosed reasons (Registered Nurses Association of British Columbia, 1977b). The issue raised was that the member had been suspended for incompetence, i.e., for failure to chart narcotic medications. As this case was not published, I have been unable to determine the end results. But from the summary which appeared in the Registered Nurses Association of British Columbia, (1977b), it appears that counsel for the member was arguing that a new trial should be heard, as the BOD had failed to give reasons for its decision to suspend the nurse. Mr. Justice Berger 39 noted that “all the evidence before (the Board) was taken down by way of official Court reporter and transcribed. The Court (hearing the appeal), notwithstanding the failure to give reasons, can examine the evidence and determine whether the charges against the appellant (the member) can be supported” (Registered Nurses Association of British Columbia, 1977b, p.11). In June 1977, the amendments to the Registered Nurses Act “require all future disciplinary hearing (by the panel or the BOD) decisions to be in writing and to carry reasons for the decision” (p.11).

39 Mr. Thomas Berger served on the Supreme Court of British Columbia from 1972 - 1982. He was retained by myself in 1996 and was unsuccessful in my Appeal to the BOD of the RNABC (Berger, 2002).
In 1979, a final decision was reached by the Supreme Court of British Columbia for the first disciplined nurse to follow through the entire appeal process. The appeal process had taken two years. This case created precedent setting law in B.C. and led to the “establishment of the doctrine of procedural fairness” (Young Consulting Group, 1999, p.10).

The landmark case, Mason, ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1979,#418236,") was heard on May 1, 1979, and involved a Registered Nurse charged with incompetence who had received an indefinite suspension from the Association by the BOD. The charges have been summarized as follows ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1979, #418236, p. 6):

- Penicillin G one mega units was administered to a patient allergic to Penicillin, and whom you should have known was allergic.

- Tetracycline 250 mg was administered via Volu-trol instead of in 500 cc of solution.

- And incorrectly entered the time a blood transfusion was given.

- In regards to a 32-week maternity patient, who had had 3 previous miscarriages, you [the nurse] failed to examine or assess the patient prior to calling the physician, failed to complete the admission notes.

- Failed to chart the urinalysis and did not check the patient between 0545 and 0745.

- 60 cc of castor oil was given to a patient in preparation for a chole-cystogram, the test therefore had to be delayed;

You charted that the patient had received a 'fat-free' supper 45 minutes prior to the dinner trays arriving on the ward.

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40 A basic principle of the law whereby once a decision (a precedent) on a certain set of facts has been made, the courts will apply that decision in cases which subsequently come before it embodying the same set of facts. (Black, 1996). A precedent is a case which establishes legal principles to a certain set of facts, coming to a certain conclusion, and which is to be followed from that point on when similar or identical facts are before a court. Precedent form the basis of the theory of stare decisis which prevent "reinventing the wheel" and allows citizens to have a reasonable expectation of the legal solutions which apply in a given situation (Duhaime, 2002).
On November 9, 1978, the Honourable Justice, Markoff, J., of the Supreme Court of British Columbia made an order for a new hearing - a “trial de novo” - stating that this was “necessary due to an absence of transcripts of the original hearing” ("Mason v. Registered Nurses Association of British Columbia (unreported) November 9," 1978: p.5).

This hearing (Mason) concerned the definition of ‘Incompetence’ as contained in Section 29D (C) (i) of the Nurses(Registered) Act. As this is the first case dealing with allegations of incompetence, the judge requested counsel to provide legal authorities “relating to the meaning of the word ‘incompetence’…” (p. 12). The decision continues (for eight pages), reviewing the authorities provided by counsel, in an attempt to define “incompetence”. On page 20, the judge concluded that:

... for the purpose of this statute the word “incompetence” falls within the definition set out in Crotwell v. Cowan, supra. Thus, while a nurse maybe fully qualified and able, if her conduct demonstrates a pattern of carelessness and she is of a disposition or temperament whereby she fails to respond to advice as to her shortcomings, she may be found guilty of incompetence.

The court went on to say that the case against Mason had been proven beyond a “reasonable doubt” (a criminal standard of proof, generally considered 99-100% true), as opposed to the civil test of “a balance of probability” (51%) (Black, 1996; Hurlburt, 2000; Jones, 1999) and the decision of the BOD should stand except as to the penalty to be administered.

41 New trial beginning from primary evidence.

42 ("Crotwell v. Cowan, 236 Ala.578, 184, So.1,") defined the meaning of ‘incompetence’, which would be used by the Supreme Court of British Columbia in professional conduct cases.
This case was important because it defined the meaning of “incompetence” in accordance with the *Nurses (Registered) Act*, and has been used since 1979 to challenge and define incompetence in health care professions across Canada. Prior to this landmark court decision, the Disciplinary Committee relied on the RNABC Committee on Assessment of Safety to Practice to defined Incompetence. As illustrated below, and approved by the Board of Directors on November 8, 1976, the following definition had been used to define incompetence.

An act or series of acts which fall below a minimally acceptable standard, that standard to be determined by, a) whether such actions could be judged as a responsible action to have been taken by a nurse with similar responsibility in a similar circumstances, and b) whether such action is consistent with standards in general use in the province which would apply in the situation under review (#421773, 1981, p.2).  

The definition above differs from the previously cited definition in that it does not require a “pattern of carelessness”. Rather, it can be applied to a single act of carelessness. Conflict between these two definitions of incompetence was to plague nursing discipline in B.C. for several years, despite the decision of the Supreme Court in Mason. It is at this point that it becomes harder for me to excuse the Association’s actions on the grounds of inexperience. Rather than learning from the Supreme Court process and the new legal precedent that had been set defining incompetence, the Disciplinary Committee chose to manipulate the words within the decision (in Mason) to revert the meaning of Incompetence to one that reflected the Committee’s view of incompetence. Consequently, nurses were still being found guilty of
incompetence for situations which did not appear to represent a "pattern of careless", but rather a single action which would more accurately be described as "negligence". 44


Other examples of problems in the Disciplinary Process at this point were highlighted in the findings of the Dolan Report (1980). This study was commissioned by the RNABC, and although I could find no specific reason in the literature I speculate that the study indicates some insight into the trouble within the disciplinary process. The study concluded in 1980 with the following recommendations for the RNABC's disciplinary process:

- Communication and the transfer of information needs to be re-evaluated;
- More formal programs be initiated to deal with problems in the workplace;
- Contact The General Nursing Council in England and Wales in respect to current follow-up methods; and
- That a survey be undertaken to assess the attitudes of the general nursing population in the province in regards to the professional disciplinary action process. (p.5)

The Dolan report ended with the following interesting quote from Maner, J. (1979) entitled “Struck off!”. Which I found to be completely out of place, and with no context or commentary. My choice to include this quote here is to illustrate what appears to me to be an attempt by the author of the report (Dolan) to suggest that there are concerns within the RNABC’s disciplinary process:

...had found it difficult to understand how statutory body administered discipline, could, at the same time offer help and development [will ensure] that a nurse is offered much needed support right through a disciplinary investigation (p.13).


44 Negligence generally refers to a "single" action as opposed to a "pattern of carelessness". This is a widely used legal definition, which has now been adopted by the RNABC (Black, 1996; Registered Nurses Association of British Columbia, 2002b).
The above quote further suggests to me that for the first time in any data sources I have located that concern was beginning to emerge regarding the closeness/proximity of the Association in relationship to discipline and its administrative duties. It also indicates that there was a lack of support for nurses undergoing disciplinary proceedings. These issues will be addressed in more detail in Chapter 5.

**Review of Disciplinary Decisions from 1975 -1979**

Until the revision to the Act in 1977, there were three categories of infractions that could be heard by the disciplinary committee: 1) Unethical Conduct, 2) Incompetence, and 3) Unethical Conduct and Incompetence. An example of each type of infraction has been included in the following section in order to gain insight into the types of behaviour considered within each category. The examples have been drawn directly from the RNABC’s disciplinary summaries. These quotes are not intended to be a comprehensive list of concerns. Rather, they are to illuminate the types of conduct for which nurses were reprimanded, and language used to express the conduct during this time period. It is also important to note here that all data available from the Association is on the public record. The information contained in the RNABC’s Decisions and Summaries indicates the position, opinions, and arguments (defence) of the actions of the member, but there are no first-hand accounts which include the nurse’s perspective. Thus, these accounts must be used with caution. Consequently, this study is limited in terms of being able to provide an all encompassing view of the cases heard.

1. **Unethical Conduct:**

In this section I provide examples of allegations considered by the RNABC to represent unethical practice during the 1970s. I have attempted to select examples that are representative of the range of concerns classified as unethical practice by the Association. I
representative of the range of concerns classified as unethical practice by the Association. I chose the cases selected by reviewing all of the Decisions and Reasons from the time period, sorting them by category of infraction and then undertaking a cursory thematic analysis of the cases to determine the main themes included under each category and the types of language used. The same procedure was adopted for each time period. The examples selected to represent unethical conduct during the 1970s are:

... found asleep in the paediatric ICU with an eight month old child asleep on her lap (#16, 1975, p.1). 45

... that after determining that a nurse on her staff had struck a patient, she did not report the incident to the RNABC (#14, 1975, p.1). 46

... the nurse slapped an unconscious patient several times. Made comment Jesus Christ I hate overdoses (# 362001, p. 1, 1979). 47

... the nurse treated the consumer in a rough and rude manner (#192316, p.1). 48

From the above quotes it appears that nurses were charged with being unethical if they were alleged to have been irresponsible, rude or rough.

2. Incompetence:

The following two examples show the range of allegations considered to represent incompetent nursing practice during the 1970s.

... removed one ampule of Nisentil from the hospital (#38, 1976, p.1). 49

45 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1975, #16").
46 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1975, #14").
47 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1975, # 362001").
48 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1975, #192316").
49 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1975, #38,").
at 0200 hours temperatures when q4h temperatures were ordered; was unwilling to notify supervisor or doctor when change of condition of very ill children etc. (#185611, 1979, p.1).  

Allegations of incompetence appear to have been defined as both criminal actions and failing to follow doctors orders or making clinical decisions which another practitioner disagreed with.

3. Incompetence and Unethical Conduct:

Once again two examples have been selected as representative of allegations of incompetence and unethical practice during this time period.

... sent a patient admitted for delivery to the toilet and baby was delivered, unattended, in toilet; inserted a #18 catheter in a quadriplegic patient for whom a #16 was ordered; administered medication to a patient with a fractured pelvis without obtaining a doctors order; etc. (#5, 1975, p.1).

... the nurse had attempted to cover up a medication error in collusion with her husband who was the supervisor at the hospital; was unable to comprehend nursing orders; showed faulty judgement; and submitted faulty documents to Nursing Unit Administration Personnel (#386122 1979, p.1).  

Incompetence and Unethical Conduct appears to have been a category used when there were several overlapping and underlying issues.

All cases presented above resulted in the member being found guilty as charged. Of these eight cases, three nurses received reprimands (#14, #16, and #362001), three received conditions on their registration (#386122, #185611, and #192316), 1 nurse’s licence was revoked (#38), and one nurse’s licence was refused to be renewed (#5).

50 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1975, #185611").
51 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1975, #5").
52 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1979, #386122").
As I have previously alluded to in the section entitled Nursing Discipline Involving Substance Abuse, in 1977, a fourth category was added which was called “Unfit/Incapable of Nursing”. This category incorporated what would now be considered nurses with drug, alcohol and mental illness conditions. Prior to the addition of this category, nurses suffering from these illnesses were generally seen as unethical, and thus categorised as such. No nurses were cited under this new category, “Unfit/Incapable of Nursing” until 1981 (RNABC, Summary of Professional Review Files, 1975-1979; Professional Conduct Review-Citations, Decisions and Reasons, 1980-1989).

Summary of Period 1975-1979

The 1970s were a period of rapidly changing societal values. Laws were changing. The women’s movement was in full swing. Alternative health care (in the form of grass roots movements, such as the homebirth movement) was erupting. And nurses and the Association were attempting to keep pace with these demands. Responses were in the form of organizational structure, education, advocacy and ethics.

The early period of disciplinary hearings in the 1970s could be characterized as a learning stage for the Association. Because of the newness of the process in the 1970s, there were no definitions, precedents or rules upon which the disciplinary committee could

53 Learning is, however, also a characteristic of the entire period through to 1996, due to the rapid developments both in society in general and in administrative law processes in particular. The increasing presence of lawyers representing nurses also led to a similar reliance on lawyers by the Association as the disciplinary process developed. To a large extent, the RNABC was dependent on these lawyers to guide the development of the legal structures of the Association. This was particularly true through the 1990s as the nursing Association struggled to keep up with a series of legal precedents across Canada and in different areas of administrative, criminal and constitutional law.

54 The RNABC apparently did not appoint in-house legal counsel until 1997. When a lawyer was finally appointed as Director of Regulatory Services, her credentials as a lawyer were not included in official RNABC documentation. She was referred to as an RN and when I questioned this she informed me that she was indeed a lawyer, but gave the impression that the Association did not wish to broadcast their move to have in-house counsel.
rely. This meant that the committee was constantly in a position of learning empirically as new issues arose. This learning echoed the apprenticeship models of early nursing training, i.e., with little or no teaching, and learning through trial and error.

Early cases represented a struggle for nurses standing in judgement on other nurses. In a way, the Disciplinary Committee embodied the conflict between the RNABC’s advocacy and public protection mandates. On reflection, it must have been hard for nurses, whose professional skills are directed to caring, to adopt a judgemental, limit-setting role. Advocacy is a much more natural nursing role, which may explain an early reluctance to address formal discipline by the nursing organization. In addition, the reluctance to become embroiled in discipline may reflect a middle-class ethic which was particularly predominant in the 1950s and 1960s. The change in structure of the disciplinary process towards a more legalistic framework and a smaller disciplinary committee, aided in formalizing the process. However, it is clear to me in retrospect that the rules put in place at this point lacked legal guidance and left the RNABC open to expensive appeals, as demonstrated by the first Supreme Court appeal being initiated just 2 years after the commencement of the formal hearings.

At the close of the 1970s, the RNABC’s disciplinary panel had now heard approximately 30 cases, representing a wide range of concerns. It was becoming apparent that concerns over conflicting roles would not be resolved at this time. A number of challenges would have to be confronted to further streamline the disciplinary process as baccalaureate training and certification in specialties became the order of the day.

55 Due to the RNABC’s indexing, it is difficult to determine the exact number of cases.
In Chapter 4, a number of challenges would become evident, as the disciplinary process continued to evolve.
CHAPTER FOUR:
THE DEVELOPMENT OF NURSING DISCIPLINE IN THE 1980s

Very often when you look at the moon, you see only a part of it, but you know there is a much larger object there. Very often we look (or converse) with a person, and we see or are aware of only a small sliver of their life and we may think that is all there is. Try to get to know more about the whole person! (Source Unknown).

Introduction

In keeping with the format of previous Chapters, Chapter 4 consists of a narrative which combines general nursing history in its social context with specific details of the disciplinary process as it developed through the 1980s (from 1980 to 1989). In my narrative I aim to illuminate an understanding of the evolution of the nursing disciplinary process in the 1980s. The 1980s represent a particularly important episode in the development of the disciplinary process. The period provides the longest continuous record of disciplinary hearings to be considered in this study and, not surprisingly, contains the greatest number of cases heard. In addition, the period covers the move to mandatory registration, which marked an increase in the Association’s responsibilities for and power over nurses. Further, the 1980s saw the closure of many hospital-based nurse training programs and the shift to college and university-based programs. The hospital schools of nursing had historically shared the RNABC’s role in disciplining nurses. Finally, the period saw the birth of the British Columbia Nurse’s Union and a clearer separation of advocacy and governance functions within nursing. The existence of an independent body representing nurses’ rights was to cause considerable conflict with the RNABC over concerns with the disciplinary process.
The year 1982 saw the introduction of both a *Canadian Constitution* and a *Canadian Charter of Rights and Freedoms*. The new Charter influenced a wide variety of court decisions, including “decisions to strike down a government abortion law, uphold cruise missile testing, condemn unfair treatment on the basis of pregnancy, affirm aboriginal rights and grant survivor benefits to same-sex couples” (Cranny and Moles, 2001, p. 280). The new Charter was also to play an important role in nursing disciplinary cases, because of its focus on human rights, which can be seen as directly related to the balancing of the rights of the individual and the need to protect society. This balancing will be elaborated on in this chapter and in Chapters 4 and 5.

For women the constitutional changes fell short of expectations as they failed to protect against discrimination based on marital status, sexual orientation or political beliefs. However, women’s rights improved incrementally through legislative change. For women in 1983, rape laws were broadened to sexual assault laws and for the first it became a criminal offence for a man to rape his wife. Domestic violence cases began to be taken more seriously and the Attorney General directed Ontario police to lay charges in domestic violence cases replacing the previous trend for men to receive no consequences for beating their female partners. In 1983, the *Canadian Human Rights Act* prohibited sexual harassment in workplaces under federal jurisdiction providing legal recourse to women whose employers demanded sexual favours. Finally in 1985, the law was changed so that Aboriginal women who married non-status men could retain their Indian status representing the end of a 14 year battle to overturn this particular form of discrimination in the *Indian Act*. By the late 1980s more women than men were gaining university degrees, however the average woman’s wage remained at only about 65 percent of the average man’s. Only 5 percent of full-time working
women were employed in managerial-level positions, while two-thirds of workers receiving the minimum wage were women (Hughes, 1995). The decade closed with the murder of 12 women engineering students at Montreal's Ecole Polytechnique, which drew attention to the strength of anti-feminist feeling in some quarters.

The Changing Health Care Context

Computers were beginning to change the face of health care as for e.g., rapid transmission of information such as laboratory results were beginning to be used in place of internal hospital mail systems. Nurses frequently bore the brunt of these new technological innovations, which led to a continuous stream of in-service training programs and a seemingly unending series of technical glitches to overcome. Computing represented a significant step away from typical nursing competencies, and older nurses particularly, struggled to integrate the new skills (Cranny & Moles 2001; The Province, 2000).

In 1983, the Acquired Immune Deficiency Syndrome (AIDS) epidemic officially arrived in B.C., although the first case was later discovered to have been in the early 1970s (Cranny & Moles, 2001; The Province, 2000). AIDS changed the face of nursing by moving the boundaries of known diseases. AIDS, in the early years, was highly stigmatized and the uncertainties created considerable fear among nurses. It also led to very strict protocols regarding infection control and isolation, which were to herald protocols as new diseases became increasingly common 56 (Canadian Association of Nurses in AIDS Care, 2000; Canadian Nurses Association (2000b). It is my belief that in some ways this may have

56 For up-to-date guidelines on routine practices, see Health Canada. Routine practices and additional precautions for preventing the transmission of infection in health care: Revision of isolation and precaution techniques. Canada Communicable Disease Report 1999; 25 (Suppl. 25S4), available at www.hc-sc.gc.ca/hpb/lcdc/dvg_e.html#infection.
enabled nurses to focus more on their own well-being at work than had been previously entertained.

**Publicly Funded Health Care**

The 1980s also saw changes to the way in which Health Care was funded in Canada. The *Canada Health Act* was established as Canada’s federal health insurance legislation. It set out the primary objective of Canadian health care policy

\[...to\ protect,\ promote\ and\ restore\ the\ physical\ and\ mental\ well-being\ of\ residents\ of\ Canada\ and\ to\ facilitate\ reasonable\ access\ to\ health\ services\ without\ financial\ or\ other\ barriers\ (Romanow, 2002, p.1).\]

The *Canada Health Act* established criteria and conditions related to insured health care services and extended health care services that the provinces and territories must meet in order to receive the full, federal cash contribution under the Canada Health and Social Transfer (CHST).\(^{57}\) The aim of the *Act* was to ensure that all eligible Canadians had reasonable access to medically necessary insured services on a prepaid basis without direct charges at the point of service.

In B.C., the RNABC began lobbying in support of the proposed *Canada Health Act* in 1983.\(^{58}\) This was to be one of the most intensive lobbying efforts ever made by the RNABC. The *Act* would ensure employment for nurses, and access to Canadians for insured healthcare. I believe that the formation of the *Act* indirectly increased the political voice of nurses across the country; although I have no specific literature to support this claim.

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57 From 1977-1995 EPF, from 1995-2004 CHST, now known as CHT.

58 "The principles of the *Canada Health Act* began as simple conditions attached to federal funding for Medicare. Over time, they became much more than that. Today, they represent both the values underlying the health care system and the conditions that governments attach to funding a national system of public health care. The principles have stood the test of time and continue to reflect the values of Canadians" (Romanow, 2002, p.1).
Universal Health Care Meets Fiscal Restraint

In B.C., it was a time of fiscal restraint. In 1983, Premier Bill Bennett brought into force his restraint package. Health Care was one area which was impacted by the restraint package. Previously, in 1980, provincial government nurses went on strike for two weeks and won a 40% increase over three years; and, general hospital nurses voted 90% in favour of a strike and won a 49% increase in wages and benefits over 27 months (Russo, 1982). In November, of 1980, 80,000 B.C. government workers (including government payroll community health nurses), walked out to protest Bennett’s plan to curtail wages. While international political barriers were coming down, in B.C. a battle was being waged in nursing over the need for further separation of governance and advocacy functions in the profession.

Nursing in the 1980s – Education in Nursing Specialities

In 1980, the RNABC had 24,935 members and ever increasing specialization continued to be the main hallmark of the nursing profession. The CNA convention was held in Vancouver, and at the convention a resolution was passed to study the feasibility of developing certification examinations in various nursing specialities (Canadian Nurses Association, 1986b). This led, in 1984, to the RNABC adopting a position that by the year 2000, entry into the profession should be by baccalaureate degree. However, up until 1986, there was no accreditation program for nursing school programs in Canada. The Canadian Association of University Schools of Nursing (CAUSN) devoted more than 12 years in developing a program to assess university nursing school programs. The major impetus was that nursing was one of the few health sciences educational programs that did not have a system of accreditation (Dodd, 2001).

In March of 1989, the Canadian Nursing Association adopted a 5-year plan to develop a National Plan of Entry to Practice a bachelor’s degree. All provinces, except Ontario, were
able to make plans to develop strategies to implement this program. Ontario, due to its regulatory authority (or lack thereof), was not able to adopt this plan. 58 Baccalaureate programs have existed since the early 1900s at the University of British Columbia, however, in the 1980s baccalaureate degrees were not required as entry to practice in B.C. 59 With the closing of the Vancouver General Hospital School of Nursing, the first class entered a 4-year BSN program collaboratively offered by the University of British Columbia and the Vancouver General Hospital School of Nursing in September 1989 (Kerr & MacPhail, 1996). Thus, this collaboration illuminated a trend towards higher education in nursing and a move further away from the apprenticeship model of nursing education.

A major issue for Canadian nursing associations in the 1980s was once again the issue of nursing education and accreditation of programs. The ability of nursing associations to speak with a unified voice on this issue was frustrated by differences in mandates between the Provinces. The differences did not prevent a consolidated front with respect to universal health care and the Canada Health Act, which was supported by nursing associations nationwide.

By 1987, RNABC membership had increased to 30,023 members. In 1988, the Nurses (Registered) Act achieved mandatory registration of nurses to practice in the Province. Mandatory registration had been discussed by the RNABC since the nursing profession was first legislated in 1918. There had, however, always been arguments for and against mandatory registration. In the late 1980s, mandatory registration for the protection of the

58 The Ontario College of Nurses carries out regulatory functions, but unlike other provinces, did not have the mandate to regulate education.

59 According to a policy statement prepared by the RNABC, in March 2003, British Columbia intends to implement a policy which will require newly graduated nurses to “achieve entry-level competencies through baccalaureate nursing education programs after 2005” (Registered Nurses Association of British Columbia, 2003f, p.1). At the time of writing, entry to practice continues to be a 2-year diploma program (Registered Nurses Association of British Columbia, 2002a).
public was becoming commonplace in professional organizations. Mechanisms for ensuring that qualified practising individuals would not be excluded had been developed. In addition, the number of nurses in the Province who were members of the RNABC gave the Association considerable political power. These factors effectively quashed opposition to mandatory nursing registration and thus, provisions were added to the Nurses (Registered) Act (Goldstone, 1981; Registered Nurses Association of British Columbia, 1973, 1975; Whittaker, 1984).

Nursing in an Increasing Litigious World

According to scholars (Campbell, 1992; Prichards 1990), there was a six-fold increase in medical malpractice litigation in Canada during the late 1970s and the 1980s. This represented a societal trend toward individual responsibility for actions, where members of the public were more likely to question the actions of healthcare professionals.

As nurses acquired greater specialization, there was a trend for medicine to “transfer function” to nursing. Anaesthesia and obstetrical emergencies in childbirth, for example, was increasingly the domain of the obstetrical nurse. Clearly, this reflected higher levels of education; however, it also represented considerably greater risk for nurses in terms of accountability and legal and professional liability. As the standards of practice had to keep pace with the rate of transfer of function skills, nurses ran the risk of being cited for practicing outside the guidelines of nursing (Black, 1996; Gibson et al., 2003; Milner, 1997).

Traditionally the accountability of nurses with regard to malpractice has been downplayed. It was not until 1980 when Susan Nelles was charged with the deaths of four infants in her care at Toronto’s Sick Children’s Hospital, that this issue was brought into sharp focus (Wiebe, 1992). Sick Children’s hospital was investigating deaths of infants dying in the cardiac care unit. The investigation led to the arrest of Susan Nelles, who was the nurse
on duty at the time of several deaths. The investigation revealed that the infants had died of digoxin poisoning, a rapid acting cardiac drug. “The fact that Nelles asked for legal counsel when confronted with the accusation... was also held against her. The court ruled a fundamental legal right is not to be construed as evidence of guilt” (available at www.canlii.org/ca/cas/scc/1989/1989.83.html, accessed December 2003, p.1). 60 “The publicity associated with the trial, the Grange Royal Commission and the subsequent lawsuit 61 awoke nurses across Canada to the personal and economic risk of their work” (Campbell, 1992, p.2). In the past, the common belief was the “the physician is ultimately responsible for the entire course of treatment and care, of the patient” (Wiebe, 1992, p.11). The Nelles’ incident illuminated the increasing responsibility and independence of nursing practice within the health care system - as well as a need for funding for legal counsel.

Turf Wars between the RNABC and the BCNU

Between 1980 and 1982, there was an internal power struggle centering on concern around the need for legal independence of the nursing disciplinary function (Registered Nurses Association of British Columbia, 1999b, 2000e). Concerns were raised regarding the legal ties, which still existed between the RNABC Board of Directors and the Labour Relation Division of the Association (Dent, 1988). The British Columbia Nurses’ Union

60 For further information on the Nelles case see “Nelles v. Ontario, [1989] 2 S.C.R”. In March 1981, nurses Susan Nelles was charged with murdering infants at Toronto’s Hospital for sick Children. Nelles was held in isolation for five days and then released on $50,000 bail. At the conclusion of the preliminary inquiry, Justice David Vanek discharged Nelles on all counts. “I fear the rather astonishing facts is there is simply no case against Susan Nelles at all,...”. (Gibson, Murphy, Jarman, & Grant, 2003, p.218). In 1985 Nelles sued the Ontario attorney general’s office and two Crown prosecutors for malicious prosecution. In 1991, the Ontario government agreed to pay Nelles $60,000 for “severe mental anguish” as she was wrongly accused. Nelles received a $30,000 scholarship and a $20,000 scholarship was established in her name at Queens University School of Nursing. Further $255,000 in legal fees were paid by the Ontario government (Gibson et al., 2003).

61 Royal Commissions and Commissions of Inquiry have played an important role in Canada. Canadians have traditionally used them to investigate extraordinary problems or solicit informed opinion on controversial issues and to set government policy more information and reports can be obtained at www.micromedia.ca/titles/GovtDocsCol/FedComs.htm. Provincial reports can be obtained at www.micromedia.ca/titles/GovtDocs_Col/ProvComs.htm.
(BCNU) was officially formed in February 1981 (British Columbia Nurses Union, 2001), thus providing an appearance of "separation of functions" (Bryce, 1993a, 1993b, 1996). The main purpose of BCNU was (and still is), "To promote and protect the socio-economic well-being of our members and their communities" (Dent, 1988). In contrast, the RNABC was responsible to "nurse in the public interest" and the duties of the Association were described as "to serve and protect the public", (Registered Nurses Association of British Columbia, 1998). It is interesting to note that I have not uncovered any materials in any of the RNABC's literature, documents, or correspondence dated prior to the separation of function that mentions or alludes to the RNABC's position on "protecting its members or membership". As previously mentioned the reference to "protection of the public" which first appeared in 1918 continued to be omnipresent. The difference in mandates of the RNABC and BCNU was to bring some clarity to the division of roles and responsibilities. It was also to lead to ongoing "turf wars" between the two organizations.

**The British Columbia Nurses Union**

The British Columbia Nurses Union became fully operational on June 4, 1981, during a special convention of the RNABC Labour Relations Division (Russo, 1982). The BCNU represented 23,000 members under a number of collective agreements. The membership was divided into sixteen separate regions, and included registered and licensed graduate nurses. The voting body at the annual convention consisted (and still does), of elected delegates from each region and the 28 members of the BCNU Council. These nurses were responsible for establishing key policy directions, bylaws, and the constitution that govern the Union's actions (Russo, 1982). The Council was central to the operation of the member-driven organization. It was composed of elected representatives from all ten regions, steward representatives from the three main bargaining groups, the president, vice-president,
treasurer, and executive councillors. Council met regularly to plan and manage BCNU business and to set policy. The Council was also responsible for the developed BCNU's strategic objectives for serving members.

The Council also developed and administered the Union's annual budget reports to the annual convention on the Union's financial status and authorized all new staff positions. The Union was also responsible for providing support and advocacy to members who had been cited by the RNABC in disciplinary matters (British Columbia Nurses Union, 1992; 2002).

**Insurance For Nurses**

Within the context of nursing discipline, it was important to understand the role of insurance in the support of nurses. Nurses were (and still are) insured in two distinct ways. The first type of insurance was provided by the RNABC and indirectly insured the public against damage caused by acts of nursing negligence. For example, when nurses were involved in a case where the hospital and doctors had been cited for medical malpractice, the RNABC insurance covered the nurse's legal expenses. This should not be confused with separate insurance carried by the Union, which insured nurses against the costs of legal proceedings initiated by the RNABC Professional Conduct Committee against the nurse (Registered Nurses Association of British Columbia, 2002b).

The development of professional insurance for nurses occurred in the late 1980s, after the Nelles case had been resolved. In 1988, the Canadian Nurses Association introduced The Canadian Nurses Protective Society (CNPS) at the request of the provincial and territorial nursing associations (Kerr & MacPhail, 1996). The CNPS was founded and operated by nurses for nurses, to address concerns regarding the increasing cost of professional liability insurance (Mussallem, 1992). The insurance was designed to cover litigation, legal advice, defence or settlement claims, the payment of legal costs and court-awarded costs. All
provinces and territories joined this program except British Columbia, Quebec, 62 and the Yukon Territories. 63 I was not able to find any data related is no data found to postulate a reason as to why the RNABC chose to opt out of this program. However, I believe it was more than likely due to the unique Captive (Insurance) Act (R.S.B.C. 1996, Chapter 227), that existed in British Columbia and provided similar insurance 64 (Registered Nurses Association of British Columbia, 2002b).

To clarify, all Registered Nurses practicing in B.C., in accordance with the Standards of Practice of Nursing for British Columbia and in accordance with the Nurses (Registered) Act, were (and still are) covered by the Captive Insurance Program (Registered Nurses Association of British Columbia, 2002b). Captive Insurance provides liability 65 coverage in the case of a negligence suit against a nurse. Examples of negligence 66 could include, “a duty of care owed to the client; a breach of that duty occurred; and harm or injury sustained by the client; and, harm or injury was caused by a breach of duty” (Registered Nurses Association of British Columbia, 2002b, p.4). The existence of insurance for nurses cited by the Professional Conduct Committee meant that in most cases from this point on, nurses undergoing disciplinary proceedings would be represented by counsel.

62 Quebec did not take part in this program due to the significant differences in the Quebec Civil law system (Kerr 1996).

63 The Yukon territories, at this time, did not have the authority to register nurses; therefore, it would have been unable to take part (Kerr, 1996a).

64 In British Columbia the RNABC purchased similar protection in 1998 through an insurance company that is wholly-owned subsidiary of the RNABC. This self-insurance is made possible by legislation unique to B.C. It should be noted here that liability insurance is offered by CNPS and the RNABC’s captive Insurance Company (Registered Nurses Association of British Columbia, 2002b) is not the same type of insurance provided by the BCNU for professional disciplinary issues.

65 Liability insurance will provide you with legal defence costs for allegations of negligence arising out of your nursing practice and compensation to the plaintiff (complainant) if there is an out of court or judgement against you.

66 Negligence is usually a “one time” incident, arising from a single mistake, as a registered nurse.
In October, 1988, the British Columbia Nurses Union established a Legal Expense Assistance Plan (LEAP), which provided unionized nurses with legal counsel, and thus a defence, if they were cited by the RNABC. These complaints generally arose from complaints by employers (Young Consulting Group, 1999). The Union's obligations also included defending its members who have been disciplined or dismissed by the employer without just cause (Wedge, 1991a). When a nurse was cited by the RNABC for alleged misconduct, and the conduct had occurred in context with his or her employment, then the BCNU was required to represent the member for the alleged misconduct. If the matter resulted in termination of employment, the matter was also heard by a labour relations arbitrator. If the arbitrator determined that the union member was terminated for unjust cause and reinstates her employment, a nurse still could not work in British Columbia by virtue of the fact her registration has been revoked or suspended by the RNABC under the Nurses (Registered) Act. Consequently, the Union actually has two roles in defending the nurse, 1) before the Professional Conduct Committee of the RNABC, and 2) before the arbitrator of the Labour Relations Board. Therefore, a nurse's employment security was intertwined with the professional disciplinary process. As a result, the BCNU had a vested interested in the process in which nurses were investigated, prosecuted and disciplined by the RNABC (Wedge, 1991a).

To apply for the Legal Expense Assistance Plan (LEAP) through BCNU, nurses had to first be members of the union. Not all Registered Nurses in British Columbia were union members and therefore might not qualify for professional disciplinary assistance through the LEAP program. The importance of this program was illustrated in a quote by a lawyer, which appeared in the report by Debra McPherson, President of the British Columbia Nurses

McPherson's report included a historical review of the development of the LEAP program, and aimed to provide guidance for the future development of the LEAP program:

*The best thing that has happened to the process (PCR) [Professional Conduct Review], in my view, is the assistance of your Union in providing legal assistance to nurses involved... In cases before the institution of the LEAP program, nurses often didn't attend or attended without legal representation, which meant disastrous results for nurses [sic] (Lawyer)(p.3).*

LEAP was envisioned as operating at arms length from the regular day to day business of the union. When a nurse was cited by the RNABC she/he was required to submit a request to the union for legal counsel. If approved, LEAP would provide legal funding to cover invoices submitted by the nurse for incurred legal expenses (McPherson, 1992a). There was no contract between the nurse, or the nurse's legal counsel and the union, and confidentiality was strictly maintained. However, further, there was no review of the program, and thus problems ensued.

Firstly, nurses were not familiar with retaining legal counsel and the question arose as to the "appropriateness of some counsel". 67 Secondly, fees incurred by the funding body (LEAP) were becoming an issue. The final concern was that no pro-active activities 68 were taking place, potentially influencing future cases, and thus the utilization of funds. It would not be until the 1992 BCNU annual convention that delegates would vote to establish a dues

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67 Not all legal counsel (lawyers) is familiar with quasi-judicial hearings and administrative law proceedings - it is similar to a physician who may not be familiar with specialty areas such as obstetrics or pediatrics.

68 Pro-active activities included gathering evidence and case law to support concerns that continued to arise in nursing hearings. The pro-active activities also involved promoting education within the union, regarding disciplinary cases.
levy of 0.1 percent of basic pay for the next five years to create a self-perpetuating LEAP fund (McPherson, 1992a, 1992b).

According to McPherson's 1992 reports, LEAP was to be internally reviewed by BCNU. The union determined that the program must be revised in order to meet its mandate, "to provide appropriate legal defence, ensure cost effective distribution of funds, generate program performance data, and be accountable to the members" (McPherson, 1992a, p. 1). The most significant change of the seven recommendations would be that the LEAP Advisory Committee would now be responsible for retaining and directing legal counsel on behalf of the member. This move would ensure continuity 69 and expertise of legal representation, 70 a cost effective program, 71 as well as, proactive research. The pros and cons of this decision will be discussed in Chapter 6.

Mandatory Registration

One final legal development in nursing was still to occur before the end of the 1980s. Bill 56 of the Nursing Statutes Amendment Act, 72 changed the Nurses (Registered) Act in several ways. Firstly, after 18 years of studying, consulting and debating, the Members of the Legislative Assembly (MLAs) agreed with the RNABC that mandatory registration with the Association would be required to practice nursing in B.C. (Registered Nurses Association of British Columbia, 1988). RNABC President Sue Rothwell welcomed the changes, stating:

"When these amendments become law, patients will be assured that nurses providing them

69 The BCNU contracts one law firm to handle all legal matters on behalf of the union.

70 The firm retained by BCNU purported to have a reputation as experts in administrative law, union issues and the disciplining of professional before quasi-judicial administrative bodies (Wedge, 1991a, 1991b).

71 The firm was contracted at an hourly rate, below-the "standard" rate for counsel who specialized in this area of law.

72 Bill 56 the Nursing Statutes Amendment Act, 1988 is an Act, which allows sections of the Act to be changed, without changing the entire Act, significant changes occurred to the sections of the Act ("Bill 56 the Nursing Statute Amendment Act," 1988).
with care are registered, qualified and accountable for their actions" (Registered Nurses Association of British Columbia, 1988, p.1).

All nurses who wished to practice as nurses in B.C. now had to be registered with one of the three nursing regulatory bodies: the RNABC, the Registered Psychiatric Nurses' Association of B.C. (RPNABC) or the B.C. Council of Licensed Practical Nurses (BCCLPN) (Nurses (Registered) Act, section 15(3)). Both the RPNABC and BCCLPN accepted the intent of the bill. Under the new legislation, it became illegal for a person to practice as a nurse and use the title "nurse" unless he or she has a valid licence or practicing membership in one of the three regulatory organizations (p.6). There were some months of delay in the process, but eventually Section 15 (3) of the Nurses (Registered) Act, which restricted the use of title "nurse", was finally proclaimed and scheduled to go into effect on August 1, 1989. The main impediment according to the RNABC was: "...government's concern that a small number of nurses, who would not qualify under the new category of Licensed Graduate Nurse, could find their employment jeopardized" (Registered Nurses Association of British Columbia, 1989, p.2). Officials of RNABC and the Ministry of Health met to address the government's concern and drafted additional rules to accommodate individual cases of hardship that might result from the new legislation (Registered Nurses Association of British Columbia, 1989). Now, graduate nurses who failed to meet the Association's requirements could continue working while they undertook refresher and other necessary courses to qualify for registration (Registered Nurses Association of British Columbia, 1989).

A second major amendment to the Nurses (Registered) Act was enacted concurrently with the mandatory licensing requirement. It was the implementation of a program to ensure continued competency. Nurses who renewed their practicing registration with the RNABC
were required to meet certain standards. Before the Act was amended nurses were required to meet RNABC standards only for their initial registration. Now nurses were required to provide reasonable assurance of recent practice, thereby providing a greater likelihood of their ability to practice nursing competently (Registered Nurses Association of British Columbia, 1989a, p. 6). More specifically, to renew practicing membership in 1989, nurses were required to have worked 675 hours during the previous five years. To renew in 1990, nurses were to have worked 900 hours in the previous five years. After 1990, the minimum requirement became 1,125 hours of work in nursing practice in the previous five years (p.6). Nurses who were unable to meet these requirements might have been eligible for other options, including course work, either self-passed or through recognized educational facilities.

Another significant change involved the writing of the Nurses (Registered) Act Rules. These Rules were now a comprehensive framework in which the RNABC could manage its affairs. The Rules included Part 1: General Provisions, Part 2: Practice of Nursing, Part 3: Approval of Schools of Nursing, Part 4: Registration Examinations, Part 5: Registration, Part 6: Continued Competence, and Part 7: Professional Conduct Review, which described the processes for the disciplinary investigations, hearings and appeals (Registered Nurses Association of British Columbia, 1989a).

In regards to the disciplinary process, the Act amendments changed the name of the Disciplinary Committee to the Professional Conduct Committee. The Decisions and Reasons produced by the panel hearing the matter, now contained the name of the nurse charged, the name(s) of her/his counsel and the Association’s counsel, as well as, the names and professions of the persons swearing testimony before the Committee. It is also noted that the
format of the Decisions and Reasons were much more legalistic, referring to "Exhibits" received by the Committee. The language contained within the Decisions became more convoluted -- citing and quoting cases - from common law authorities 73 and statutes. These changes indicated the increasing role of administrative law practices and thus a reliance on the legal system (Black, 1996; Hurlburt, 2000; Jones, 1999). The following exemplifies this use of language:

The Professional Conduct Committee relied upon the following evidence, Exhibit 3, Exhibit 4, and the sworn testimony of ... and ... used the following authorities to support the findings... (#382074, 1989, p. 1 & 2). 74

Proven by sworn testimony of ... ..., having considered the evidence and having made a decision under Section 26 (2) (a) (ii) ... and pursuant to Section 27 (1) (b) (#594325, 1989, 2 & 5). 75

Despite the amendments to The Nurses' (Registered) Act 1988, and the Nurses' (Registered) Act Rules, Part 7, Professional Conduct Review (PCR), heated debate between 76 the lawyers who represented unionized nurses charged by the RNABC with professional disciplinary concerns ensued (Wedge, 1991 a, 1991 b). Theses disputes were thought to be due to the fact that despite the amendments to the Act, no major alterations occurred in regards to

73 Common law is law that is made by judges, or "Judge-made law". Law which exists and applies to a group on the basis of historical legal precedents developed over hundreds of years. Because it is not written by elected politicians but, rather, by judges, it is also referred to as "unwritten" law. Judges seek these principles out when trying a case and apply the precedents to the facts to come up with a judgement. Common law is often contrasted with civil law systems, which require all laws to be written in a code or written collection. Common law has been referred to as the "common sense of the community, crystallized and formulated by our ancestors" (Duhaime, L., www.duhaime.org/ lawfirm.htm) accessed January 2002).

74 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1989, #382074,")

75 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1989, #594325").

76 The debate was between lawyers who represented the union and lawyers who represented the RNABC, as well as lawyers who represented the parties (nurses, and the Professional Conduct Committee).
professional discipline. In response to these concerns, in 1989, the Board of Directors of the RNABC adopted new rules. But no major revisions were undertaken. The concerns put forth by the British Columbia Nurses Union with regard to the professional Conduct Process and the Act (Rules) can be summarized as (Wedge, 1991a):

Increasing legal involvement and therefore the need for assurance that nurse’s rights are protected at every step of the disciplinary process (Wedge, 1991a, p.3).

Social, moral, ethical, and technological advancement increasing the complexity of practice of nursing which need to be addressed in the discipline process (p.3).

In addition to the increasing role of law and lawyers in the discipline process, other changes were occurring in the legal arena, which probably impacted directly upon the nursing disciplinary process. One of these was the Canadian Charter of Rights and Freedoms. Under the Charter, the right to pursue a profession became a constitutionally protected right under section 7, which provides that “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice”("Canadian Charter of Rights and Freedoms," 1982). Consequently, our courts have said “to deprive a person of the right to practice his or her profession is a deprivation of that person’s liberty” (Wedge, 1991a, p.6. Other issues and advancements affecting the nursing profession, included abortion, euthanasia, and advanced life-saving

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77 Revisions included rephrasing of rules that were already in existence.

78 Abortion—the Supreme Court of Canada’s decision in 1988 endorses a women’s right to self-determination in relation to abortions. Ethical dilemmas relating to this are discussed in Curtin (1982, p.240): “The responsibility, legally and morally, for ensuring that patients’ needs are met and that patients are not neglected because of differing values”.

79 Euthanasia—derived from the Greek work that means good or pleasant death (dictionary.com, 2003).
directives and technologies. These advancements required the nurse to grapple with his or her own moral and ethical beliefs while taking into consideration the belief system of the patient, the practicing physician, and the policies and laws imposed.

The introduction of the *Canadian Charter of Rights and Freedoms* heightened the awareness of the rights of the individual with Canadian society and highlighted the RNABC's awareness of individual rights (Young Consulting Group, 1999). There followed an explosion of case law with respect to professional disciplinary tribunals. This explosion was due to significant increases in the challenging of the decisions of professional bodies. This meant that the disciplinary process was being looked at critically - and from a different light - as the process had to be in accordance with the law of the land. Almost concurrently, the RNABC enacted further changes to the disciplinary process. In retrospect, these changes may be seen as the RNABC's reaction to increased external scrutiny on the disciplinary system.

One of these changes, which occurred in 1985, was that the Board of Directors adopted a policy that would allow nurses whose conduct was under investigation to “Resign with Prejudice” (Registered Nurses Association of British Columbia, 1986b). This policy allowed nurses the option of applying to the Board of Directors indicating that they did not intend to contest the citation. This application had to occur prior to the commencement of the hearing. If the BOD accepted the nurse’s resignation, the nurse would have to apply to the BOD for reinstatement, as if she had been terminated from the Association. If the BOD did not accept the nurse’s resignation, the hearing proceeded in the usual manner. Upon application for

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80 Advanced technologies and directives included do not resuscitate orders, and the creation of Advanced Directives and Substitute decision making Acts (Kerr & MacPhail, 1996).
reinstatement, the BOD had the option not to reinstate the nurses membership (Registered Nurses Association of British Columbia, 1986b).

In 1984, a report\(^{81}\) had apparently been submitted to the Board of Directors of the RNABC indicating a 67% increase in disciplinary activities over the previous year (Clarke, 1985). In addition, the (unidentified) report also expressed concerns about the RNABC’s peer-review process as it currently stood. In response to these concerns a new Committee was established to conduct a review of the disciplinary process. The Committee consisted of a nurse representing the Referral and Review Committee (as it was then called), a member of the Discipline Committee (as a representative of one of the peer reviewers), a nurse administrator, a public representative and two “direct patient”\(^{82}\) care nurses. Further assistance was obtained from RNABC legal council and members who were from the professional review and discipline process \(^{83}\) (Clarke, 1985). The findings from the newly established Committee concluded that the RNABC had “accepted responsibility under the Nurses (Registered) Act. One of these responsibilities is the professional discipline function” (Clarke, 1985, p.3). Other findings indicated that the goal was to protect the public from “inadequate” (Clarke, 1985, p. 3) nursing care; to review questionable behaviours in relationship to practice standards, incompetence and unethical behaviour; and, to ensure these members do not practice as registered nurses. “The process used in professional discipline must be fair to all those involved; in particular it must at all times be conducted in a manner

\(^{81}\) The report was not identified in the Clarke report and I was unable to locate further details as to its origin or authorship.

\(^{82}\) Nurses actively practicing direct patient care.

\(^{83}\) It is interesting to note that in the literature many committees use similar names, which makes it difficult to determine exactly who is who and what their responsibilities are.
that is consistent with the principles of natural justice and with the *Nurses (Registered) Act*, and other laws that may apply" (Clarke, 1985, p. 3).

The single most interesting aspect of this report is that the "secondary considerations" (Clarke, 1985, p. 3) include, are designed to include accountability to the public and to the members of the Association, to ensure ongoing support for the practice of self-regulation of the profession. The promotion and provision of education to members is advocated so that members can be actively involved in the professional disciplinary process and maintain a balance between the disciplinary function of the Association and its other responsibilities (e.g., membership and educational program review) (Clarke, 1985). Other recommendations included renaming the disciplinary process to that of the Professional Conduct Review, which would eliminate the word "peer", as in "peer review" which the membership did not "share a consistent meaning for..."(Clarke, 1985, p. 3) As well, according to Clarke (1985), this new term would reflect the process and not have a negative or punitive connotation. Other concerns were how to handle, store and disseminate information, develop clear policies and procedures regarding disciplinary process, and to implement a nine-stage process that would provide a distinct process.

The last major revision to the *Nurses (Registered) Act* occurred in 1984 and 1985. Within the review, the Board of Directors adopted a new Professional Conduct Review Program with supporting policies (Registered Nurses Association of British Columbia, 1992b) A quote taken from one of the articles entitled, "Professional Conduct Review Process - Protecting

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84 The principles of natural justice were derived from the Romans who believed that some legal principles were "natural" or self-evident and did not require a statutory basis. These two basic legal safeguards govern all decisions by judges or government officials when they take quasi-judicial or judicial decisions. The two basic tenants are- audi alteram partem (the right to be heard) and nemo judex in parte sua (no person may judge their own case) apply (Duhaime, L., www.duhaime.org/lawfirm.htm) accessed January 2002.

The professional conduct review program is not a punitive program. Rather, it is designed to protect the public, the profession and the individual nurse. Standards of nursing practice must be maintained to protect the health and safety of the public if society's trust and confidence in the profession is to be justified. The conduct review process only begins if a complaint is submitted to RNABC. The review process involves several major steps:

- submission of a complaint;
- investigation of the complaint by a registered nurse on the RNABC staff;
- consideration of the seriousness of the conduct in question by the Committee on Referral and Review;
- assessment of the information and decision whether to hold an inquiry by the chairman of the Discipline Committee; and
- formal hearing before a panel of the Discipline Committee, as established under the Nurses, (Registered) Act (Registered Nurses Association of British Columbia, 1986a).

It is important to note that the process can be ended at the complaint stage if the person making the complaint decides, after discussion with staff, not to proceed. It can also end at the assessment stage if the Discipline Committee chairman determines that the complaint is not serious enough, or that there is not sufficient evidence to warrant a formal inquiry (Registered Nurses Association of British Columbia, 1986a, p.15).

The article went on to explain in detail each step within the disciplinary process and elaborates on the "Who", "How", "When", "Where" and "Why" of the process (listed above) and the actions which would be taken by the RNABC. Thus a clear process for disciplinary hearings was now available in written form, in publications designed to educate members of the RNABC about the Professional Conduct Inquiry Process.

Up to this point, in my account of disciplining in the 1980s I have focused on the changes to the disciplinary process. I now turn to the impact of these changes on the
practicing of disciplining nurses in B.C. by using examples taken from the summaries of the
Registered Nurses Association of British Columbia of disciplinary processes during this
time.85


In the 1980s, the Decisions and Reasons of the Discipline Committee were primarily
based on the interpretation of the Registered Nurses’ Act, 1977, Section 29. The first five
cases in 1980 were heard under the Nurses (Registered) Act, 1979, Section 22-40. The
categories in which nurses could be disciplined remained the same as in the 1970s, although
new categories were added. Nurses could now be cited for a “Breach of Conditions” and a
“Breach of the Act” (Registered Nurses Association of British Columbia, 1983, 1986a,
1989b).

A breach of conditions occurred when a nurse who had already been disciplined and had
had conditions placed on his or her registration failed to meet the conditions. A breach of
conditions was generally punished with a revocation of the member’s registration (# 570860,
1988; #509912, 1987; #578150, 1988; #463715, 1987).86 A breach of the Act, generally
involved misrepresentation or fraud in applying for registration by way of providing false
documentation, or by breaching the Constitution or Bylaws of the Association. The first case
charging a nurse with this category was in 1984 (#455833, 1984).87 The nurse’s membership
was terminated.


87 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1984, #455833,").
The following section consists of examples of disciplinary hearings held under each category:

1. **Unethical Conduct:**

The following two examples are representative of nursing conduct determined to represent unethical practice in the 1980s.

...it is reported that the nurse struck an extended care unit, quadriplegic patient five times while assisting a nurse’s aid with his care. (Reprimanded - five conditions placed on registration (#295844, 1989, p.1).)

...attended as a nurse upon a patient L.H.’s readmission to hospital after she had formed a close personal friendship with this patient. Engaged in an unauthorized form of therapy with patient S.W. while the patient was a tenant in her home. The therapy involved physical touching which eventually led to physical intimacy and sexual contact etc... Membership suspended and term and conditions placed on registration (#594325, 1989, p.1& 2).

...between 1983 and 1985 the member repeatedly treated residents in a rough and abrupt manner, left residents exposed, addressed people in a demeaning manner, requested personal and private information in public, performed procedures on residents without explanation, ignored individuals needs, and harassed a resident’s family. Membership terminated (#242622, 1986, p.1).

Unethical conduct continued to be characterised by rude or rough behaviour, however, examples also began to appear which denoted conduct of an inappropriate sexual nature between nurses and patients. The Disciplinary Committee, in its Decisions and Reasons, began to refer to definitions of Unethical Conduct and Incompetence derived from case law,

88 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1989, #295844.").

89 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1989, #594325.").

90 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1986, #242622.").
in 1983. For example, after 1980, the Mason case was referred to\textsuperscript{91} in every hearing where Incompetence was at issue. In decisions where the Nurse was charged with Unethical Conduct, references were made to \textit{Registered Nurses Standards of Practice}, which was first published in 1984 (Registered Nurses Association of British Columbia, 1998b, 2000f) and the International Council of Nurses (ICN), \textit{Code for Nurses}, May, 1973. The \textit{Code for Nurses} stated:

\textit{The nurse maintains the highest standards of nursing care possible within the reality of a specific situation. The nurse uses judgement in relation to individual competence when accepting responsibilities. The nurse when acting in a professional capacity should at all times maintain standards of personal conduct which reflect credit upon the profession (p.6).}

\textsuperscript{91} In cases where Mason was referred to, it does not mean that the committee agreed with the definition used, but seemed to acknowledge its existence.


The Code was clear that nurses were expected to provide competent care and the client's perceived best interests must be a prime concern of the nurse. Ethical violations were seen to have occurred when a nurse neglected to provide competent care. The obligation of the nurse was to engage in continuing education and in the upgrading of knowledge and skills relevant to their area of practice. In seeking or accepting employment, nurses were to must accurately state their areas of competence, as well as, their limitations (Canadian Nurses Association, 1989, 1991).
2. Incompetence

During the 1980s incompetence had been defined by the Supreme Court of British Columbia as a “pattern of carelessness” and citations showed a trend towards illuminating a pattern with the allegations cited.

First complaint ...made seven medication errors on one shift; her organization was poor; and she had allowed IV’s (Intravenous Infusions) to run dry. The second complaint alleged that her charting was inadequate or inaccurate, she allowed IV’s to run dry and TPN’s (Total Parental Nutrition) to run to slowly; she failed to make out laboratory requisitions or made them out incorrectly... (#509572, 1980, p.1). 92 Conditions of continuance of membership, conditions removed July 1982 (Registered Nurses Association of British Columbia, 1983).

... administered narcotic drugs to patients without an existing doctor’s order authorizing the administration of such drugs and... administered narcotic drugs to patients more frequently than authorized by relevant doctor’s orders for the administration of such drugs and... narcotic drugs... by routes contrary to routes authorized by relevant doctor’s orders for the administration, you administered narcotic drugs... in quantities in excess of the amount being administered by your colleagues and in excess of quantities sanctioned by accepted standards of nursing practice... etc(#523189, 1984, p. 1 &2). 93

The nurse was initially found not guilty of Unethical Conduct, but guilty of Incompetence. The decision was to suspend the nurse with conditions in 1984 the conditions were modified in 1985; and, the nurse’s membership was terminated in 1986 for a failure to meet the condition which had been placed on her membership in July 1984 and April 1985 (Registered Nurses Association of British Columbia, 1986a). In the decision to suspend the nurse the justification was as follows:

92 (“Registered Nurses Association of British Columbia, Decisions and Reasons, 1980, #509572,”).

93 (“Registered Nurses Association of British Columbia, Decisions and Reasons, 1984, #523189,”)
demonstrated a lack of knowledge with respect to medications and the administration of medications...incorrectly identified Atropine as a suitable medication for treatment of hypotension; ...failed to check the blood pressure of a patient to whom Nitro-glycerine had been administered; ...incorrectly administered two Septra DS tablets to a patient when the order was written to give two Septra tablets; ...was unable to describe signs and symptoms of an insulin reaction etc. ((#151085, 1989, p. 2-4). 94

The quotes above illuminate the trend to citing, quoting and supporting the decisions of the disciplinary committee within their own Decisions and Reasons. The citation is a good example of the use of language denoting repetition of an action in an attempt to support the case law definition of incompetence. The Supreme Court in Mason required that there be a “pattern of carelessness”, to support a finding of Incompetence. Note the usage “first complaint”, “second complaint”, as well as the first complaint’s inclusion of seven medication errors on one shift, which suggests a pattern of action.

3. Incompetence and Unethical Conduct:
For allegations of incompetence and unethical conduct during the 1980s, the RNABC appears to have used this as a label for allegations which did not seem to fit in other categories. Thus there does not seem to have been a rigorous definition of incompetence and unethical practice that allegations had to meet. The following examples show the types of allegations included in this category.

...your practice in connection with the administration, handling charting and obtaining doctor’s orders for narcotic drugs has created concerns whether you have misappropriated narcotic drugs contrary to ethical standards of the profession of nursing (#523189, 1984, p.1). 95

94 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1989, #151085.").
95 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1984, #523189.").
...you administered narcotics drugs to patients by routes contrary to the routes authorized by the relevant doctor's orders for the administration of such drugs (p.2).

...you administered narcotic drugs to patients in quantities significantly in excess of the quantities being administered by your colleagues and significantly in excess of the quantities sanctioned by accepted standards of nursing practice (p.3).

The committee found that the member was not unethical in respect to findings, but was incompetent. No explanation was provided as to why the nurse was not unethical but incompetent, although I suspect that it was due to a trend to find nurses who were having difficulties with medication administration incompetent. Medication errors were generally more easily documented and a pattern of carelessness could be shown, which fit with the Mason definition of incompetence. The member was suspended with conditions. Her conditions were subsequently modified due to a failure to meet her revised conditions, and her membership was terminated in 1986.

3. Unfit/Incapable of Nursing

The category of unfit/incapable of nursing, as has previously been described, was a new category developed for the management of cases involving drugs, alcohol, and mental illness. The following examples demonstrate the types of allegations considered:

Unethical conduct contrary to the ethical standards of the professional of nursing and Incapable of nursing by reason of a habit or condition, resulting from addictions to or abuse of drugs, of a nature and extent that it is desirable in the interest of the public and the member that she no longer be permitted to practice...(#569392, 1984).  

The Disciplinary Committee ...finds she is suffering from a mental condition of such a nature and extent the she is

96 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1984, #569392, ").
incapable of practicing as a Registered Nurse (#327275, 1986). 97

It is further interesting to note that nurses who were alleged of suffering from a mental condition (#145211(1981); #327275(1984); #182559(1987); #562263 (1987); #577575 (1987); #282750 (1988); #290920 (1989) 98were less likely to be charged with being unethical, than those with drug and alcohol addiction or abuse (#134015 (1982); #461225(1986); #542995 (1986); #569392 (1986); #354057(1987); #460815(1987); #576550(1987); #603915(1987); #505589 (1988); #524395(1988); #578150(1988); #218384 (1989); #508007 (1989). 99I carried out a statistical descriptive summary of the charges related to mental illness, alcohol and drug abuse, addiction or misuse occurring between 1980 and 1989, which I believe provides insight into the important role that these conditions played in disciplinary hearings. Of the 79 new hearings conducted between 1980 and 1989, seven were related to mental illness, (8.8%), nine were found to have drug addiction or abuse problems (9.4%), three were alcohol related (4.8%), and one member was charged with the combination of drug and alcohol addiction/abuse (1.3%). I also noted that there were

97 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1986, #327275,").


only three charges in the first five years (1980-1985), and 17 charges from 1986 -1989 - a 708% increase.

By way of examples, nurses were cited for “a mental condition resulting in the Incapacity to practice nursing”; “Incapacity by reason of a physical or a mental condition”; or by “Incapacity of nursing by reason of a habit or condition resulting from an addiction to or abuse or misuse of alcohol” (Registered Nurses Association of British Columbia, 1983, 1986a, 1989b). It was reported, for instance, that a nurse who had worked a night shift at a large city hospital Vancouver General Hospital, but was employed by a Registry 100 had called the Care Coordinator with a warning that “someone was trying to kill her patients with pinworm medication”(143873, 1981, p.1).101 The nurse’s membership was terminated due to “Incompetence” and “Incapable of nursing by reason of a physical or mental condition” (Registered Nurses Association of British Columbia, 1983, 1986a, 1989b).

Another nurse was cited for:

Repeated episodes of abnormal behaviour and lack of amenability to treatment since inception of her illness. This is shown by the necessity for .... Non-voluntary committal for psychiatric treatment on five separate occasions between 1980 and 1984. Non-voluntary committal status indicates that... was suffering from a mental disorder that made her a danger to herself or others and that she lacked insight in that she did not seek and/ or agree to treatment voluntarily (#143873, 1981, p.5).102

Examples of disturbed thought patterns and irrational thinking, (p.6).103

100 A registry is a central office where the public can locate nurses who are willing to work as private duty nurses, as well, Institutions can hire nurses for hospital work.

101 (“Registered Nurses Association of British Columbia, Decisions and Reasons, #143873, 1981,”).

102 (“Registered Nurses Association of British Columbia, Decisions and Reasons, #143873, 1981,”).

103 (“Registered Nurses Association of British Columbia, Decisions and Reasons, #143873, 1981,”).
The member's registration was terminated in April, 1985, after an Appeal was heard by the Board of Directors (Registered Nurses Association of British Columbia, 1986a, p.1).

In one final example it was:

...alleged the nurse came on duty while under the influence of alcohol on three occasions. She was unable to complete her assignment, her speech was slurred and she spoke in a loud voice and ... the nurse came to work with a strong odour of alcohol on her breath..... She was loud, shaky and had to be reminded to carry out her nursing duties (#134015, 1982, p.1-2). The nurse registration was terminated January 1982 (Registered Nurses Association of British Columbia, 1983).


... Increased recognition is being given to problems faced by nurses with alcohol and drug dependencies. In the past, nurses with drug related problems nearly always had their membership terminated by the Disciplinary Committee. Now however, when a nurse is cited by the RNABC for substance abuse, and admits having this problem, the disciplinary committee may suspend the nurse's registration on the condition that she or he undergoes a designated treatment program.

The distinction between “ethical and incompetence” issues and “addiction” issues (unfitness to practice) allowed the RNABC to address each of the issues in a more appropriate case-specific manner. Yet the distinction between bad behaviour and illness took over a decade to develop. And it is surprising to me to note such longstanding confusion over this issue in a health care profession, where one would assume that the distinction would be automatic. I wonder if there was almost a throw back here to the failure of early nursing to distinguish between ethics and etiquette. Perhaps, there was a fear of reverting to the drunken image of nursing (Rafferty, 1996) that might have been could be postulated as lurking in the shadows, waiting to reappear in the image of modern nurses.
Summary of Nursing Discipline in the 1980s

The 1980s can be classified as a period of consolidation for the disciplinary process. The main changes occurring in the process during this period involved the development of procedures for handling disciplinary issues involving mental illness and addictions. This reflected a change in societal attitudes towards addictions, which resulted in the availability of a wider variety of treatment regimes within the community. Treatment options were accompanied by a change in societal attitudes towards addicted individuals, who began to be seen as people suffering from an illness, rather than degenerate individuals who were somehow at fault for their antisocial behaviours. The increase in cases involving addiction and mental illness may also have reflected the significant stress experienced by nurses within the health care system, as the health care crisis hit with full force.

The 1980s also saw a series of successive changes in rules for disciplinary hearings. Changes were largely procedural and structural, with RNABC and BCNU lawyers arguing that they did not go far enough. The period also saw an increased legalization of the disciplinary process. BCNU insurance led to more nurses being represented in processes and being better able to defend themselves against allegations.

Finally, the 1980s also saw an escalation in the number of cases that related to drug or alcohol abuse and mental illness. These were cited under the reason of “Unfit to Practice”, which had been implemented in the late 1970s. Despite the progress on paper toward a more procedurally fair process, (which resulted from devoting considerable resources to independent review processes), the changes were widely criticized by stakeholders, especially the BCNU. This is not surprising to me, given the mandate of the BCNU, and what seems to me to be a certain reticence by the RNABC to apply the more fundamental recommendations of the independent reviews. It seems that perhaps the RNABC’s
interpretation of self-regulation/self-policing and curial deference may have limited their vision of their need to defer to widespread precedents in administrative law at this time. However, this reticence was to lead to more vocal criticisms in the 1990s, accompanied by increasing costs as appeals became more common. Granted, it seems that perhaps the RNABC's interpretation of self-regulation/self-policing and curial deference may have limited their vision of their need to defer to widespread precedents in administrative law at this time.
CHAPTER FIVE:  
NURSING DISCIPLINE FROM 1990 TO 1996: A BATTLE OVER THE DISCIPLINARY PROCESS

No accurate thinker will judge another person by that which the other person's enemies say about him (Hill, N. (undated))

Introduction

My goal in Chapter 4 was to describe the consolidation of the nursing disciplinary process in the 1980s. In keeping with the format of previous Chapters, Chapter 5 consists of a narrative which combines general nursing history in its social context with specific details of the disciplinary process as it developed through the 1990s from 1990 to 1996. The narrative aims to continue to illuminate an understanding of the evolution of the nursing disciplinary process. This chapter includes three additional sections: a summary of RNABC cases that were appealed to the Board of Directors and the Court of Appeal; a review of the disciplinary process as it existed in 1996; and a discussion of the changes that were implemented to the disciplinary process in 1996. The discussion of appealed cases is included because it illuminates the attitude of the higher courts to the issues in the disciplinary process, such as due process, procedural fairness, disclosure and legal interpretations and application of the Nurses (Registered) Act and Act (Rules). The review of the disciplinary process is presented because it represents the most evolved form of the process to date, and as such is the endpoint of the development process I aimed to follow in this study. Finally, the changes implemented in 1996 are described because they illuminate the way in which the RNABC chose to respond to the criticisms which had been made following an internal investigation process. The current process, which is the process developed in 1996, forms the foundation for any future
developments, and thus, the strengths and weaknesses of this format must be understood in order to suggest future improvements.

The 1990s were especially important because they saw the development of a full-scale battle between the RNABC and the BCNU over the disciplinary process. This dynamic formed the focus of developments in the disciplinary process during the decade and was to lead to a major revision of the process in 1996 when the last full disciplinary hearing took place.

Canada in the 1990s

During the 1990s Canada saw a number of crises which revolved around ethnic identity. The First Nations people were involved in a number of struggles for recognition of their rights including the Oka crisis and treaty negotiations in British Columbia and the Northern Territories/Nunavut. French Canadians struggled with the issue of separation from Canada.

On a policy level, the early 1990s saw drastic cuts in federal funding which undermined Provincial support for social assistance, transition homes, training and education programs, and supportive housing services to women challenged by single parenting, ill health, racism, or insufficient paid work. Governments’ statutory obligation to assist those in need ended with the elimination of the Canada Assistance Act in 1996 (Friend of Women and Children in BC, 1996). This meant that nurses were caring for clients who were increasingly disenfranchised. Immigration continued to drive growth in British Columbia, which led to the introduction of new issues into the wider society. Schools began to acknowledge Chinese New Year and Ramadan along with the Christian holidays previously recognized (Cranny and Moles, 2001). Immigration was to play an important role in nursing, as foreign trained nurses were touted as a solution to BC’s nursing shortage.
The BC human rights code was instrumental in entrenching equity issues in BC law. Identity politics marked the decade, as the complex interactions of sexual, racial, sexual orientation and other forms of discrimination were dissected (Cranny and Moles, 2001). In 1993, Canada’s refugee guidelines were changed to include women facing gender-related persecution. In 1999, Canada’s Supreme Court ruled that job standards and tests could not be solely based on capabilities that would favour men (Gibson et al., 2003).

Health Care Fiscal Challenges, Reorganization and Decentralization -1990s

The 1990s saw a more turbulent, more chaotic, and more challenging economic and health care environment. Reorganization and decentralization were the key principles underlying institutional changes. Kerr and MacPhail (1996) describe this in the following way:

...[these] continue to be times of rapid and unprecedented change in health care. All of the structures, functions, roles, and expectations that have defined delivery and consumption of health-care services are being challenged (p.193).

The delivery of nursing care was also undergoing rapid change and development. While the debate over team and primary nursing care continued, “…case management and managed care” were introduced. These methods of delivering nursing care were in response to the ever increasing health care costs, while endeavouring to achieve optimal patient care. The basic assumptions underlying this delivery system are described by King (1992).

Health care reform was sweeping the country, according to Kerr (1996) and Kerr & MacPhail, (1996a). In Canada, provinces continued to be responsible for health care and its

104 (1) Health care resources are finite; (2) health care should proceed from a structured multi-disciplinary plan; (3) collaborative team efforts, with activities coordinated around defined, patient centred outcomes, result in quality, cost effective care; (4) Patients and families are empowered through informed and participatory decision making; (5) accountability for optimal patient care and responsible use of resources is career satisfaction are enhanced in a work environment that enables one to practice in accordance with professional ideals and standards (King, 1992, p. 15-17).
with the federal government providing financing for health care under the Canada Health and Social Transfer (CHST) program. Prior to 1996, the transfer program was known as Established Program Financing (EPF). The CHST created a single fund aimed at giving provinces the flexibility to allocate funding among various programs. However, a concurrent federal government initiative, aimed at addressing budget deficits, cut provincial transfer payments. This cut resulted in a fall of approximately 33% in transfer payments over four years, which seriously constrained flexibility for CHST funds (National Forum on Health, 1997). In Canada, health care reform was supposed to be characterized by three elements: reductions in the number of acute care beds; greater emphasis on health promotion; and, greater participation of all affected parties in decision making (Kerr & MacPhail, 1996b).

In British Columbia, in 1991, The British Columbia Royal Commission on Health Care and Costs, known as the “Seaton Report”, was held. The report noted that about 25% of all acute care between 1989 and 1990 was unnecessary; further, significant costs could be saved by providing community-based care as opposed to hospital admissions. As a result, downsizing or “rightsizing” became common. This move caused the displacement of nurses from within hospitals, as 72% of nurses had been employed by hospital, prior to 1989 (O'Brien-Pallas, 1992). The number of nurses receiving unemployment insurance in 1990 was 1876; in 1992, as a result of downsizing the number had soared to 3742. The trend to downsizing was to continue to provide nursing with new challenges, as hospitals started to show an increasing acuity of their patient populations (Kerr & MacPhail, 1996b).

The move to community care also impacted nursing training. In 1991, the Vancouver Hospital School of Nursing graduated its last class after 92 years. In the process, the hospital-based system of nurse training came to an end. In 1993, the Comox Valley was chosen to
house an 18-month nursing pilot project and the B.C. government announced *New Directions for a Healthy B.C.*, also known as the *Closer to Home Project* (Seaton, Evans, Ford, Fyke, Sinclair, & Webber, 1991). Under *Closer to Home*, the Province was divided into 20 health regions with 100 Regional Health Boards and 80 community health councils. The broad intention of *Closer to Home* was to cut costs and to decentralise care to the community level (Seaton et al., 1991). The educational role of nurses in providing informed consent and in assisting patients to take responsibility for their own health was increasingly emphasised during this period (Kerr, 1996a).

The women's movement took on a less prominent role than in earlier years, however, gains continued to be made. The first female Premier of a Canadian Province was Rita Johnson, appointed on 2nd, April, 1991 (British Columbia) and Vancouver's Kim Campbell became the first female Prime Minister of Canada (The Province, 2000). Reproductive technologies such as in vitro fertilization gained prominence. In 1992 an IVF clinic opened at B.C. Women's hospital. It became the first women-centred health-care facility in the province. In the same year, in response from pressure from a growing alternative homebirth movement, a formal midwifery program was established at Grace Hospital with governmental funds allocated specifically for this purpose. Access to abortion was further protected in 1995 with the *Access to Abortion Services Act*, which created no-protest zones around abortion clinics (Womenspace, 2003). The impact of violence in the lives of women also came to the forefront in the 1990s. Statistics revealed violence omnipresent at all levels of society and identified it as a major threat to their health (Womenspace, 2003). Women also achieved combat roles in the U.S. military, although there is some debate over whether this actually constituted progress (Westerman, 2003).
Regulatory Changes

Between 1992 and 1997, the RNABC initiated an action plan with goals such as enhancing nursing standards and self-regulation. As well, it was announced that the disciplinary program would be reviewed. In 1995, a second continued competency project was initiated by the RNABC and important submissions were made to the Health Professions Council entitled *The Scope of Nursing Practice*. It was the RNABC's position that creating reserved acts for nurses is neither a necessary nor feasible approach to the regulation of nursing. According to a document prepared by the RNABC, entitled *RNABC's Position on Scope of Registered Nursing Practice* which is undated), the RNABC indicates that it has been involved with the “…government and other health regulatory bodies to explain its position…” in terms of legislation affecting Reserved Acts for Registered Nurses. The RNABC does not support the proposal by the Health Professions Council to “…list specific activities that registered nurses can initiate, or to limit initiation to activities of daily living” (Registered Nurses Association of British Columbia, 2003g, p.1; Registered Nurses Association of British Columbia, 2003g, 2004).

The Professional Conduct Review process was revised to make it less adversarial, and incorporated an alternative dispute resolution process in the form of the Consensual Resolution Process. Mandatory criminal clearance also became a requirement for registration. The inclusion of a criminal clearance requirement can be seen as a preventative measure to “protect the public” by providing information to the organization regarding an applicant’s prior criminal convictions. The RNABC could thus exclude persons whose pre-existing activities were not compatible with the professional practice of nursing ("Nurses (Registered) Act, RSBC, 1996, c.355,").
In 1991, after years of sporadic debate, studies and assessment of the Code of Ethics, a revised code was introduced once again by the CNA. This time more attention was given in the code to the practical applicability of the material and nurses in practice were involved in its preparation. The new Code expressed and sought to clarify the obligations of nurses to use their knowledge and skills for the benefit of others, to minimize harm, to respect client’s autonomy and to provide fair and just care for their clients. For those entering the profession, this Code identified the basic moral commitment of nursing, and could serve as a source of education for self-evaluation and for peer review. For those outside the profession, this Code could serve to establish expectations for the ethical conduct of nurses (Canadian Nurses Association, 1991).

Legal Struggles - RNABC v BCNU

Any nurse can have a bad experience such as this without deserving the professional death penalty (McEachern, 1987, p.8, in Churan, 1987).

The ethical conduct of the RNABC itself was also called into question by the BCNU during this period. A battle over the treatment of nurses in the disciplinary process ensued. At the 1990 Annual BCNU Convention, delegates represented some 23,000 Registered Nurses employed in certified bargaining units. According to the RNABC, there were 33,813 Registered Nurses or Graduates living in the province of British Columbia. Unionized Nurses in the province (Registered Nurses Association of British Columbia, 1990) called on the RNABC to make changes to the Professional Conduct Review Process (Campbell, 1992; Wedge, 1991b). The following are Resolutions made at the BCNU Annual General Meeting.

Resolution 7:
WHEREAS: We believe that under the Nurses (Registered) Act there are no provisions for natural justice in the discipline
and review process. Therefore, when RNABC investigates a complaint against a nurse, the civil liberties of that nurse may be in jeopardy.

RESOLVED: That BCNU will actively pursue changes to the Nurses (Registered) Act and/or any other relevant legislation to ensure that standards of natural justice are met and that the civil liberties of nurses are protected (Campbell, 1992, p. 2).

So how did this discussion commence? Six lawyers from five independent law firms who had been involved in providing representation to nurses charged under the Act submitted a report to the RNABC, after lengthy conversations, correspondence and debate amongst themselves and RNABC, evidenced by briefs, letters of correspondence, reports (Bryce, 1993; Craig, 1992; McPherson, 1992a, 1992b, Registered Nurses Association of British Columbia, 1992a; Wedge, 1991a, 1991b). The report expressed the lawyers' concerns with the RNABC's professional disciplinary process and its corresponding Act and Rules. The position BCNU counsel represented was that the RNABC PCC process "was flawed" (Service-Brewster, 1991, p.1). These conversations and reports led the RNABC Board of Directors to initiate a comprehensive review of the Professional Conduct Review process (British Columbia Nurses Union, 1992).

The Wedge Report: A Devastating Critique of the RNABC Disciplinary Process

According to BCNU, there were five major principles that required immediate attention. These can be summarised in the following highlights from reports prepared by Catherine Wedge, barrister and solicitor, who represented nurses charged under the Nurses (Registered) Act from 1975 to 1996 (Wedge, 1991a). Because of her intimate involvement in the majority of hearings at the RNABC, as BCNU counsel, I consider Wedge to be a primary source, rather than the secondary source role (which could be attributed to her as a report writer).
There is also a dearth of data from the RNABC in response to Wedge's concerns. Its literature during the period remains silent on disciplinary issues, except to provide information for complainants and nurses cited and educational materials regarding the disciplinary process. This silence may result in an apparent lack of balance on my part in the data presented and I have attempted to consider the RNABC point of view in an effort to ameliorate this lack of balance within the data.

Wedge raises a concern about an apparent lack of natural justice and procedural fairness in the professional conduct review process. Natural justice and procedural fairness are central tenets behind the tribunal process, and are held so by administrative lawmakers. The areas of focus of Wedge report is outlined below (Wedge, 1991a, 1991b):

1. Procedural Concerns: There were several procedural concerns regarding the notification of members, the investigation process, the content and delivery of the citation, and how the hearing is conducted.

   The letter [sent to the member being investigated] is misleading and non-informative;
   
   …It does not advise the nurse that the investigation officer will conduct a widespread search of all information including employment information relating to that nurse;...if the investigating officer discovers conduct of concern to her she will investigate that additional conduct on her own initiative without further notice to the member (Wedge, 1991b, p.7).

   The member complained about does not receive a copy of the original complaint; nor the name or names of the complainant (Service-Brewster, 1991, p.6; Wedge, 1991b, p.6). “[Also the issue of confidentiality is at issue]… the letter [advising the member she is being investigated by the RNABC] indicates that every effort is made to maintain confidentiality”.

   “The experience is [Wedge] the RNABC makes little effort to maintain confidentiality”
2. Impartiality Concerns: The RNABC’s investigation was seen as “anything but impartial and the RNABC is in a position of ‘conflict of interest’\(^{105}\) by misleading their members” (Wedge, 1991b, p.9).

Nurses are often charged with matters reaching back three to four years, which were never drawn to their attention. To complicate matters, charges are not set out clearly prior to the hearing, standards alleged to have been breached are not cited, and without identifying details the nurse and her counsel are left unprepared and thus unable to enter an adequate defence. One author stated that the method used by the RNABC has the air of a “witch-hunt (Wedge, 1991, p.7).

Further concerns were put forth regarding the lack of “alternatives to assist the individual in a positive, constructive supportive way…” (Service-Brewster, 1991, p. 2). It has been suggested in the data presented by BCNU that an alternative disciplinary process should be developed to address concerns that deal with matters of a personal nature (rudeness, abruptness, disrespect) among co-worker’s and clients. As well, BCNU feels that remedial programs such as further education, and mentorship should be put in place to deal with concerns steaming from a lack of education or support on the job.

3. Disclosure: Another major issue regarding procedural fairness and natural justice was the lack of disclosure provided to nurses cited by the RNABC Professional Conduct Committee. The disclosure of documents held by the RNABC [and access to] its

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\(^{105}\) A conflict of interest can arise where a duty to one person or group of people prevents one from acting for the opposing person or group, in a dispute arising from the same issue or matter. For example a lawyer cannot prosecute and defend the same action, or give advice to both sides in a dispute.

On the basis of her report, Wedge (1991b) recommended that the \textit{Nurses (Registered) Act} be revised to provide full discovery rights to the nurses under citation. It was also recommended that the \textit{Act} be revised to provide full rights for discovery of documents, as it was the experience of some counsel that the RNABC would only disclose documents that supported the complaint. "They will withhold any documents which may put incidents into conflict (or is the word context) or exonerate the nurse" (Wedge, p.8).

4. Innocent until Proven Guilty?

\textit{One of the greatest concerns is the failure of the RNABC to accept the basic tenet of the justice system that someone is innocent until proven guilty, or in the case of a disciplinary proceeding, innocent until the RNABC proves that the conduct complained of in fact occurred (Wedge, 1991b, p.13)}

In support of this claim Wedge stated, for example, that "counsel for the nurses have found that they have been put in the position of attempting to prove the negative, e.g., the person was not there as opposed to the fact that the person was there" (Wedge, 1991b, p.13). The requirement that counsel for the member must prove that the nurse did not commit the
offence or actions set out in the citation is contrary to the more widely accepted rules of law. The burden to prove the case—is the accuser [RNABC] not the defendant [the nurse] (Black, 1996; Gibson et al., 2003).

5. Charges Arising from Personality Conflicts: Finally, Wedge stated that a process needed to be developed to address “less serious” concerns—the suggestions put forth were that a conflict resolution process be developed. Examples of the need for such a process are highlighted below by quotes taken from Wedge’s (1991a, 1991b) reports.

...many issues dealt with by the conduct committee are issues of safe practice, nothing more or less. Yet the member involves the full burden of the criminal-like proceedings, investigation, citation, allegations of (incompetence) and (unethical behaviour) and a full blown disciplinary hearing... often there is not much more than a personality conflict (Wedge, 1991b, p.5).

Wedge’s implication appeared to be that the RNABC invoked an onerous legal process too often over minor matters of concern, which Wedge suggested is unnecessary and unfair.

Another report (as prepared by Campbell [(1992)] analyses and supports the findings of Wedge. The Campbell report ends by stating that the BCNU wished to facilitate a discussion that would move to improve “our relationship with the RNABC” (Campbell, 1992, p.1). They suggested that adopting the recommendations of the report would move the judicial fairness of the Professional Conduct Committee (PCC) into a “new era”, and further expresses its position by stating that it wish to “move away from a win-lose mentality” (Campbell, 1992, p. 1). The end result of the battle between the RNABC and the BCNU over the disciplinary process was a decision by the RNABC to conduct a 5-year multi-stage study to address these concerns. The study commenced in 1992 with the RNABC disciplinary program to be reviewed. It is difficult for me to ascertain from the data, the make-up and
independence of this 5 year study, as these issues were not directly addressed in any
RNABC documents.

As has been evident in my narrative in Chapter 3 through 5, it should be noted that the
RNABC commissioned several “task forces” “reviews” and “committees” to review their
own disciplinary process over the 21 year period between 1975 and 1996 of the formal
disciplinary process. These reviews frequently include “representatives” of the public and
different areas of nursing care, however it is difficult to ascertain the independence or
otherwise of these committees and the degree to which true representation was even sought
(Campbell, 1992; Clark, 1985; Registered Nurses Association of British Columbia, 1992b,
p.1). I have been unable to locate any documents from the RNABC laying out criticisms of
the BCNU, however, I can imagine that the RNABC also had concerns regarding how the
relationship between the two organizations was progressing.

**BCNU Proposes a College of Nurses**

The BCNU’s criticisms of the RNABC were not strictly limited to the disciplinary issue,
but also extended to related criticisms of the Association’s structure. Besides the discussion
and resolution to request the RNABC to review its disciplinary process, a resolution was
tabled, by members of BCNU to investigate the feasibility of a College of Nurses, “Members
from across the province voted to pass the resolution to lobby for an independent licensing
and disciplinary body called a College of Nurses” (McPherson, 1992b, p.2).

*During the course of the debate, it became clear to the union’s executive and delegates to the last three BCNU annual conventions, that one organization cannot perform both functions There was, and currently is, a conflict of interest between being the regulating body responsible for disciplining nurses in order to protect the public, and being the organization responsible for nurse’s education, licensing and research. A single organization cannot effectively promote the*
interest of nurses and the interests of the public (McPherson, 1992b, 2).

Further, the union noted that the *B.C. Royal Commission on Health Care and Costs* recognized this conflict in recommendation 361 (p. D37) which stated, “Two separate bodies be created for all regulated or licensed professions so that there is a clear separation of membership promotion and licensing and discipline function” (McPherson, 1992b). That is, there was seen to be a need for a clear separation of function between membership including economic welfare and working conditions and licensing and disciplinary functions. As the BCNU documents unfolded, clarity was brought to their position. BCNU believes that a College of Nurses should be responsible for licensing and discipline functions, and that these functions be removed from RNABC. The union went on to say that they intended to lobby the government to ensure that BCNU was involved in “determining the structure, regulatory function and composition of the College Board” (McPherson, 1992b, p.2).

Delegates to the BCNU 1992 convention debated this issue and resolved to:

...lobby the B.C. Government to enact changes to the Nurses' (Registered) Act to establish a B.C. College of Nurses for the licensing and discipline functions and remove the licensing and discipline functions from the RNABC; and, That BCNU lobby the B.C. Government that BCNU be involved in determining the structure, regulatory function and composition of the College Board (McPherson, 1992b, p.2)

The members also voted to send the resolutions to every BCNU member so that the membership would understand the reasons underlying the resolutions.

The BCNU’s proposals constituted a divergence of the structural organization of the professional nursing Association from that seen in other Canadian jurisdictions. In most
provinces and territories (with the exception of Ontario and the Yukon), provincial
governments had entrusted the administration of nursing associations to themselves. As I see
it, the administrative functions of nursing associations can be seen in two parts: *Regulatory
functions* including discipline, determining standards of practice, and *Educational
requirements* for licensure and professional functions, including practice advice, continuing
education, promoting nursing as it relates to the “protection of the public”.

These two administrative functions are linked and only one membership fee is required to
be paid. Membership has been mandatory since 1989. The act of self-government has been
is considered by many authors to be the determining factors in the definition of a “true
profession” (Du Gas, 1999; Hurlburt, 2000; Kelly, 1973; Kerr & MacPhail, 1996a, 1996b;
Kerr, 1996a; Mawani, 1999; Mussallem, 1992; Registered Nurses Association of British
Columbia, 1999b). According to Mussallem (1992), occasionally provincial governments
question the self-governing authority for the profession, but in such instances in the past the
government or the courts have withdraw objections because, in the view of the court “
professional competence … was best left in the hands of peers who were capable of assessing
competency” (Campbell, 1992, p. 4).

**A Limited Response to Concerns by the RNABC**

The RNABC’s reply to the concerns from the union was presented in an article by Elaine
Baxter, president-elect of RNABC at the time (*Nursing BC*/November-December, 1992).

Why is the B.C. Nurses Union involving itself in issues of professional regulation and discipline when the mandate of most unions is the economic and social welfare of their members? (Registered Nurses Association of British Columbia, 1992a, p.11).
Baxter's article explains that the BCNU resolutions were passed by a 75% majority, at the 1992 BCNU Annual General Meeting. The Association's concerns were that the union had over stepped its boundaries and that nurses voted in favour of the resolution without being totally informed about the issues. In support of Baxter's concerns, Arlene Bruce, a BCNU member and elected member of the RNABC's Board of Directors, attended the convention and stated, "I was shocked that those resolutions were passed" (Registered Nurses Association of British Columbia, 1992a, p.11).

This response from the RNABC seems to me to be somewhat defensive. From my perspective, there is a clear relationship between the disciplining of nurses and their economic and social welfare, especially if, as the union alleged, the disciplinary process was being improperly applied. However, the stances of the two nursing organizations are quite disparate. Thus, while it is clear that BCNU has an interest in the debate, it is equally clear that, where safety of patients is in question, the Association's position would be that patient safety must hold priority over the nurse's economic welfare. I see the crux of the debate being over issues of due process. These issues, and highlights the importance of procedural fairness and natural justice. The comments by McPherson, Bruce, and Baxter also illuminate the growing discontent between the RNABC and the BCNU (Registered Nurses Association British Columbia, 1992; McPherson, 1992b). At the same time, it is important to note that both the BCNU and the RNABC could be seen as two hierarchical organizations engaged in a power struggle. Support of the nursing body was critical to both organizations at this juncture and both had an interest in persuading nurses to support their position.
More Pressure on the RNABC Regarding Discipline

Pressure was placed on the RNABC by the BCNU in an ongoing fashion. Between 1993 and 1996, BCNU retained George Bryce, Barrister and Solicitor, to review the position of the union, and to provide legal advice as to whether the RNABC was acting in a “conflict of interest”, in regards to several matters (Bryce, 1993a, 1993b, 1994a, 1994b, 1996). The correspondence also suggests that the union was seeking legal advice as to how to proceed against the RNABC. This is in contrast to BCNU’s earlier attempts to find a resolution to their concern regarding the disciplinary process through a less adversarial approach; perhaps due to the failure of the latter.

Correspondence from George Bryce to the British Columbia Nurses Union was located in the BCNU library and thus determined to be of public record.  

I have been asked to consider the status of the current activities of the Registered Nurses Association of B.C. (RNABC). Specifically, I have been asked to identify those activities which are inappropriate for the RNABC to engage in and those where the RNABC maybe acting illegally (Bryce, 1993b p.1, 1993c).

The primary purposes of Bryce’s these activities were summarized in his correspondence as follows: To identify if:

1. the non-statutory activities of the RNABC that could be undertaken by the BCNU or another nursing organization; and,

2. those membership promotional activities of the BCNU that could be undertaken by the RNABC or another nursing organization.

107 George Bryce is a Vancouver lawyer in private practice who specializes in health care and administrative law. From June 1990 to November 1991, he acted as the Assistant Legal Counsel to the BC Royal Commission on Health Care and Costs.

108 Documents of “public record” are available to all persons, whether they are members of the organization holding the documents or not.
A secondary goal was to identify areas where the RNABC and the BCNU could be more cooperatively active (Bryce, 1993a, p.4).

There was not to be a resolution to these and other debates between the RNABC and BCNU for several years. The ongoing conflicts would eventually be one of the reasons leading the RNABC to shift to an alternative Professional Conduct Committee Process of Consensual Resolution. This new process was justified as a strategy to address some of the concerns of the BCNU. It would not be until 2003 that more complete separation of functions would be legislated with the proposed formation of a College of Nurses governed under the Health Professional Act, which I will say more about in Chapter 6.

The RNABC’s Five-Year Plan

The RNABC did attempt to undertake a proactive role during the tension-filled years of the dispute with BCNU. A five-year plan (1992-1997) was proposed to promote “enhanced self-regulation” (British Columbia Nurses Union, 1992, p.2).109 Essentially, this meant that practice standards would be clearly defined, assistance and encouragement would be given to the individual members by education and supported services, and education would be delivered to nurses on the importance of self-regulation to the profession. “If the member is unable to meet the standards, then a ‘fair and just’ [emphasis BCNU],110 disciplinary process must be in place to safeguard the public” (British Columbia Nurses Union, 1992, p.2).

Inge Schamborski, RNABC President at the time, warned that nurses needed to be aware “that through provincial legislation nurses have been given the “privilege to establish its own rules and standards of practice… [however] … The public expects us to protect them from

109 A BCNU document is cited here, as there is no documentation available through the RNABC explaining their position in relationship to this matter. The BCNU literature explains the RNABC’s position in a positive light and thus I have considered it to be accurate.

110 Within this quotation printed by BCNU- the union has paraphrased RNABC’s mandate “to protect the public” (Registered Nurses Association of British Columbia, 1992c), while adding their own emphasis in quotations “fair and just”.
unsafe, incompetent and unethical practices (British Columbia Nurses Union, 1992, p.2).
This was an important announcement to nurses at the time, because a statistical survey found
that only 44% of nurses were aware that “the RNABC must give priority to the public interest
over nurses’ interest” (Bryce, 1994a, p.2).

The RNABC’s five-year plan consisted of three phases. Included in phase one was the
formation of 12 focus groups representing nurses and significant stakeholders involved in the
disciplinary process (such as lawyers, hospital administrators and educators), to gain insight
into the current Professional Conduct Review Program; and, to identify its strengths and
weaknesses (Registered Nurses Association of British Columbia, 1992a). The second phase
would analyse the data gathered from the focus groups and engage in further discussions to
consider the social, economic, professional, legal and political ramifications of the concerns
voiced. The final 19-month phase was to involve developing, revising, implementing and
evaluating a draft outline and the then current PCC program, as well, as the Nurses
(Registered) Act and Act (Rules). Throughout the five-year plan nursing disciplinary hearings
continued. It appears that as the plan progressed and recommendations for improvements
were uncovered, changes were instituted into the process in an incremental, piecemeal
fashion. These iterative changes are described in the following section.

Disciplinary Hearings in the 1990s: Changes to Process
The 1990s brought about significant change, challenges and opportunities within the
Professional Conduct Inquiry Process. As of 1993, the Professional Conduct Committee was
able to accept Diversion Agreements. Diversion agreements were agreements that were
reached between the RNABC and the member to correct behaviours brought to the attention
of the disciplinary committee. Not all members were afforded this opportunity. The decision
to invoke a Diversion Agreement rested solely with the Association and, according to
RNABC literature, was assessed on an individual basis, keeping in mind the mandate of the association to "protect the public" (Registered Nurses Association of British Columbia, 1992).

As well, the 1990s saw amendments to the 1979 Nurses (Registered) Act, in 1990 and 1993, under the Nursing Statutes Amendment Act, 1988. The new amendments made writing of the Decisions and Reasons more legalistic in terms of language and the citing of case law standards and such legal aspects of a case. There was also a shift in the formatting of the Decisions and Reasons. Commencing in 1994, section 26: The Hearing, and section 27: The Penalty, became clearly separate events. Further, reasons for the panel's findings were required to be given as a justification and support, and the relationship to penalty was to be spelled out. For instance, the section which addressed the Findings of Facts was usually very lengthy (20-30 examples), as opposed to the findings laid out in the 1970s and 1980s where cases only stated a few facts. Also, the Decisions and Reasons began to address the Standard of Proof. This was very similar to a court decision, which looks at the difference between the civil and criminal tests in relationship to proof. At one end of the spectrum is the civil test which is "on the balance of probability" or 49/51 at the other end of the spectrum is the criminal burden of proof "beyond a reasonable doubt" 99/100 (Black, 1996; Hurlburt, 2000; Jones, 1999). Since Nursing Professional Conduct Inquiries concerned allegations of serious misconduct and had potentially serious consequences for nurses charged, the Professional Conduct Committee began to apply a high standard of proof, very near to beyond a reasonable doubt. An example indicates that, "In making its findings, the Professional Conduct Committee has relied only on clear and convincing evidence" ("Milner v. Registered Nurses Association of British Columbia Vancouver (unreported) Registered Nurses
Association, dated February 14," 1996). In what follows I will use excerpts from hearings between 1990-1996 to illustrate how these new standards were applied, as well as the categories of complaints that were used.

**Review of Disciplinary Decisions From 1990 to 1996: Categories of Complaint**

The categories of charges laid remained unchanged from previous years, that is, Unethical Conduct, Incompetence, Fitness to Practice, Unethical Conduct and Incompetence, Breach of Conditions and Breach of the Act. Drug and alcohol charges seem to appear in many different forms. The charges were sometimes interwoven into Unethical or Incompetent practice, or the charges sometimes stood on their own in a form of impaired ability to practice. There also seemed to be more overlapping of the categories, and the category titles became more specific to the individual concern. For example a nurse was charged with

...*demonstrated nursing knowledge and skills below acceptable nursing standards;*

...*continued to make errors and omissions despite having the deficiencies in her conduct and practice brought to her attention and reviewed with her;*

...*failed to meet the expectations and standards required to pass a diagnostic assessment of her nursing performance at ... College in September 1994* (#705208, 1995, p.2). 111

After the hearing was undertaken, the nurse was found guilty of incompetence, although the decision was not unanimous and terms and conditions were placed on her membership.

Another example is of a rather unusual way to initiate a citation in stating that the nurse had:

...*demonstrated nursing knowledge and skills below the standards for nursing in British Columbia”* (#273167, 1995, p.1). 112 This case found the nurse:

111 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1995, #705208,").
...guilty of incompetence under Section 26(2) (a) (i),
guilty of conduct contrary to the ethical standards of the
profession of nursing, under Section 26(2) (a) (ii), and
suffering from a mental condition that impairs her ability to
practice nursing, under Section 26(2) (b) (p.2).

This citation was unusual in that the citation found the nurse guilty prior to the hearing. In
this way, it corroborates Wedge's concern that the nursing disciplinary process did not
presume innocence until the nurse was found to be guilty through a proper process (Wedge
1991a). As well, this case had a rather unusual twist at the end. Normally a member was
afforded a hearing under section 26, and a separate, section 27 hearing was held in regard to
penalty. In this case, the member was handed an interim suspension until the committee was
able to hold a penalty hearing. The Professional Conduct Committee decided on the basis of
the evidence before it that it was not in the best interest of the public to allow the nurse to
continue to practice nursing in the interim (p.10). The nurse in question agreed to accept an
undertaking.

...not to apply for reinstatement of my membership, or
otherwise seek to become a member of the Association without
first obtaining the approval of the Board of Directors which,
in considering an application for approval, may exercise the
same discretion as if my membership had been terminated as a
result of disciplinary action under Section 27 of the Nurses
(Registered) Act.

In discussing the categories of complaint during the 1990s, it is important to note that the
Diversion Agreements process introduced a significant unknown into the data I have been
able to retrieve. Because of its confidential nature, there are no records available to the public.

112 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1995, #273167.")
or to members of the Association that address the number, nature or outcome of complaints selected for diversion.

Continuing with my descriptive examples from each category of charge against nurses cited by the RNABC during the 1990s, I have found the following examples, which further illuminate the concerns addressed by the Professional Conduct Committee.

1. **Unethical Conduct**

   Again, many of the charges under this category involved emotional instability and mental illness.

   ...began to see a psychiatrist during the spring or summer for treatment of depression and anxiety...During this period of time ... had little insight into the effect her behaviour had on her peers and patients. Her personal emotions interfered with her judgement and her nursing practice...gave confidential information learned from the patient LM's medical records and from her role as a nurse to LM's estranged husband... The information ...disclosed included, a) notations and physicians' orders on the patient; b) details about confidential discussions; and c) treatments and proposed discharge plans. ...behaviour toward a patient, LB, was interpreted by LB to have sexual overtones ... (113 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1992, p.2-3)."

   The Professional Conduct Committee chose to suspend the nurse’s membership, and then place conditions on her continuing membership as opposed to terminating her membership for the following reasons:

   ...expressed remorse for the breach of confidentiality and she demonstrated some insight with respect to how personal stressors affect her own behaviour.

   ...stated that she has sought psychiatric help for her problems.

   ...expressed a willingness to deal with her problems.

This following hearing was commenced in March, 1990. The citation noted 10 charges (findings) relating to the care of one patient R.B. The behaviours in question occurred more than five years prior to the charges being laid, a fact that makes the case of significance, because the nurse no longer exhibited the problem behaviours and presentation of evidence was impacted by the considerable time lapse (# 468600, 1990).114

The ethical infractions did occur five years ago and since her suspension and verbal reprimand at ... in 1986 ... states under oath that she has not recommended deliverance ministry/exorcism to another client (p. 15).

In or about April of 1985 ... was assigned as primary therapist to an out-patient R.B... who had recently made a serious suicide attempt and who was experiencing emotional problems resulting from childhood sexual abuse. She advised the patient R.B. that demons had entered her and that the only way she could be well was to go for deliverance ... advised R.B. that she was praying that the demons would not disrupt her time with her (p.2).

This next nurse was found to be in violation of the ethical standards of the profession as outlined in the Code of Ethics for Nursing, Canadian Nurses Association, reproduced. April 1989 (Canadian Nurses Association, 1989, p.2). Specifically she violated:

Value II - Based upon respect for clients and regard for their right to control their own care, nursing care should reflect respect for the right of choice held by clients.

...promoted views to her patient that are not supported in acceptable nursing practice or theory... (p.2).

Value V - The nurse is obligated to provide competent care to clients (p. 3),

...did not provide competent nursing care when she recommended deliverance ministry/exorcism to her patient instead of proven and acceptable modes of treatment (p.3).

114 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1990, #468600,").
It was the decision of the committee to suspend the nurse’s membership until such times as she had completed an independent study in the field of Ethics under the direction of an individual who specialized in both ethics and nursing (e.g., nursing instructor at a college or university), approved by RNABC. The study was to include two papers: one on the complements and conflicts between nursing and religion, and, the second to identify how her own belief system would impact her future patient care. A third document - a contract identifying how she would monitor her own nursing practice to ensure that no ethical or practice standard violations occur - was also to be produced (#468600, 1990, p.13).

In this case the requirements appeared to respond to the need to protect the public while providing useful education and conditions for the nurse. It is, however, difficult to more fully assess this finding due to the absence of the voice of the nurse charged in any of the summaries, a problem that is shared by all of the cases included in this thesis, with the exception of my own. That is, as only the RNABC’s evidence and opinions are presented and no exculpatory evidence is available for analysis, so there is limited possibility to assess the aptness of charges to the specific (alleged) offences.

2. Incompetence

Incompetence continued to be defined as a “pattern of carelessness” and as being of a disposition or temperament whereby the nurse charged failed to respond to advice as to their shortcomings. Two examples of nurses cited for incompetence in this period are presented below. The first quotation is a list of the allegations used to show a pattern of negligence (i.e. incompetence) for the first nurse:

Thirty eight findings of fact which led the committee to find the nurse guilty of incompetence and a decision to impose
conditions on the continuance of membership (#628660, 1992). The incidents cited included:

During an evening shift on 26 May, 1989 ... failed to empty the catheter bags or calculate the fluid input and output for four patients assigned to her care (p.2).

On the night shift of 7 November, 1989 ... was observed giving a pm Ativan tablet to a patient. She failed to chart the administration of this medication in the appropriate place in the nursing notes (p.2).

On 7 February, 1990, while ... was working the evening shift in the emergency department, she failed to prepare intravenous fluids mixed with medications as ordered for a patient. ...left the unit without checking this patient and as a result the intravenous infusion ran dry. ...also failed to chart the administration of some medications until she was called back from another nursing unit to do so. The supervisor spoke with ... on 8 February, 1990, with respect to these problems (p.2).

On 10 April, 1990 during a night shift ... left a medication tray with the 0600 hours medication cards in a patient's room. The tray also contained a medicine cup full of Tylenol #3s. When called at home by the head nurse about the incident ... stated "Oh, I forgot to put them back"(p.3).

...failed to ensure that the morning blood work was done on a patient prior to her discharge (p.3).

...demonstrated difficulty in organizing and prioritizing care for her patients and inappropriately declined assistance offered by another registered nurse and the clinical instructor (p.4).

...demonstrated a lack of general knowledge concerning Crohn's Disease. ... was unable to describe the action of the drug Prednisone in the management of inflammatory bowel disease (p.5).

The conditions placed on the nurse's membership are quoted below, at page 11-12.

1. Advise ..... College of the conditions placed on her membership.

2. Successfully complete both the theory and preceptorship portions of the refresher course at .....College that she is

115 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1992, #628660,").
currently registered in, on or before 31 May, 1992, and request ...College to forward copies of her final transcripts to RNABC.

3. Obtain employment in nursing within one year of completing the refresher course.

4. Advise RNABC once she has obtained employment.

5. Advise her employer of the conditions placed on her membership. The employer must verify with RNABC that they are aware of the conditions on her membership.

6. Work for only one employer at a time on a single medical or surgical unit. .... must work a total of 18 months on the same unit and must work 72 hours a month.

7. Arrange for her employer to forward reports to RNABC at least every three months until she has been employed for a total of eighteen months. These reports must indicate that ... performance is satisfactory and meets all standards for nursing practice.

The reasons cited by the committee for not terminating or suspending the nurse’s membership included:

> At the hearing [the nurse] showed some awareness and remorse with respect to the seriousness of her practice problems” “... made an effort to improve her nursing practice by attending the refresher course ... A suspension would prevent ... from immediately applying the knowledge and skills she would have acquired during her refresher course (p.12).

As well, the committee felt they could “protect the public from unsafe nursing care and to assist ... to develop the skills necessary to practice nursing in a safe manner” (p. 12). In this case, it seemed to me that the RNABC showed insight into the seriousness of the consequences of suspension on the nurse, and recognition that currency of practice was important for a nurse who was apparently working to rehabilitate practice deficiencies.
In a second example, there were some 31 findings of fact of which I have chosen a representative sample. The member was immediately suspended with terms and conditions placed on her ability to apply for reinstatement in the Association (#612223, 1991).116

...has a poor command of the English language. Her comprehension of English is poor and she is unable to express herself adequately. She needs repeated instructions in order to carry out specific nursing duties.

...lacked knowledge of the role of a registered nurse in British Columbia. She told the Committee that her nursing education did not include making nursing diagnoses or making decisions based on these diagnoses.

...gave Insulin to patient JR at 0800 hours and 1000 hours rather than at 0800 hours and 2200 hours as ordered.

...failed to chart or sign for medications for three patients assigned to her care.

...poured Theophylline 200 mg when the physician's order was for Theophylline 400 mg.

The conditions were as follows:

...must successfully complete the refresher program for nurses with English as a second language at ... College, or an equivalent approved by RNABC as described ... This program must include an obstetrical nursing practice experience and instruction in, (p.10).

1. If ... is unable to take the .... College refresher Course for nurses with English as a second language, she must,

2. If ... is unable to take the .... College refresher Course for nurses with English as a second language, she must,

   a) successfully complete a refresher course approved by RNABC;

   b) pass the Test for Spoken English (TSE) at the level required by new registrants at RNABC (p. 10).

3. If ... is unable to arrange for an obstetrical nursing practice experience during her refresher program, she must arrange

116 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1991, #612223,")
for a preceptorship in an obstetrical area of not less than four weeks duration following the refresher program (p.10).

4. The Committee recommends that upon completion of the above conditions ... return to nursing practice as soon as it is possible (p.10).

Prior to this complaint the member had passed the TOEFL,117 a refresher course in nursing approved by RNABC and a “Pharmacology for Nurses” course at a B.C. Community College; as well as, the CNA’s registration exam (#612223, 1991). These facts suggest that there may be other issues, which are not related to the nurse’s competence in this case. The Professional Conduct Committee chose to suspend the nurse’s membership with the specified conditions for the following reasons, (#612223, 1991, p.10-11).

...demonstrated consistently poor practice with respect to the administration of medications. Her knowledge base was lacking in many areas, her ability to follow through with appropriate nursing care based on her assessments was poor, and her poor English comprehension inhibited her ability to practice nursing safely. To remedy this, she requires upgrading in nursing knowledge and skills as well as English comprehension.

The Committee believes that the refresher course that ... took in 1986 was inadequate for her needs. The Committee also believes that, because ... did not work for two years following her completion of the refresher course, her ability to use to knowledge and skills gained from the course was reduced.

There was evidence heard by the Committee that .... has difficulty taking courses while maintaining a work schedule because she becomes exhausted. For that reason ... must apply herself to a full-time, comprehensive refresher course.

The Professional Conduct Committee explained that they chose to suspend membership as opposed to terminating membership for the following reasons:

117 TOEFL Test of English as a Foreign Language.
During her work experience...showed a willingness to address her difficulties, albeit her attempts were unsuccessful.

The Committee believes that...perceived that the environment in which she was working was non supportive and this may have affected her ability to perform. The Committee believes she should be given another opportunity to demonstrate competent nursing practice.

According to the Decisions and Reasons of the Committee, conditions were placed on her registration along with a suspension for the following reasons, “...suspension was chosen to protect the public from unsafe nursing care and to assist ... to develop the skills necessary to practice nursing in a safe manner” (#612223, 1991, p. 11). In this case, the very heavy workload that may be involved is addressed. However, the decision to suspend the nurse, rather than require part-time practice while studying, is interesting when compared to the previous case. While an attempt was made to tailor conditions to individual members, there is also an aspect of arbitrariness between these cases. I do not see consistency between when a nurse was encouraged to return to practice as soon as possible and when a nurse was suspended for a specified period. This case also makes me wonder how many foreign trained nurses run into similar difficulties, and what resources are available to them for improving practice and English language proficiency. Foreign trained nurses form an increasing proportion of nurses in the Province due to the globalization of nursing as the solution to the nursing shortage.

During this time period, it was noted that the requirement to prove a “pattern of carelessness” led to the inclusion of long lists of alleged offences in citations for nurses charged with incompetence. Lists, on occasion, reached 20 or 30 incidents over a period of several years for individual nurses. An interesting consequence of this was that the citations read to me as though someone followed the cited nurses around for a period of time
attempting to ‘catch’ incidents of carelessness. On one occasion, the search for evidence resulted in a nurse being accused of a “pattern of forgetfulness”. At the hearing, the only evidence to support this was that the nurse had “on one occasion forgotten to bring doughnuts to a staff meeting”. This allegation occupied a considerable portion of the hearing (Campbell 1992, p. 16). In this case the investigative process appeared to aim to produce a list of offences as potential candidates for “a pattern of carelessness”.

This approach exemplified what I have noticed in this time period as a tendency of the RNABC investigative process to seek out information designed to meet the legal test for incompetence, however apparently frivolous and in the absence of exculpatory evidence. Rather than to investigate the complaints against the nurse. It is my suggestion that this type of investigative process is based on focusing on seemingly trivial concerns rather than true breaches of competence to practice or ethical breaches. A good example of this approach can be seen in my own case,118 where the investigator was initially presented with one alleged incident. She then proceeded to interview, and attempt to interview, past supervisors and employers. Despite a dearth of evidence, the Association’s counsel still attempted to show a “pattern of carelessness” from these interviews. When this failed, counsel for the RNABC attempted to argue that the alleged “pattern of carelessness” had occurred over a period of approximately seven hours (Total Reporting Services, 1995-1996). In further examples (other than my own), the initial complaint contained a list of incidents, as complaints alleging incompetence were originated by employers. In these cases, incidents frequently spanned a period of years (Craig, 1992; Wedge, 1991a, 1991c). In such cases, Wedge (1991) suggested

that complaints may reflect simple personality conflicts within the rank and file of a healthcare facility.

In order to illustrate some of the problematic dynamics seen within the Professional Conduct Inquiry process, I have chosen to review the following case. The case concerned a newly graduated\textsuperscript{119} member. This is important, as new graduates were (and are) subject only to the specific skills and knowledge required of new graduate nurses (Registered Nurses Association of British Columbia, 1999b). The nurse was cited because she “demonstrated nursing knowledge and skills below acceptable nursing standards; continued to make errors and omissions despite having the deficiencies in her conduct and practice brought to her attention and reviewed with her; failed to meet the expectations and standards required to pass a diagnostic assessment of her nursing performance at...University-College in September, 1994 (#705208, 1995, p.2).\textsuperscript{120} The findings of fact by the committee were 23 in number. Below are a few examples of the alleged incidents which illustrate the scope of allegations:

... when starting an intravenous infusion failed to maintain "sterile technique and failed to assess her patient for allergies;

left one patient's medication, Dilantin, on another patient's bedside table. When a nurse brought this to her attention ... asked her not to tell the unit's Clinical Instructor;"

...discharged a patient without assessing his need for pain medication. Following his discharge, the patient returned to the unit and requested pain medication. .... then gave him medication for pain but failed to adequately assess his pain and/or chart her assessment;

...failed to document that she had given a pre-operative medication to a patient and later, when reminded to chart the

\textsuperscript{119} Between January and November 1992, received 97 hours of orientation and worked approximately 500 hours as a nurse at the Hospital - prior to problems arising.

\textsuperscript{120} ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1995, #705208,"
administration of the medication, failed to indicate that her charting was retrospective.

As a result of the "practice problems" identified by the Clinical Instructor, it was agreed that the instructor would supervise ... nursing care for 11, eight-hour day shifts from September 24, 1992 and October 20, 1992. The practice problems are identified below, as "Finding of Fact" of the Professional Conduct Committee (this is assumed to be the written statements and the testimony from the agency's clinical instructor (p. 2).

...failed to document the intake and output for a surgical patient who had undergone a total hip replacement;

...failed to maintain sterile technique while changing a dressing and during the procedure stated in front of the patient, "I always blow this".

...asked a patient who had been recently admitted from the intensive care unit what rate his oxygen flow was to be set at;

...failed to adequately chart her assessment and intervention with respect to a patient's skin breakdown; she did not adequately describe the extent and character of the skin breakdown or what ointment had been applied;

...failed to have a patient ready for the operating room when the porters arrived at the appointed time;

...breached a patient's confidentiality by announcing a patient's operative procedure in front of other patients;

...was unfamiliar with the care required by her patient who was diagnosed with diabetes and renal failure. She lacked knowledge of how to assess the functioning of the patient's AV (Arterial-Venous) fistula...;

Many of these allegations represented common or normal nursing practices and others could easily be explained as occurring due to the nurse being under pressure from high case loads or being expected to work in areas which were not her area of specialisation. While she apparently made some mistakes, on the basis of the available evidence, it is difficult to see her pattern of practice as incompetent. However, the member was found incompetent by the Committee, although the decision was not unanimous. The member was suspended with
terms and condition on membership (#705208, 1995). During the section 26 hearing, the member testified that she was enrolled in a Nurse Refresher Program. In regards to the Refresher program the committee found "Additional Findings of Fact" at page 12.

The Nurse Refresher Program at ... consists of two self-directed study courses.

The supervisor for the Nurse Refresher Program at ... testified that this program is primarily designed to assist experienced nurses who are returning to nursing after absences from practice of between five to ten years. The supervisor testified that in the past five years ... has had limited experience in dealing with registered nurses who had conditions placed upon their membership. Only one nurse who was found guilty of incompetence has taken the ...Nurse Refresher Program and that nurse failed to successfully complete the program.

The committee determined, based on the above evidence from the supervisor of the refresher program, that the refresher program would therefore not be suitable for the member.

Terms and conditions of the suspension of membership were placed upon her registration with the agreement that these conditions must be met within three years from the date of this decision. They are as follows, at page 12:

Re-enter at the beginning of the second year and successfully complete, including all preceptorships, an RNABC approved basic nursing education program - diploma or baccalaureate - of her choice. ...must provide RNABC with proof of successful completion of this program;

Advise the educational institution of the suspension of her membership 'and the terms and conditions, and arrange for the program coordinator to verify with RNABC that she has done so.

This is the only case I could find that required a nurse to re-enter into a basic nursing program after graduation when she had successfully written her registration exam. The cost of this process, both financially and emotionally, must have been insurmountable for the
member. As well, I would question how this member could have successfully graduated from a B.C. nursing school without the necessary practice skills. This example raises bigger questions about evaluation of students in schools of nursing and the available resources for new graduates and others who need remedial help, especially in an era where there are so few experienced, senior staff.

3. Unethical Practice and Incompetence
There were several examples of this category from 1990-1996. I have provided one example below with another presented afterwards. These examples were chosen, as the clearest examples of allegations of incompetence and unethical practice.

...on one occasion... was administering medication to the resident, the resident pinched [the member]... slapped the resident on both sides of the face (# 149104, 1992, p. 2);

...on one occasion...the resident...went down on one knee, which she would often do. ...[the nurse] pulled the resident's head back by grabbing her hair and said “what the hell are you doing?” The resident...was a schizophrenic and may have been mentally handicapped. She had a fractured hip which had been repaired (p.2);

...On a regular basis...would stop the resident...from whistling by inserting a cracker in her mouth. ...would initiate this action without consulting the resident (p.3);

...moods would swing from pleasant to angry and explosive. These mood swings happened regularly over small incidents with both residents and staff (p.3);

...on one occasion, the resident...inappropriately touched another resident and... [the nurse] pushed the resident away from [the other resident] and called him a dirty old man (p.4);

...many residents had physician’s orders for PRN sedatives and tranquillizers. ...used chemical restraint on numerous occasions without considering other alternatives available to deal with the difficult behaviour. Chemical restraint was her first choice of action and she encouraged and advocated that other staff follow suit (p.6);

121 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1992, #149104,").
...was unable to answer questions about the disease processes that were prevalent in the resident population, b). certain medications she administered on a regular basis (p.6);

...Since graduation in 1953...had never taken any continuing education courses, yet she practices in a specialized field (p.7).

The use of chemical restraint was common practice in many settings, and once again we lack data regarding the context and the nurses' perspective for the more serious allegations.

The committee found (unanimously) that the member...

1. verbally abused residents
2. physically abused residents
3. demonstrated an inappropriate use of chemical restraint
4. made medication errors
5. failed to recognize the rights and humanity of the residents
6. lacked knowledge of the disease processes in the resident population, the nursing process and professional behaviour
7. provided inadequate and unsafe nursing care to the residents
8. failed to demonstrate professional leadership and to act as a role model for other staff

The committee found that behaviours 1, 2, 3, 5 and 8 constituted unethical conduct, while behaviours 3, 4, 6 and 7 constituted incompetence.

...The Professional Conduct Committee regards ... unethical behavior with grave concern. This behavior cannot be tolerated in a registered nurse. The Professional Conduct Committee believes that ethical behavior relates to the moral norms of conduct set by society and one cannot be unethical without knowing it. Nurses are bound by these moral norms. A nurse should not have to be told that it is wrong to slap a resident, pull her hair or call someone an animal. ...should have known that her behavior was unethical without having to be told by another person (p. 8).
The nurse, by entering the profession, is committed to moral norms of conduct and assumes a professional commitment to health and the well-being of clients. As citizens, nurses continue to be bound by the moral and legal norms shared by all other participants in society. As individuals, nurses have a right to choose to live by their own values (their personal ethics) as long as those values do not compromise the care of their clients. Ethical violations involve the neglect of moral obligation, for example, a nurse who neglects to provide competent care to a client because of personal inconvenience has ethically failed the client (p.9).

...skill upon which to base her nursing practice and it is every nurse's responsibility to maintain and upgrade her knowledge and skills to ensure her competence to practice. [the members] lack of knowledge is considerable and impacts negatively on every aspect of her nursing practice. She has not taken any continuing education courses since graduation in 1953. She is unable to practice nursing safely at the present time because of her severe knowledge deficit (p.9).

The result of this hearing was that the member was suspended for a period of 24 months.

The member was entitled to reapply for practicing membership at that time having met the following terms and conditions:

...successfully pass the ...Graduate Nurse Refresher Program and provide RNABC with proof of successful completion;

...if the member wishes to return to geriatric nursing, she must take the elective module on geriatrics;

...provide RNABC with an annotated bibliography which includes at least 12 readings from professional books and journals on the topic of elder abuse;

...successfully complete a course, in stress management and provide RNABC with proof of successful completion (p.11).

The conditions continue to read that upon compliance with the above conditions, the member could apply to the Professional Conduct Committee Chairman to have the suspension lifted. If the Professional Conduct Committee Chairman was satisfied that the member had adequately complied with the conditions of her suspension, the Chairman, acting
on behalf of the Professional Conduct Committee, could lift the suspension of membership. The use of the language, "may apply", left room for discretion on the RNABC's part, but there was no evidence of the criteria they would use to exercise that discretion.

In this example, the decision continued, stating at page 12 that:

Following restoration of her membership and return to practice as a registered nurse and for a period of not less than one year, the Professional Conduct Committee hereby imposes the following conditions on the continuance of [the member] membership the member must,

...inform her employer of the conditions upon her membership and arrange for her employer to confirm with RNABC that they have been notified of the conditions;

...arrange for performance appraisals to be forwarded to RNABC at three months, six months and 12 months following commencement of employment. These appraisals must address all of the standards set out in the Standards for Nursing Practice in British Columbia and must indicate that [the member] is meeting all standards at an acceptable level (p.12).

In summary, this member was suspended for 24 months, had to meet conditions of her suspension, reapply for membership, and if accepted, have her practice monitored for another 12 months. From reading this case, I wonder whether the committee considered the working environment in which the nurse functioned and the support resources available to her for assisting with difficult patients.

Another example in this category was with regard to a nurse who had graduated in 1967. She came to Canada in 1971 and obtained her British Columbia registration in March, 1972. From 1973 until 30 September, 1991, [the member] worked full-time in the neurosurgery unit
From 1988 to 1991, the citation included a number of incidents, including:

...On or about March or April, 1988...was caring for a patient...whose diagnosis was severe hemiparesis. On 31 March 1988, while attempting to transfer this patient to a wheelchair...pulled on his affected arm. The patient indicated to...that she was hurting his arm but despite this ... [the nurse] continued with the transfer and pulled on his arm once or twice more. ...stated to the patient, “Oh, you're just not trying to get better” (p.3);

...On 5 April, 1988...was found with no leg rest on his wheelchair, contrary to the patient's plan of care. [the nurse] had taken the leg rest away as she felt it was not necessary. She did this without consulting appropriate members of the health care team (p.3);

...In October, 1988...assisted another nurse in transferring the patient...to a wheelchair. The patient complained that ...had handled her roughly. ... [the panel] perceived the transfer to be “uncoordinated” (p.3).

The charges were summarised as follows:

...admitted to administering the drug Nimodipine without adequate knowledge of its action and side effects (p.7)

...demonstrated poor communication skills

...failed to respond to complaints from patients or constructive criticism

...lacked insight into her capabilities, her limitations and the consequences of her actions

...failed to use the nursing process to assess, plan and evaluate care was very task orientated and lacked flexibility in providing patient care

...demonstrated knowledge deficits with respect to chemical dependency, pharmacology, medication administration procedures, feeding techniques, transferring techniques, positioning techniques

...put patients at risk by providing inadequate and unsafe nursing care

122 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1992, #368933,")
...subjected patients to unnecessary discomfort, embarrassment and pain
...verbally abused patients
...handled the patients in a rough manner
...demonstrated a lack of understanding of the multidisciplinary team approach.

According to the committee, these behaviours constituted incompetence. In making a finding of incompetence, the Professional Conduct Committee relied on the judgement of the Honourable Mr. Justice Anderson in *Mason v. The Registered Nurses Association of British Columbia* (1979), 13 B.C.L.R. 218. The committee also found that the member had breached the Standards for Nursing Practice in British Columbia and her actions were determined to be unethical, based on the following facts.

- verbally abused patients
- humiliated patients
- treated patients roughly
- placed her own needs before those of the patients
- failed to value the dignity and autonomy of her patients, and failed to recognize the patients' right to choose
- failed to recognize and address practice deficiencies which had been identified for her
- lacked empathy in her communication with patients and their families
- failed to recognize the contribution of other disciplines in providing patient care (p. 12).

The decision of the committee was to suspend the member for a minimum of 12 months and for a maximum of 24 months. During this time the member was required to:

1. Successfully complete the...Graduate Nurse Refresher Program and provide RNABC with proof of successful completion;
2. Attend counselling with Dr..., or another clinical psychologist or psychiatrist approved by RNABC, at least once a month or more often as recommended by... or [an] alternate therapist. ...must arrange for progress reports to be forwarded to RNABC at six-month intervals from the date of this decision. These reports must address attendance and progress towards treatment goals; focusing on effective communication and sensitivity towards the feelings of others (p.14).

The Professional Conduct Committee decided not to terminate [the member] membership because:

...has expressed some desire to deal with her communication problems.

...has begun to show some understanding with respect to how her communication patterns affect inter-personal relationships.

...has made some attempts to address her problems by seeking counselling.

...has acknowledged and has some insight into some of her knowledge deficits (p.16).

Further the member had successfully completed the following courses offered at .... College, namely,

Self-discovery and Esteem Building and Communicating Effectively); and Effective Problem-Solving; or courses other than the specific courses listed above, provided that they are similar and approved by RNABC, as well as performance evaluations at 6 and 12 months, commencing employment (p.14 & 15).

This matter was not closed as the member appealed the decision of the Professional Conduct Committee to the BOD of the RNABC and to the Supreme Court of British Columbia. I was unable to follow this case, due to the fact that, if the matter was heard, no written decision was available. Thus, I suspect that the matter did not reach the Supreme Court of British Columbia, and that the matter was dropped.
As the examples above illustrate, in charges of unethical conduct and incompetence some cases read as disconnected lists of nursing actions with no contextual data provided, which I find concerning. Other cases read more as lists of actions which could have been exacerbated by a poor relationship with a supervisor. In the latter, often charges were vague and seemed to lack objectivity, and/or used dated evidence. Because of the abbreviated form in which allegations and findings are presented this could be seen as an artefact of the style chosen by the RNABC for presenting citations. However, the consistent failure to write in a clear unbiased format describing corroborated facts and present contextual data for the allegations seems to me to be at least a serious weakness on the part of the Association. At worst the failure signalled a tendency to find nurses incompetent and unethical based on insufficient evidence and unfair procedure.

To me, the sentencing did show some attempt to address the individual situation of the nurse charged, however, several cases refer to conduct which may represent not uncommon nursing practice in certain situations. Further, many citations in this category refer to “abruptness”, “roughness” and “rudeness”. These are subjective allegations and in my experience on the wards, patients may respond to assertiveness or haste due to short staffing, as “rudeness”. This is not to say that there were not valid concerns about the nurses’ actions. Rather, it is to say that the situation/context in which the behaviour occurred is important, and thus should be made available as evidence at the hearing in addition to the reported behaviours. From my reading of the cases, this contextual data is not provided as evidence or considered in the decision making process.
4. Unfit to Practice

In this section I present an example of conduct that is contrary to the ethical standards of nursing, and illustrates nurses suffering from a mental condition that impairs her/his ability to function. The example was chosen because it represents a change over the previous management of nurses who were “unfit to practice” by the RNABC (#373119, 1990): 123

...was aggressive and excited, and strongly criticized a patient who had levied a complaint against her. ...admitted that she was depressed during this time period (p.2);

As a result of...mental condition she was unable to accept constructive criticism, supervision and unable to work as a team member;

On three separate occasions she was given the opportunity to align her nursing practice with the policies of...hospital and failed to do so;

The Committee concluded that...psychiatric disorder interfered with her ability to function as an effective member of the health care team (p.2);

...made suggestions to the patient J. D., who was not her patient, regarding his treatment without first consulting with other members of the health care team. Those suggestions included avoiding certain foods and keeping a diet diary. [The member] had previously been a patient at the same time as J.D. at...hospital (p.2);

...resigned at the end of a shift, after having accepted a primary care assignment (p.3);

According to the rationale of the Committee they found that this,

“sudden withdrawal of nursing care regardless of whether or not it was approved, from her primary care assignment jeopardized the patient's well being” (p. 3);

It is noted here that the Committee acknowledged that the member was suffering from an illness.

The fact that...was ill is not in itself unethical or unprofessional but...failure to seek treatment is unprofessional and places patients at risk (p. 3).

123 ("Registered Nurses Association of British Columbia, Decisions and Reasons, 1990, #373119,").
This statement reflects a “change in attitude” of the Committee and is the first and only example I could locate which suggests what the committee’s view on mental illness was, that is, “an illness is not in itself unethical or unprofessional ...” (p. 3), and that “it is not unprofessional to suffer from mental illness...” (p.4). The Professional Conduct Committee concluded that the nurse was suffering from a mental condition that impaired her ability to practice nursing. The Committee in its decision went on to justify its findings and support its decisions by the following statement, “All Registered Nurses in British Columbia must meet standards for practice. ...was unable to meet certain of these standards and she breached the code of ethics as a result of her mental condition” (p.7) Further, “This mental condition has from time to time negatively affected her nursing care and was demonstrated in the following ways” (p. 7):

1. An inability to work effectively with other members of the health care team
2. A lack of objectivity by putting her own needs before those of the patients'
3. An inability to follow established policies
4. A lack of accountability for her own actions
5. Role confusion between that of patient and nurse
6. An inability to recognize when she is ill and to withdraw from the practice of nursing during acute episodes
7. An inability to accept constructive criticism and to use it to improve her nursing practice
8. An inability to evaluate her own competencies objectively (p.7).

The Professional Conduct Committee, having considered the evidence and having made a decision under Section 26(2) (a) (ii), and Section 26(2) (b), decided to impose a combination of remedies under Section 27(1) of the Nurses (Registered) Act. They did this by imposing for a period of time terms and conditions and, following the lifting of that suspension, to impose conditions on the continuance of her membership. The
terms and conditions of the suspension of membership are as follows, at page 9.

...if...moves, she must provide RNABC with her new address, name of her new psychiatrist and new support mechanism. There is to be no interruption in this monitoring process. ...must see a psychiatrist at least once a month;

...must arrange for her psychiatrist to submit to RNABC every three months written reports respecting her health and treatment regime. These reports shall specify her attendance, compliance with treatment regime and all acute episodes noting time, duration and whether treatment was sought by...or directed by her support mechanism at the onset, and information respecting how her support mechanisms were used by....;

...must develop a support mechanism approved by RNABC. This must be independent of her psychiatrist;

...must provide RNABC every month with a written report indicating what support mechanisms she is utilizing and how, as well as a summary of her treatment regime throughout the month;

....immediately prior to her application for removal of suspension...must provide RNABC with an up-to-date mental health assessment from an independent psychiatrist approved by RNABC regarding her health and fitness to practice nursing.

In this case the RNABC appears to have been attempting to address the illness that was impeding the nurses’ fitness to practice. However, in so doing, I wonder if they had adopted the role of a mental health consultant and was acting outside the legal mandate of the Association, which does not include provisions for the Association to exercise clinical judgement. Upon compliance with these terms and conditions, and after serving 2 full-years of suspension, the member was able to apply to be re-instated. If she was accepted for re-instatement, the following conditions were to apply, as laid out below (p.9-10):

....for a period of not less than one year of full-time employment as a registered nurse following her restoration to membership, the Professional Conduct Committee hereby
imposes the following conditions on the continuance of her membership (p.9):

...must inform her employer of the conditions upon her membership and meet regularly with the employee health nurse, employee assistance counsellor, or equivalent person who is knowledgeable of her problems. Meetings should be monthly;

...must arrange for the employee health nurse or equivalent person to provide a report to RNABC every three months regarding her attendance, health status and fitness to practice nursing;

...must arrange for RNABC to receive a medical report from her attending psychiatrist at the end of this period of time, outlining her treatment regime, how well she has adhered to her regime and her fitness to practice nursing.

Reasons for Decisions under Section 27 were justified by the Professional Conduct Committee, as illustrated below. The Professional Conduct Committee decides to first suspend membership on terms and conditions as opposed to reprimanding or placing conditions on membership for the following reasons:

1. ...illness has existed for a long period of time, in excess of ten years, with no consistent treatment regime being followed by her

2. ...exhibited no sign of recognizing the onset of acute episodes of her disease process

3. There is no consistent evidence to date that ...would follow a treatment regime of her own volition unless RNABC monitors her.

Notwithstanding the possible over-reaching of its mandate by the Association in the last case, the above cases highlight the increasing importance of terms and conditions being placed on a members’ continued ability to practice during the 1990s. This amendment to the Act in 1985, allowed considerably more leeway to the committee, and cases were able to be
evaluated on an individual basis. My review of the cases between 1990 and 1996 indicates that typical terms and conditions included:

1. Obtain employment in a supervised practice setting in a full-time or full-time equivalent position and

2. Arrange for independent or employment performance evaluations to be submitted to RNABC at 3 months, 12 months and 24 months

3. Undertake further training such as refresher courses, or specific courses on ethics.

Here it must be remembered that nurses were responsible for the costs incurred, such as taking a refresher course, travelling to Colleges for assessments, paying for required childcare, and making up the loss of wages. In the final member's situation above, it is alluded to that she attempted to take a refresher course while working fulltime, which likely was difficult and, according to the data I obtained, was unsuccessful. I cannot help but wonder if more nurses would voluntarily take upgrading, refresher courses, continuing education and advanced preparation in nursing if the programs were more economically feasible and accessible to shift workers.124


In summary, the 1990s was a time of rapid change, economically, politically and in the area of human rights. Within health care, the government was appointing commissions to look into restructuring, rationalization and cost cutback. Economically, there were times of fiscal restraint and political scandal regarding government spending. In the area of human rights and the law, we saw court challenges concerning abortion, women's rights and

124 The cost of taking a Physical Assessment Series- 5 Friday classes is $675.00 (Registered Nurses Association of British Columbia, 2003b). Workshops run by RNABC- Planning Performance Reviews - 1 day at RNABC in Vancouver, $105.93. The cost of the refresher program is estimated to be $1933.00, as of July 2003.
euthanasia. Further, in the area of health care, the period saw many more changes to the Professional Conduct Inquiry Process conducted by the RNABC, including the implementation of a new Code of Ethics by the Canadian Nursing Association (year) and amendments to the *Nurses (Registered) Act and Act (Rules)*. The BCNU and the RNABC remained at odds, making challenges to each other regarding to procedures and jurisdiction within the mandates of the two groups.

I have observed that in this time period the number of nurses who went to full professional inquiry hearings decreased. The number had tapered off from the growing trend in the 1980s, although charges were for similar offences and the categories of complaints remained unchanged. Probably the most significant change was noted in relationship to penalties - it seems that fewer nurses were handed outright revocation of their registration. The penalties of the 1990s were geared towards education and rehabilitation. It was commonplace to see requirements to undertake further education, and specifically courses in communication and ethics, as well as, refresher courses with a practical component. However, in some cases (#705208, 1995; #368933, 1992),\(^\text{125}\) the terms and conditions were prohibitively costly while concurrently impeding the nurses from earning a living through their chosen field. This resulted in a risk that conditions on membership were effectively a termination of membership.

I speculate that this method of rehabilitation and penalty may have been one of the reasons why nurses, or their counsel, attempted to Appeal decisions to the Board of Directors of the Association and, if necessary, to the Supreme Court of British Columbia. They may not have appealed to have their membership reinstated, but to have the terms and conditions applied to their memberships amended to reflect more realistic and achievable goals. To this end,

\(^\text{125}\) ("Registered Nurses Association of British Columbia, Decisions and reseasons, 1990, #373119").
end, several appeals do not address whether a nurse was guilty of the charges, but rather addressed the terms and conditions set down by the RNABC Board of Directors (#575771, 1992; #666240, 1992; #616148, 1994; #789541, 1994). It is important to note that if the RNABC revoked a member’s registration (membership), that nurse is not entitled to work as a nurse in B.C. Thus, the financial and personal costs to the nurse were substantial, and often devastating. Notwithstanding the need to protect the public, it seems to me that in many of the cases a remedial strategy could have been adopted involving supervised, mentored, part-time or a changed practice setting in conjunction with course-work. The standard application of a two year suspension from practice while undertaking remedial coursework seems to me in at least some cases (from the available evidence) to be punitive and may, in fact, have interfered with the nurses’ rehabilitation.

Review of Appeals to the Supreme Court and Court of Appeal from 1978 to 1996

As I have indicated in my summary above, a number of appeals were generated by the Association’s disciplinary decisions between 1990 and 1996. The history of these appeals in BC throughout the operation of the formal disciplinary process is important, so I will close my historical review of the RNABC disciplinary process by reviewing these appeals separately here. The first appeal was held in 1978, the last was my own in 1996. In what follows, I provide a list of cases that were appealed to the Supreme Court of British Columbia. While the list is not all encompassing, it includes all cases which followed the inquiry process of the RNABC in its entirety. That is, it includes all cases which followed the process from the hearing before the Disciplinary Committee (panel), to an Appeal before the Board of Directors, and then to an Appeal before the Supreme Court of British Columbia.

One case (Brock-Berry)\textsuperscript{127} went to the British Columbia Court of Appeal. My purpose of providing a summary of appealed cases here is to illuminate the trends in the nature of case and to highlight the procedural amendments to the disciplinary process recommended and/or ordered by the higher courts. Such recommendations and orders were to have a significant influence on the RNABC's transition to its current disciplinary processes.

\textbf{Mason v. Registered Nurses Association of British Columbia, S.C.B.C., November 9, 1978.} The Mason case revolved around the issue of the legal definition of Incompetence, which had previously not been defined within the context of "professional (nursing) practice, or for that matter in other professions in B.C. Mason, was successful in having the term defined, and her penalty was rescinded. The Mason case is used today, and is considered by the court to be "case precedent law".

\textbf{Churan v. Registered Nurses Association of British Columbia, S.C.B.C., December 22, 1987.}\textsuperscript{128} This case involved the matter relating to a nurse's right to be heard, and to have legal counsel present to defend her case at any stage of the hearing process. The situation developed because the member chose, at the beginning of her hearing, not to retain legal counsel. The case was initially heard in 1986 during the period when nurses were solely responsible for retaining, instructing and paying for counsel (the LEAP program was not yet in existence). The court found that at any stage of a professional conduct hearing, a nurse could elect to retain counsel, and that the Professional Conduct Committee should have allowed an adjournment during the hearing when the nurse requested an adjournment to retain and instruct counsel. Due to the fact that the Committee had refused to allow the nurse


to retain counsel, the decision of the Committee could not stand, and the court referred the matter back to the Association for a new hearing.

Brock-Berry v. Registered Nurses Association of British Columbia, S.C.B.C., dated February 17, 1994 and BCCA - dated August 31, 1995, CA018500. This case was heard in two courts, and it is the only case I have located that proceeded to the highest court in British Columbia - The Court of Appeal. Several issues were raised by Brock-Berry. She did not contest the facts that the Committee had found her to be guilty of conduct contrary to the ethical standards of nursing, but rather the reasons or justifications for the penalty (termination of membership) that had been imposed. The grounds of her Appeal were three-fold. The recommendation of the Judge in the findings, which I think speaks for itself was that:

in all circumstances, hold a separate hearing for the purpose of imposing a penalty under s.27 of the Nurses (Registered) Act, (p. 130), and...[the committee] improperly took into account, imposing a penalty under s.27 of the Nurses (Registered) Act, dishonesty of Ms. Brock-Berry...and [the Committee was] not entitled to take into account [said issues] in imposing a penalty absence of remorse or insight and denial of any wrong-doing on the part of the nurses in question... (p.18).

The circumstance which allowed this matter to be heard in the Court of Appeal stemmed from the fact that the RNABC apparently did not like the findings of the Honourable Mr. Justice Shabbitt's of the Supreme Court, who found in favour of Ms. Brock-Berry. The RNABC appealed his decision on the grounds that the judge erred in his decision. The appeal

129 The legal issue hear was this “I [the court] must decide if the requirements of procedural fairness has been satisfied in this case ... I am not satisfied” (p.12) Chucran v. Registered Nurses Association, Vancouver Registry No. A862078.


131 The next level of Appeal, allowed for in Canadian law, is an Appeal to the Supreme Court of Canada.
was dismissed. “The directions by the Honourable Justice Shabbitt do not entrench on the Board’s determination of professional discipline questions, but seek to rectify the consequences of a failure to adhere to the principles of procedural fairness” (p.19). The results were that Ms. Brock-Berry won, aided in the clarification of what constitutes “procedural fairness” with regard to professional disciplinary hearings. In complying with the courts, it was determined that the Association must hold a separate hearing under s.27, with regard to a penalty, and the:

*Member can not be found guilty of conduct not contained within the citation, the member must be informed of the nature of the misconduct alleged...and the burden is on the association to prove those allegations...a charge properly laid and proven (p.19).*

**Hanos v. Registered Nurses Association of British Columbia, S.C.B.C.** An appeal was launched in the Supreme Court of British Columbia after the Professional Conduct Committee invoked section 24 of the *Nurses (Registered) Act*, on October 23, 1995. Section 24 allows the Association (*Nurses (Registered) Act*, 1979).

*Extraordinary action to protect the public*

24. (1) If the professional conduct committee considers the action necessary to protect the public during the investigation of a member or pending a hearing of the professional conduct may

(a) set limits or conditions on the practice of nursing by the member, or

(b) suspend the registration of the member.

The BCNU took this case to appeal arguing that the allegations against a nurse must be proven before the nurse’s license could be revoked. The appeal was unsuccessful, as the court

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131 ("Hanos v. Registered Nurses Association of British Columbia, S.C.B.C.").
found that in the interest of the public, the Association could exercise its judgement. A hearing was held under the *Nurses (Registered) Act*, as well as a penalty hearing under section 27, and the member was terminated from the Association on November 8, 1996. No other information is available in regards to this member.

**Yeung v. Registered Nurses Association of British Columbia, S.C.B.C.**\(^\text{132}\) was heard in 1993, and prior to the inclusion of the *Freedom of Information and Protections of Privacy Act* in the *Nurses (Registered) Act*, in 1996. The issues raised in Yeung were related to disclosure of documents held by the Association. Counsel for Yeung argued unsuccessfully that the member was entitled to the letter of complaint, and all documents within the control of the Association. Members’ counsel was unable to prove that the Association held documents that they had not disclosed. This case was unlike Milner, where the member had in her possessions documents produced by the RNABC, which were able to be tendered as evidence, and thus proved that the Association had withheld documents.\(^\text{133}\)

**Milner v. Registered Nurses Association of British Columbia, S.C.B.C., 1997 and 1999a and 1999b.**\(^\text{134}\) My personal struggle commenced in May 1995, at a time when I was not currently registered with the Association. I was present, along with a doctor and four other women, at a home labour. The mother was transported to a local hospital where the infant was stillborn some 1.5 hours after admission. A complaint was laid by the hospital in

\(^{132}\) ("Yeung v. Registered Nurses Association of British Columbia, S.C.B.C.,").

\(^{133}\) Milner was able by way of the *Freedom of Information and Protection of Privacy Act* to obtain documents held by the RNABC.

\(^{134}\) Milner was able by way of the *Freedom of Information and Protection of Privacy Act* to obtain documents held by the RNABC.
question. The issues regarding my appeal have been outlined as follows, although it should be noted that two other applications (and thus written decisions) occurred in relation to this matter prior to the appeal being heard in the Supreme Court of British Columbia. One issue was the requirement for disclosure of evidence from the Association. A second issue was an application for the Association to produce the documents in their possession and to have the court allow admission of fresh evidence at the appeal. The two main grounds of appeal were:

1. That by virtue of failing to make full disclosure of all material documents and witnesses, in advance of and during the course of the disciplinary hearing, the RNABC has either breached the rules of natural justice or the Member's constitutional right under s. 7 of the Charter, to make full answer and defence; and,

2. That there was no evidence on the face of the record to support the findings of fact made by the Professional Conduct Committee ("Milner v. Registered Nurses' Association of British Columbia Vancouver, A972468 (unreported), Vancouver, B.C., December 9, 1999," p.2).

The end result (after 6 years of complaint and appeals) was that the court ordered that the decision of the Professional Conduct Committee and the Appeal to the BOD of the RNABC could not stand and that the matter was to be referred back to the Association. In February 2000, the RNABC wrote to me indicating that the matter had been closed. The Association

135 The release indicated that if the mother released the hospital from any legal responsibility, the hospital would lodge a complaint with the Association.

did not appeal to the Court of Appeal (as they had done in Brock-Berry). My membership within the Association was reinstated.

My case highlighted issues involving procedural fairness and natural justice. More specifically, the decision of the court underlined the "member's rights" in regards to a professional conduct inquiry. According to the court, members should be entitled to have a copy of the complaint, the investigators notes, and other information in the possession of the Association whether inculpatory or exculpatory. As well, the procedures and rules of the Association must be in accordance with the principles of natural justice ("Milner v. Registered Nurses' Association of British Columbia Vancouver, A972468 (unreported), Vancouver, B.C., December 9, 1999,"). Madame Justice Boyd of the Supreme Court of British Columbia at paragraph 13 and paragraph 26 wrote:

[13] On a review of all the case authorities, it appears clear that more recently the standard of disclosure in the case of professional disciplinary tribunals has been expanded far beyond the narrow administrative law model. Professor Casey's remarks succinctly and eloquently articulate the standard of disclosure. The Courts have repeatedly and properly acknowledged that in disciplinary proceedings, the individual professional's ability to pursue her livelihood, as well as her professional and personal reputation are often at stake.

[26] In the final result, I conclude that Rule 7.12 is contrary to the rules of natural justice. Here, the Act does not contain the clear and express statutory language sufficient to permit the RNABC Board of Directors the power to abridge the common law rules of natural justice.

Summary of Appeals

The appeals I have reviewed above illustrate trends in professional disciplinary hearings in British Columbia. The decisions frequently cited precedents from administrative tribunals, as well as criminal and civil law cases. Overall, the higher courts applied curial deference to the findings of fact presented by the RNABC on the grounds that members of the same
profession were more able to judge the conduct of its own members. In this way, the courts supported the RNABC’s role in self-regulation—and, thus, self-policing. In issues of procedural fairness, natural justice and the law, the judges consistently found that the RNABC had transgressed the bounds of these standards in its application of the Nurses (Registered) Act and administrative and criminal law procedures. The best example of this is seen above in my own case. The court’s concerns about procedural fairness, natural justice and the law were also raised in the Decisions and Reasons for Judgement of each of the other appeals I have reviewed. It is interesting to note that until 1996, despite episodic recommendations for change or changed interpretation of rules, no clear effort was made to incorporate these changes until the Consensual Resolution Process was implemented in 1997. Even this new process could be seen as an attempt to mask the problems brought to light by litigation, rather than to correct the underlying issues due to the non-transparency of the process.

Summary of the Formal Disciplinary Process as it existed in 1996

In 1996, the formal nursing disciplinary process had evolved through a period of 21 years. The process, as it existed at this point, represents the endpoint in the development of the formal hearing process, as no further hearings have been undertaken to date. There have also been no substantive procedural changes instituted in the formal hearing process since 1996. It is thus the fully developed disciplinary process of the RNABC, which existed in 1996 and still exists today, that I have chosen to present in this section.

The format I have chosen for this section is the flow chart provided by the RNABC, which shows the sequence of potential steps in the disciplinary process and the order that they may follow under different circumstances (Registered Nurses Association of British Columbia, 2003b, p.2). I have found that this flow chart, which I have provided in Appendix
IV, illustrates the process in an accessible and succinct format for what can seem to be a very confusing process.

The Transition to a New Professional Conduct Committee Inquiry Process

My goal in presenting the process of the Professional Conduct Committee Inquiry Process was to illuminate its development to its final state as it rested in 1996 when the last hearing was undertaken. My intention from the outset of my thesis was to gain insight and understanding into the process which I had first become involved with in September 1994.

Although the avenue of a formal hearing remains a possibility for nurses charged by the RNABC, there have been no formal hearings since the resolution of my case approximately in December of 1999. I personally initiated my Appeal to the Supreme Court of British Columbia on September 22, 1997 (which was heard, in several applications to the court, commencing in December, 1998). And another 2 years and 3 months later, the final decision was handed down on December 9, 1999. In total, from the time that I was initially notified by the RNABC that my nursing practice was being investigated, until the Supreme Court of British Columbia resolved the matter, some 6 years and 2 months had passed. It would be another 10 months until the matter of costs would be settled, as the court had ordered that the RNABC was required to pay monies to me with regard to the costs. There is no literature suggesting a link between the end of formal hearing processes and the RNABC having to pay costs to me, although mine is the only documented case I have been able to find where this happened. In addition, the RNABC incurred considerable expenditures to defend the appeals of my cases and others. Interestingly, one of the reasons cited in the literature for moving to

137 ("Milner v. Registered Nurses' Association of British Columbia Vancouver, A972468 (unreported), Vancouver, B.C., December 9, 1999,").
the Consensual Complaint Resolution Process is to provide a more cost-effective process (Registered Nurses Association of British Columbia, 1997).

The adoption of the Consensual Complaint Resolution Process followed a trend in British Columbia towards an Alternative Dispute Resolution process (ADR). Along with cost effectiveness, an ADR process is promoted as having the potential to produce superior resolutions and to resolve underlying issues in disputes (Beer, 1997). However, concerns have been raised regarding large power imbalances between parties in an ADR process, and over involuntary participation in such a process. In addition, an ADR process is always "off the record" until some sort of a formal resolution is produced, which makes appeals of agreements impossible (Beer, 1997).

**Consensual Complaint Resolution Process**

The Consensual Complaint Resolution (CCRP) involves the RNABC negotiating directly with the nurse in question to determine appropriate action and to address the concern(s) of the complainant. This process is strictly confidential. Only the name of the member, the fact that they entered into a consensual resolution process, and whether the process is complete or still ongoing, are public information (Registered Nurses Association of British Columbia, 2003a).

The agreement reached outlines how the concerns, as seen by the complainant, will be addressed. In cases where the concern is minor, it is arguable if RNABC should be involved. However, if the Association continues their past practice of pursuing these seemingly minor concerns e.g., where the nurse was rude to a colleague or family member, ordering an apology may be appropriate. For more serious infractions, voluntary resignation of a nurse's registration may become necessary. According to the RNABC, this only occurs when the problem(s) cannot be rectified (Registered Nurses Association of British Columbia, 1999a).
To ensure that the agreement meets the mandate of the Association (i.e., it is in the public interest and the public is protected), the chair of the Professional Conduct Committee, in consultation with two advisors, must approve the agreement. One of these advisors must be a public representative, and the other a registered nurse. Agreements and the negotiation process are confidential unless otherwise specified. The public is notified, however, when restrictions are placed on the nurse’s practice, or when the nurse is prohibited from practising by publication in a local newspaper and in Nursing B.C. Nurses who agree to have conditions placed on their registration (such as agreeing to attend weekly or monthly counselling sessions or not working as the only nurse in a facility) are monitored until such times as the conditions are met or removed (Registered Nurses Association of British Columbia, 1999d, 2000c, 2000d). Once the CCRP process is complete, there is no record available to the public of the complaint or agreement except with the consent of the nurse for application for registration with another professional body, such as the American College of Nurses, and State or Provincial licensing bodies. It should be noted that if the Association and the member are unable to come to a mutual resolution regarding the complaint, the Consensual Resolution process become null and void, and a full Investigation and Inquiry process is commenced. As I have explained, I have found no record to date that this has happened since the inception of the CCRP in 1997.

The goal of the Consensual Complaint Resolution Process is purportedly to reach a mutually acceptable agreement between the nurse under review and the RNABC. The Association must be able to address the complaint in a way that meets the Association’s
responsibility to act in the public interest. It is a non-adversarial process, whereby the nurse meets with an RNABC representative, shares information, reviews the concerns and then develops a strategy for resolution through a negotiation process. Others who may be involved in this process include the member’s lawyer, or representative/support person; the complainant, who is invited to provide information to further the process, but is not entitled to be a party; and the nurse’s employer and other health care professionals. This is designed to prevent any interaction with, or identification of, the complainant by the nurse (Registered Nurses Association of British Columbia, 1999c, 1999f, 2000a, 2000b, 2000e). As I have previously stated, concerns have been raised over the use of ADR processes in some settings and it is my belief that these may apply to the RNABC Consensual Resolution Process. The final development of the Consensual Resolution process served to silence much of the criticism of the Formal Hearing Process due to its in camera nature and mediated outcomes.

138 Nurses (Registered) Act, R.S.B.C 1996,c. 335, s. 3(1)

The final format of the “Duties and objects of the Association” is presented below:

3 (1) It is the duty of the Association at all times
(a) to serve and protect the public, and
(b) to exercise its powers and discharge its responsibilities under all enactments in the public interest.
(2) The Association has the following objects,
(a) to superintend the practice of nursing by its members;
(b) to govern members according to this Act and the rules;
(c) to establish, monitor and enforce standards of education and qualifications for registration of members;
(d) to establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice among members;
(e) to establish and maintain a continuing competency program to promote high practice standards among members;
(f) to establish a patient relations program to seek to prevent professional misconduct of a sexual nature;
(g) to establish, monitor and enforce standards of professional ethics among members;
(h) to require members to provide an individual access to the individual's health care records in appropriate circumstances;
(i) to inform individuals of their rights under this Act, the rules and the Freedom of Information and Protection of Privacy Act;
(j) to administer the affairs of the Association and perform other duties through the exercise of the powers conferred by this Act or the rules;
(k) to carry out objects in the constitution not inconsistent with the foregoing.
This resulted in an absence of publication of statistical data regarding nurses cited, or of the results of any discipline-related proceeding.

**Chapter Summary**

I have provided a detailed account of the events associated with the RNABC’s disciplinary process from 1990-1996, as it was a period of significant change. Case specific examples from 1990-1996 were included to draw attention to the progression, definitions, procedures, amendments and developments, as they occurred. I addressed changes within the RNABC inquiry process along with wider societal trends (e.g. women’s and labour movements) which most directly impacted on nursing as a predominantly female healthcare profession. In addition, I noted relevant developments in the Canadian legal system, because of their influence on the administrative law governing the RNABC’s disciplinary processes. It is my overall impression that the 1990s could be characterized as a full-scale battle for the RNABC, as it was confronted not only by the BCNU over several issues, but also by a number of lawyers and at least one individual nurse (myself). All of these salvos had some direct and/or indirect relationship to the disciplinary process, its Act, Rules, and outcomes. While the Association endeavoured to respond to the barrage of complaints and concerns that were addressed to it through the five-year plan, its responses were seen by many of its critics as inadequate and, as I have just addressed, the Consensual Complaint Resolution Process might be interpreted as serving to silence the barrage of complaints rather than respond to them.

The only publications relating to the Consensual Complaint Resolution Process were regular publications in the *B.C. Nurse*, stating that a specific nurse had reached an agreement through the Consensual Resolution process. For instance:

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139 The criticisms of the five year plan have been laid out earlier in this Chapter.
(Registered) Act. The Act, which had been proclaimed in 1918, had provided the legislative ability for the Association to self-regulate.

The decision was made by the Provincial Government in February, 2003, to recind the Nurses (Registered) Act, and thus, registered nurses will be regulated under the already existing Health Professions Act, which currently regulates 23 other health professions.\(^{140}\) This move will also result in the formation of a College of Nurses, which has been the request of the BCNU for over 10 years. It remains to be seen if the disciplinary process under the Health Professions Act will better serve nurses and balance the rights of nurses with the mandate of the Association/College to serve and protect the public. The new legislation, which will repeal the Nurses (Registered) Act and place the regulation of nurses under the Health Professions Act, influenced my conclusions and recommendations in several ways, and so I will close the Chapter by focusing on what I see as the future possibilities the Health Professions Act brings.

The closing of this thesis marks an important transition for me. For more than 6 years of my life, from 1994 to 1999, I was involved, on a day-to-day basis with the RNABC disciplinary process. My whole life became consumed in the process, and I lost sight of the wider contextual issues framing the disciplinary process in which I had become involved. The goal of this thesis from the outset was not to retry my case, but rather to begin to understand the evolution of the disciplining of nurses in British Columbia, the forces which supported the process, and the forces which may have worked against it. As well, I had come to realize that to understand this process as it had developed over time I needed to look at wider issues, such as the changing ideologies and evolving power struggles within society.

\(^{140}\) See Appendix III for a table regarding the designation of a “Health Profession” (Ministry of Health Planning, 2003).
Only in this way would I gain insight into ‘how things came to be the way that they are?’, and through this, be able to put forward tentative suggestions to move the disciplinary process forward and bring it into line with justice-based trends within administrative law and the wider society.

Methodological Considerations

To gain an understanding of the RNABC’s disciplinary process, I realized that there were several areas of study which needed to be included. It was not possible to examine the RNABC’s disciplinary process in a vacuum. The process was complex, and wove together several concurrent threads - the history of nursing, the changing roles of women in society, the development of nursing organizations and associations, the growth of nursing ethics and standards of practice (and thus regulations), as well as the evolution of the Canadian legal system within the wider societal context.

It is my position that one cannot begin to understand the present, and look towards the future, without a reasonable understanding of the past. My goal from the outset of this thesis was to gain an understanding of the evolution of the RNABC’s disciplinary process, and to look to elements of this history which may affect the future. Therefore, I believe it was necessary to look to the past. The historical methodology enabled me to gain insight into the formation of the Association, its goals, aspirations, and struggles. In addition, the methodology enabled me to unravel the legislative changes in an attempt to understand the power legislated to the Association as a self-regulating profession. The methodology also helped me to understand the development of the Association’s roles and responsibilities to the citizens of British Columbia. One initial difficulty I encountered was the definition of a time frame and specific methodology which would allow sufficient latitude to answer the questions posed. Looking back at my goals, I had set out to chart the social, moral, ethical,
legal, political and economic forces which have historically acted on the RNABC in general and its disciplinary processes in particular, as well as the evolution of these forces to their present form. More specifically I intended:

1. To survey the evolution of the Professional Conduct Inquiry Process in relationship to social, moral, ethical, legal, political and economic history.
   1.1 To sketch out a chronological perspective of the historical development (social, political and economic) of the disciplinary process in nursing in B.C.
   1.2 To incorporate an overview of the legal system and the application of administrative law in parallel with the disciplinary process.
   1.3 To highlight the moral/ethical dimensions of the profession, and more specifically, those dimensions with regard to the Association in relation to the disciplinary process.

2. To comment on the impact, significance, and fairness of the Professional Conduct Inquiry Process as it has evolved over time.

3. To comment on the future, including potential directions for professional disciplining in nursing.

The time frame consideration revolved around how far back in time it was necessary to go in order to provide sufficient background context to understand emerging patterns. There was also a more minor consideration regarding a suitable end date for the study. The following section will elaborate these time frame considerations in some detail and I will then provide a section addressing the breadth of contextual material presented. The section ends with brief subsections addressing further scoping issues and limitations with the methodology, including my access to historical data.
Time Frame Considerations

The first decision I made was a scoping consideration regarding when to begin and end my analysis in order to define the boundaries and context for the study. My decision was to begin with a brief overview of the history of nursing as it evolved from the 1800s to 1975. This overview traced the changing philosophies and social contexts of nursing as it evolved and key power dynamics framing this development. Special attention was paid to the period in the early 1900s when nursing became legislated as a self regulating profession. The year 1975 was chosen as a starting point for the more detailed analysis, because this was the start date for the formal discipline process by the RNABC and detailed data were available. In terms of an end date, after 1996, there was a dearth of data on nursing disciplinary cases due to the adoption of the Consensual Resolution Process by the RNABC. This provided me with a natural endpoint for my research.

Considerations with the Use of Historical Methodology

Historical methodology can create difficulties by appearing to be nothing more than a list of 'so called' facts, or a chronological description of what has happened. Historical methodology, when correctly applied, involves the weaving together of data into a narrative. This is a reflexive process, which involves a series of clearly defined steps to determine what data will be included and what left aside; and, what type of source material will be used and what weight will be given to the material (Christy, 1975). In addition, consideration is given to the validity and reliability of the data and to the standpoint of the author within the societal context of the day. This contributes to the richness of the narrative, and it is this same quality which enables the different threads of the narrative to be traced through time, synthesised, and then projected into the future.
In the case of the specific material I studied, I have come to believe it is important to consider the actions or inactions of the Association within the context of society throughout the time frame presented. Thus, the disciplining of nurses within the development of the RNABC cannot be seen as a single static occurrence. Rather, these two aspects must be seen as an integrated process which developed over time as the Association attempted to keep pace with the changes unfolding in the larger world. In relation to disciplinary issues, examples can be seen in Chapters 3, 4 and 5 of how the Association adapted the disciplinary process to reflect trends in the wider society. In the early 1980s, for instance, the RNABC developed of procedures within the disciplinary process which dealt with addiction as an illness rather than as a moral failing. This reflected a change in the way that society viewed alcohol and drug abuse.

I believe it is important that readers not look at disciplinary issues from the standpoint of observing individual nurses being cited by the Association, passing through the complaint process, and finally being punished for their actions. The disciplinary process, I suggest, incorporates a much wider and more complex set of issues. Power struggles between the British Columbia Nurses Union and the RNABC, attempts by the courts to address conflicts of interest through the separation of functions within the RNABC, employment issues within an overstretched health care system, and most recently, plans by the Provincial government to rescind the Nurses (Registered) Act, are all intertwined with the disciplinary process. Other contributing factors include the struggles of the women’s movement, changes to the educational system from a hospital-based apprenticeship model to a college and university-based baccalaureate approach, and the constantly evolving relationship of nursing to technological advances. All of these contributing factors led to a widening scope of ethical
considerations for the nursing profession. These diverse themes account for the inclusion of narrative threads outside the narrow scope of nursing and nursing discipline - narrative threads that are particularly important within Chapters 3 and 4 and to a lesser extent in Chapters 5.

Further Scoping Issues

The historical methodology introduced several issues of scope beyond the narrow issues of time frame and subject matter which have already been discussed. Firstly, I chose to limit my data to primary and secondary source documents that were in the public domain. The reason for this was that due to the sensitive nature of the topic of discipline, and the time frame which I wished to cover, I decided that sufficient data could not be uncovered to discuss the experiences of nurses who had undergone misconduct proceedings. Initially I wanted to conduct interviews to support my findings, but during some preliminary discussions it became apparent that members were unwilling to discuss these experiences, mostly due to the emotional toll it had taken upon them. Le Duke (2000) had a similar response when she attempted to gather experiential data from nurses who had been disciplined in New York State. She supports my position that many nurses are unwilling to discuss their experiences, which, of course, makes research in this sensitive area difficult (Le Duke, 2000). There were additional problems encountered in that nurses who had been involved in the disciplinary process in the earlier years were generally unable to recall any specific information regarding discipline (Le Duke, 2000).

Thus, my research was limited in its potential for providing data regarding the opinions of the nurses charged. I suggest that once the *Nurses (Registered) Act* has been rescinded, more nurses may be willing to discuss their experiences and an ethnographical account of their
experiences could be very useful in developing a future disciplinary process which serves nurses as well as the public.

**Limitations with the Methodology**

A further limitation I encountered with the methodology included the absence of first-hand accounts of nurses who sat on the professional conduct committee disciplinary boards and panels. When one looks at the documentary evidence, the context of nurses and board members as complex, multi-dimensional human beings is lost in the discourse. Consequently, first-hand accounts would have provided a richer texture to the narrative, and would have enabled me to include comments from members who were in the position to preside over other nurses' fates and to understand their thoughts and struggles. In addition, an ethnographic account would serve to provide insight into their opinions as they experienced the development of the disciplinary process first hand.

It is my suggestion that the accounts of board and panel members may illuminate hidden power struggles which underlie the evident struggles between the RNABC and the BCNU. These power struggles should be understood in the context of wider power struggles within the health care system (Rodney & Varcoe, 2002).

The existence of these wider dynamics suggests to me that the accounts of nurses who sat on disciplinary panels might have some interesting and useful suggestions, which would aid nurses in the future to develop a process to balance the interests of the various stakeholders. Examples of stakeholders in this process would include the RNABC, BCNU, Health Professions disciplinary groups, the Provincial government, health care institutions, lawyers, nurses, and members of the public. A discussion between these parties could potentially be facilitated by a mediated round-table discussion which brought together all of these parties with the aim of developing a disciplinary process that addressed the needs of all concerned.
Another methodological limitation was the inability to track cases due to the unclear and variable record keeping system used by the RNABC for collating Professional Conduct Inquiry records. From 1975 to 1996 the RNABC Disciplinary Committee, in its various guises, heard an estimated 230 recorded cases of nursing discipline. Of the cases that went to full hearing, an estimated 98% resulted in a loss of nursing license or a reprimand of some sort. The exact number of cases is difficult to determine because the filing system used by the RNABC frustrated my ability to follow cases throughout the entire disciplinary process. This is particularly true of hearings held between 1975 and 1979, when hearings were catalogued using several seemingly uncoordinated numbering systems which are not possible to cross-reference. In addition, rather than recording all disciplinary sanctions, the RNABC library only holds records of those that went to a full hearing. Thus, this excludes determinations on nurses who were disciplined but who chose not to go to full hearing, and either agreed with the Professional Conduct Inquiry Committee and Resigned with Prejudice, or chose to accept the disciplinary action(s) taken against them.

**Early Nursing to 1975: The Development of a Formal Disciplinary Process**

Chapter 3 commenced with a prelude to the narrative. I started with a quick sketch of the arrival of the first nurses in Canada in the early 1600s; the development of nursing in the new

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141 43 (1) After making a decision under section 42 (2), the professional conduct committee may do any or any combination of the following,
(a) reprimand or censure the member;
(b) suspend the membership of the member for the period of time, either definite or indefinite, and on the terms and conditions the professional conduct committee in its discretion thinks proper;
(c) impose conditions on the continuance of the membership of the member;
(d) terminate the member's membership by striking the member's name from the register.
142 The three person committee of RNABC member who act as judge and jury in matters of nursing misconduct.
143 The nurse was charged and did not wish to contest the allegations and decided to resign their membership precluding the possibility of future nursing practice.
144 Where the offence was not grave enough to warrant loss of registration the nurse may accept a program of supervision and/or remediation (Registered Nurses Association of British Columbia, 1995).
colonies; the arrival of nursing on the West coast with the founding of British Columbia; and the struggles surrounding the enactment of the *Nurses Act* in 1918. The Chapter continued with an overview of major trend of nursing developments, through the years of the Depression, World War II and the rapid technological developments in medicine and specialization in nursing following the war. These advances were linked to changing mores and, the informal disciplinary process developed in parallel to uphold standards of practice. A synopsis of the findings of this historical overview is included below.

The pioneer nurses were nuns who were expected to obey the rules of their order in the Service of God. Throughout the early nursing period, discipline was de facto in the hands of Matrons and Benefactresses. It operated in an informal fashion, beginning with the recruitment process. Conformity to the Matron’s rules was expected of those fortunate enough to be selected. As the colony developed, nursing followed the norms of early colonial society, where women had few rights and were expected to perform a subservient supportive role to the male physicians (Domville, 1891; Gibbon, 1947; Mc Pherson, 1996; Rafferty, 1996; 1997).

After the GNABC was formed in 1918 and became the RNABC in 1935, it had sole legislative authority to “revoke” membership within its organization. The *Nurses Act* also provided the Association with the ability to make rules or regulations, which were contained within the bylaws of the Association. The power to suspend nurses was added in 1935; however, there is no record of any use of these powers until 1975. Also, there is no record of any formal process to handle disciplinary matters before this date. It appears that throughout this period, disciplinary matters continued to be handled at the hospital/school level where
students were dismissed for infractions to the rules of specific matrons (Canadian Nurses Association, 1926, 1968; Coburn 1988; Gibbon, 1947; Kerr, 1944; Murphy, 1957).

As schools and hospitals became separate, the focus of nursing training changed to include a greater emphasis on the "ethics" rather than the "etiquette" of nursing (Lamb, 1979; 2004). This occurred concurrently with an increase in status for nurses in accompaniment with the human rights movement, women's liberation and the labour movement. Nurses were increasingly expected to advocate for the rights of the patient rather than blindly following doctor's orders, as had been expected in the period immediately after legislation as a profession. At the same time, there was an increase in specialization among nurses as medicine advanced through technological innovation. More people began to attend hospitals as infrastructure and medical insurance improved access. The adoption of bargaining for nurses as a function of the RNABC during the period of improving labour rights was eventually to lead to the court's involvement in determining issues of conflict of interest between the protection of the public and advocacy roles for Nursing Associations throughout Canada. In British Columbia the separation of roles was instrumental in the adoption of a formal disciplinary process by the Association in 1975.

**The Formal Disciplinary Process from 1975 to 1996**

In the remainder of Chapter 3, I described the unfolding of the formal disciplinary process of the RNABC beginning in 1975 and ending in 1996 with the development of a quasi-judicial investigation and hearing process. The development of a formal disciplinary process represented an important achievement for the Association in its 57 years of legislated self-regulation. The changes, setbacks, and achievements of the formal disciplinary process, as well as examples to illustrate and highlight this process were elaborated in Chapter 3.
Chapters 3, 4 and 5 all followed the formal disciplinary process through three distinct time periods - the 1970s, the 1980s and the 1990s. Each Chapter described the evolution of the disciplinary process in the context of the amendments to the Act, the development of the rules, changing ethical issues, developments in the legislative process, legal precedents and the major parties who were impacted by these changes. Specific examples are provided from “Citations” and “Decisions and Reasons” of the RNABC’s Professional Conduct Inquiry Committee in its various guises within each time period. These examples illustrate the evolution and trends of charges and penalties imposed.

Overall, the initial period of the formal disciplinary process was characterized as a period of empirical learning for the Association. This period entrenched many of the problems that would become apparent in the disciplinary process during later years. The Association struggled with issues of how to discipline its peers, costs, both in time and money of the process, the apparent conflict between confidentiality of the process and the public protection mandate, transparency, and a rapidly developing legal system with which they (as nurses) lacked familiarity. There was a lack of clear definitions of the charges in many cases. An example of this, which was highlighted in the Mason case, was the absence of a definition of “incompetence”. There was also a blurring of the distinction between ethics and etiquette, which harkened back to the early days of legislated nursing practice, and a similar conflict over the characterization of addictions as a moral problem as opposed to an illness.

As the 1980s began, nursing registration became mandatory. Between 1980 and 1985 there was a seven-fold increase in charges related to drug and alcohol abuse handled by the Association (reflecting changing societal attitudes), and high levels of stress within the nursing profession as the health care crisis took hold.
Conflict of interest issues came to plague the Association. The BCNU gained strength with its foundation in 1981. It developed the LEAP fund in 1988 to ensure that nurses cited by the Association received legal support. This led to the increasing legalization of the disciplinary process, which also reflected trends in the wider society. Throughout this period, criticisms of the Association, especially originating from BCNU, became increasingly apparent. However, I found that there was a marked lack of response to these criticisms by the RNABC. A legitimate determination to “protect the public” and an unfortunate adversarial relationship with BCNU at this time, seems to have resulted in an apparent inattention to the legitimacy of many of the criticisms and a seeming failure to learn from past mistakes.

This apparent inaction by the Association reached a head in the 1990s with escalating costs arising from legal challenges to the disciplinary process and formal complaints against the Association by the BCNU. Allegations against the Association by lawyers who had been involved in the disciplinary process included lack of procedural fairness and the breach of the principals of natural justice (Wedge 1991b). These allegations were further supported by the judges presiding over appeals of decisions by the Association. These judges found that the rules of the Association were in breach of natural justice, thus infringing on nurses’ constitutional rights, and that administrative law procedures were being violated.

Responses by the Association frequently appeared to be cosmetic rather than directed at addressing the underlying root causes of the concerns. However, to their credit the Association did take the concerns seriously enough to orchestrate several studies to address the issues. However, in the data I was able to retrieve I observed a curious failure to implement the majority of the recommendations from these studies, and the disciplinary
process retained the underlying structure which had initially been implemented almost two decades prior. There were minor developments (such as the creation of additional categories under which nurses could be cited), and there was also (perhaps predictably) a gradual increase in related legal procedures. For example, the ability of the Association’s disciplinary panel to subpoena attendance at a hearing, demand the production of documents, search and seize evidence and make rules that governed its disciplinary process was implemented in this period.

The last formal hearing before the disciplinary committee of the Professional Conduct Review Committee was held in 1996, which thus served as a natural endpoint for the Chapter. This brought about an abrupt end to some 21 years of formal inquiry processes through the development of the “Consensual Resolution” process. The history behind the development of the Consensual Resolution process stems from ongoing exchanges between the RNABC and BCNU, as well as, input from internal and external reviews by consultants of the RNABC’s disciplinary process.

In reflection, in some ways the richness of data during the 1970s, 1980s and 1990s presented a problem for the research. The problem was that this richness encouraged a focus on the details of the disciplinary process and not the struggles between actors who were clearly and obviously involved in the process. As my final conclusions demonstrate, the encouragement to focus on the details perhaps obscured some of the more hidden dynamics and underlying forces which were potentially more important to the result than the obvious forces evidenced in the narrative.

**Synthesis and Conclusions Prelude**

The historical methodology provided valuable insights into ‘how things came to be the way that they are’. It also provided an account of the various actors who impacted the
development of the nursing disciplinary process. The historical perceptions gained provided important insights into the dynamics of the process of change and its challenges and successes. Tentative ideas were tendered regarding the interactions of wider societal forces and attempts to produce an effective, efficient, and fair disciplinary process. And more ideas can be offered on how to balance the mandate of protection of the public from unsafe nursing practice with the legal requirement to provide cited nurses with a transparent process conforming to the principles of natural justice.

In this section I will focus on a synthesis of the historical methodology and conclusions. I will first concentrate on unravelling these tentative inferences regarding the interaction of interests in the development of the nursing disciplinary process. I will then outline the characteristics which I believe are necessary for a future disciplinary process which could be successful in balancing the RNABC’s mandate to protect the public and the judicial systems requirements to ensure procedural fairness and natural justice. I will conclude by providing recommendations for a series of steps which have the potential to develop a balanced disciplinary process, taking into account the lessons I have tried to bring forward from the past. These recommendations are in keeping with the critical paradigm which informs my research and forms the portion of my research which advocates for transformation of the way that the disciplinary process is enacted.

**Historical Forces on Nursing Discipline**

Throughout the history of nursing in British Columbia, and further back into the earliest colonial period in Canada, there appeared to have been internal peer pressure within the ranks of nurses directed at conforming to acceptable standards of decorum. In my view, this is easily understandable, because society tends to function to maintain the status quo. Although there have been gradual developments towards increasing autonomy for nurses, vestiges of
the complete subservience of nurses to the doctors (which began with the Nightingale model of nursing) are still seen in the nursing profession with concept such as “the following of doctors orders”. In some ways, the earliest religious sisterhoods demonstrated higher levels of independence of practice than the trained nurses who followed them by directing their practice to the service of God and the poor without the intervention of others.

The history of nursing could be characterised as a series of attempts to create greater autonomy, and thus greater respect, for the professional status of nurses. This history occurs in tandem with trends for increasing autonomy for women and also for the recognition of the rights of workers in the wider society.

Within nursing, attempts to improve nursing autonomy have included the movement for legalized nursing, the movement for mandatory registration and continual struggles over educational standards and credentialing. The disciplinary process can also be seen within the context of struggles for autonomy and legitimacy. The carrying out of the disciplinary function by the nursing profession can be posited as an effort by the nursing Association to be seen as competent in actualising its mandate for protection of the public. Disciplining members, as has previously been mentioned in Chapter 3, is commonly regarded as one of the distinguishing features of a legitimate profession.

The need to be seen to be competent in protecting the public from incompetence could perhaps be seen as one reason for the RNABC’s focus on this public protection side of their mandate to the perhaps inadvertent exclusion of issues of fairness to nurses and legal precedents. As documented in Chapter 3, the RNABC was in receipt of a series of complaints regarding the procedural fairness of their disciplinary process. Complaints stemmed from sources including the BCNU, the legal profession, and members of the
Association who believed that they had been unfairly treated and the judiciary, who issued a series of findings against the Association with regard to the legality of their disciplinary process. These complaints occurred over a period of approximately 15 years, covering the majority of the history of the formal disciplinary process.

**The Historical Tensions between the British Columbia Nurses Union and the Registered Nurses Association of British Columbia**

Officially formed in February 1981, The British Columbia Nurses' Union (BCNU) "roots are firmly planted in the struggles of the past" (British Columbia Nurses Union, 2004, p.1). Historically, the struggle for socio-economic welfare began with the formation of The Graduate Nurses' Association of B.C. (GNABC) which was officially established in 1912. The organization immediately commenced the struggle for "quality healthcare, decent working conditions, and benefits like the eight-hour day" (p.1). When the GNABC was renamed the RNABC in 1935, the Association continued to perform both advocacy functions, focused on improving working conditions for nurses, and regulatory functions focused on ensuring that nurses were sufficiently educated to perform quality safe care to the public. When the Saskatchewan court decision came down in 1973, the RNABC was forced to create a separation between the advocacy and regulatory functions which were considered to be in conflict of interests. From 1975 to 1981, the separation of functions was internal in the RNABC. The advocacy and regulatory functions were both carried out within the same building and in many ways the separation was more cosmetic than real.

In 1981, BCNU officially took over the advocacy function from the RNABC. Thus from 1918 to 1981 the nurses association performed advocacy functions. The removal of jurisdiction over the advocacy function was imposed through the legislature and this imposition may be at
the root of the struggle between the union and the Association. The separation of functions is also challenging because there is arguably an overlap between the advocacy and the regulatory functions. This overlap stems from the fact that a nurse’s economic wellbeing is tied to his or her ability to work. This ability to work became inextricably linked to the regulation of nursing, when in 1988 registration became mandatory to practice nursing in the Province. Thus, rather than functioning as two collaborative bodies in the governance of professional nursing, the two organizations appear since the formation of the BCNU to have been acting in an antagonistic fashion focused on who had control of nurses. The imposition of “separation of functions” appears to have been interpreted by the RNABC as a loss of control over nurses, which they were reluctant to relinquish. This is understandable in the context of their long history in the advocacy role. The newly formed BCNU appear from the beginning to have been involved in a struggle to maintain control over their newly appointed advocacy mandate; to protect the social and economic wellbeing of their members. The discipline of nurses is the area of professional nursing, which most clearly intersects the advocacy and regulation mandates of the two associations. It is therefore logical that the disciplinary process became the focal point of the struggle between the two organizations. This struggle took the form of a series of complaints by the BCNU over “problems” in the Professional Conduct Inquiry Process. As my historical review has indicated, these problems were validated by a series of findings against the Association by the Supreme Court of British Columbia, which highlighted concerns regarding the administration of the nursing disciplinary process.

The RNABC and BCNU’s Roles in Disciplinary Processes

Despite these complaints, the RNABC refused to address the underlying issues of procedural fairness. Changes the RNABC did implement included beginning to provide written justifications for their decisions and reasons, as well as, creating more concrete
definitions of the charges for which nurses could be cited. In addition, there was an overall trend from suspending or terminating memberships to requiring nurses to undertake educational training directed towards the remediation of delinquent aspects of practice. These changes appear initially to be progressive moves, and in fact, the existence of written decisions and reasons has been useful to several nurses in their appeals. However, careful reading of the Decisions and Reasons reveal that, in many cases, they serve to defend the position of the Association more than to explain the reasons for the decision. For example, in the Decisions and Reasons #192316, (1980, p.1)” ...the nurse treated the consumer in a rough and rude manner”. There was no consideration that this incident took place in a male remand centre, that the nurse was the only healthcare professional on duty, and there was no discussion in regards to the “rough or rudeness”. The decision was that the nurse was unethical and no reasons were given as to substantiate the decision. Another example is drawn from case #5, (1975, p.1) “...sent patient ...to toilet and baby was delivered, in toilet”. There was no indication that the nurses had acted against hospital protocol, and there was no reason expressed by the Board of Directors to explain why this particular action was deemed unethical and incompetent. The failure to address issues of specialization, as well as the failure to address the nurses’ level of or lack of experience, also led to some decisions which either expected specialized nurses to function at a non-specialized level of practice, or demanded too much of “green” nurses. In case #705208 (1995, p.2) a newly graduated nurses was found to be incompetent, as she lacked nursing knowledge and skills below acceptable standards. One of the problems cited was in regards to the initiation of intravenous fluids. The other finding of fact was in regards to a lack of knowledge regarding a patient who was diabetic and in (acute) renal failure. As well, the patient had an AV (Arterial-Venous) fistula,
which the nurses did not know how to assess. These are competencies that are well beyond those expected of a new graduate nurse (Registered Nurses Association of British Columbia 1999h), notwithstanding the requirement for competent nursing practice. The fact that a new graduate might be put in the position of practicing in a setting requiring advanced nursing skills seems to me to be symptomatic of pressures in workload and acuity resulting from the crisis in healthcare. In this case the targeting of the new graduate nurse could be seen as scapegoating the nurse for problems which are systemic in cause. (Lamb, 2004; LeDuke, 2000; Rodney & Varcoe 2002).

Further, in my own case, the three committee members of the PCC who presided over my case did not have any experience in the field of obstetrics and were not familiar with current practices. Other cases reviewed indicated that the presiding committee members were not familiar with the skills and knowledge of a newly graduated nurse (Registered Nurses Association of British Columbia, 1979a, 1983a, 1996a). Institutional issues, such as the documented overwork of nurses and working in non-conventional settings, were not addressed in the Decisions and Reasons. In fact, detailed data which may have supported, explained or exonerated nurses’ actions, did not occur within citations, or decisions and reasons. BCNU argued in a number of cases that where a citation resulted from staffing issues within an institution, rather than sacrificing the nurse, the institution should be brought to task for the understaffing, or for placing nurses in areas outside their area of specialization. This data is particularly important, as I have emphasised and elaborated on in Chapter 5 because the context can have a significant affect on a nurse’s ability to practice.

An important issue to understand in order to move forward will be why the RNABC is/was so resistant to adopting changes which from a rational perspective seem so obvious? I
suggest that it would be interesting to look at other professional bodies to determine whether they have experienced similar growing pains. Studies conducted in the United States by (Le Duke, 2000, 2001; Johnson, 1997; Kany 2000, Lewallen & McMullun, 2001), have demonstrated that nurses are generally dissatisfied with the disciplinary process of their Associations. According to the research, nurses do not feel supported and feel that the process is unfair. By way of example, in the United States a submission by the American Nurses Association to the Subcommittee on Labor, Health and Human Services, Education and Related Agencies Committee on Appropriations submitted to the United States Senate on “patient safety and medical errors”, illuminates the point regarding “blame”:

Many health care institutions are creating an atmosphere of ‘blame’ in which individual health care providers are increasingly held accountable for adverse patient outcomes. Mistakes by health care providers are viewed as individual failings rather than as systems failures, and are dealt with in a punitive framework... The severity of discipline for practice errors has increased... The scope of responsibility, independent judgment and decision-making has been expanded, while nurses' autonomy and decision-making abilities are more constrained... Thus, nurses - concerned with changes in health care systems and the effect of those changes on their practice and their patients - have taken special note of the particular relevance that systems-based approaches to health care error have for them and for their profession (Foley, 1999, p.1).

Legal opinion supported in the U.S. by Johnson (1997) and in British Columbia by (Wedge, 1991), suggests that in both jurisdictions, a less than administratively fair process exists. In both places, the respective Association is not taking into consideration the working conditions of nurses, and the process of discipline is punitive verses rehabilitative.

The move to educational remediation for nurses facing discipline appears to be a positive move at first sight, in that it appears to support nurses to mitigate weaknesses in their
practice. However, on closer examination I found that nurses required to undergo educational remediation were generally suspended in the interim (1-3 years), required to undertake lengthy and costly courses, and were frequently expected to re-take significant proportions of their initial training rather than focussing on specific deficiencies. The result of these requirements was that many nurses required to undertake such educational remediation were unable to do so. I inferred that combining an inability to earn a living while being required to undertake further education proved impossible for many nurses for economic reasons. This conclusion is shown in the appeals to the Board of Directors for “Variations in Terms and Conditions” of suspensions. Thus, the apparently softer and supportive remediation approach in many cases was synonymous with being terminated.

The failure to address issues of disclosure (highlighted in my own case) provides another interesting example. After many years of inaction in the face of complaints regarding disclosure, the RNABC opted in 1997 to institute the Consensual Resolution Process. Again, this process may appear to provide a more enlightened process for the treatment of nurses. However, given the history of procedural change in the nursing Association and wider concerns regarding power differentials in Alternative Dispute Resolution processes (Beer, 1997), I believe this change must be viewed from a more critical standpoint. The Consensual Resolution Process represented a mechanism for suppressing the disclosure requirement required by the judge from my appeal. It also serves as a means to ensure that costly appeals, such as my own (however justified) are more difficult to achieve, and thus can be seen as a cost saving mechanism. Finally, the failure to allow for disclosure within the Consensual Resolution Process or to utilize independent mediators or other strategies designed to provide
balance in situations of unequal power between parties leaves the process open to abuse by the RNABC.

The confidential nature of an alternative dispute resolution process means that the process is not open to any sort of public scrutiny or oversight by members of the Association. While confidentiality is necessary for the mediated process and aims to protect the parties, in cases where there are concerns about fairness and power imbalances, I am worried that it could function to hamper any attempts to rectify these concerns. I note here that there is currently no evidence that I have been able to retrieve to either support or allay these concerns.

Throughout, the BCNU played an interesting role in enabling this power imbalance. Although the BCNU supports nurses cited by the RNABC by providing them with legal counsel (provided that the nurse is a Union member), the Union also has an incentive to keep costs down. Thus, nurses may be advised to cooperate with a Consensual Resolution Process (which may not be in their long-term interest) in order to save money for the Union. The use of specified lawyers by the Union, rather than allowing nurses to be free to choose their own counsel, may further exacerbate this effect.

Insight from the Historical Perspective

When examined in the context of the long-term struggle of nurses to consolidate their autonomy as a profession, the dynamics of the nursing disciplinary process highlight the roles of the various actors in supporting this autonomy or ‘keeping nurses under thumb’. Historically, nursing was under the complete control of the doctor; however, there have always been matrons, mother superiors, head nurses, nursing supervisors, and nurse managers, who have functioned as the materialistic gatekeepers to the profession. That is, they have had a critical role in deciding what constitutes acceptable nursing practice, and the consequence of unacceptable practice often based on their own empirical definitions. I
suggest that the Disciplinary Committee of the RNABC can be seen as a modern incarnation of this gatekeeping function. In this role, the disciplinary committee has served, perhaps inadvertently, to perpetuate the subservient role of the nurse.

When I began my research, I defined discipline from the dictionary definition. After completing my research, a reflection on the disciplinary process demonstrates to me that my original definition was overly constraining. An integrated understanding of discipline is more complex and must consider institutional constraints and personal and family issues pertaining to the specific situation of an individual nurse and her practice setting. A holistic understanding of discipline would also view discipline as a more encompassing and less negative process. Nurses concerned about their ability to practice safely in situations of overwork could raise these issues without fear of being seen as incompetent. They would also be able to request assistance when dealing with personal health issues or temporary failures in support networks.

While arguably nurses have achieved greater societal recognition for the work that we do, as well as respect within the healthcare team, I submit that many nurses do not receive sufficient recognition for their considerable experiences and skills. In the area of professional conduct, it is arguable that significant progress has been made since the early days of nursing in colonial Canada. While structures have been established with the appearance of providing an open and transparent process for nursing self-regulation, detailed analysis reveals a process that functions in a more arbitrary fashion, while not fully reflecting the judicial norms which have developed within the wider Canadian society. This raises questions for both professions generally and for the government as it devolves authority for discipline to members of self regulating bodies through the doctrine of curial deference.
Looking to the Future

An important question is raised by the lack of progress toward a procedurally fair disciplinary process for nurses in British Columbia; given the history of nursing discipline in British Columbia, how can change be orchestrated to facilitate the development of a process that balances the need to protect society from incompetent and unethical nurses, with the concurrent requirement to provide nurses with a fair and just disciplinary process? The solution currently being considered by the legislature is to rescind the Nurses (Registered) Act and replace it with the Health Professions Act (Registered Nurses Association of British Columbia, 2003b). This would result in the formation of a College of Nurses, which I elaborate on below. I believe this development needs to be evaluated in the light of past experiences and also in the light of those characteristics which are necessary for a disciplinary process to conform to the principles of procedural fairness and natural justice. As illuminated in the data, the importance of a fair and equitable process within the context of self-regulating professions and in the context of administrative law cannot be over emphasised (Bay, 1998; "R. v. Stinchcombe 68 C.C.C. (3rd)," 1991). The characteristics of fair and equitable processes are defined in administrative law, and, in addition a number of specific recommendations were suggested by Wedge and others to ensure an equitable process which would conform to the principles of procedural fairness and natural justice. I outline the characteristics I believe are important below:

- Members should be notified within a reasonable time frame of the alleged incident.
- All complaints should be received by the Association/Registrar of the College in writing.
- The member should receive a copy of the letter of complaint, within a specified timeframe.  

- Members should be afforded their basic right to know and answer the opposing case (Wedge, 1991b, p.4).  

- The Association/College should only handle complaints that are within its legislative authority.  

- The investigation process can not be used as a ‘fishing expedition’.  

- Full disclosure of all documents within the care, control and custody of the Association/College should be disclosed to the member within a specified time period.  

- Careful separation of advocacy and regulatory functions must be achieved to ensure impartial decision making.  

Reflecting on my own analysis it is my perspective that perhaps more important than understanding what must be included in an improved disciplinary process is the need to understand the obstacles to progress. Throughout Chapter 3, it was evident that the BCNU,  

145 Disposition should be measured in weeks not months (Wedge, 1991b, p.4).  

146 Wedge states that: In regards to unethical conduct- conduct contrary to the ethical standards of the profession should be removed. It is far too broad, vague and uncertain to found serious charges and penalties. In keeping with the serious nature and consequences of the proceedings grounds should be spelled out in the legislation, for example, criminal conduct (stealing drugs) or breaching patient confidentiality. Secondly, “misrepresentation” should be removed from what is presently (1991) section 26.2(a) (iv) of the Act. Serious misconduct, “fraud” is the issue. ... Another concern is the broad scope of Section 26 of the Act, and in particular 26 (2) (ii)... “Conduct contrary to the ethical standards of the profession of nursing”. .... Nurses have the right to know the precise ethical standard by which they are being judged and it is incumbent on the RNABC to advise nurses clearly of the expected standards of ethical conduct (Wedge, 1991b, p.4-5).  

147 The letter to the member does not distinguish between the conduct which is actually the subject of the complaint and the conduct in which was the subject of the investigator's personal concerns (Wedge, 1991b, p.5).  

148 “... these notes are not given to the nurse to confirm as to the correctness of the [investigators] statements” (Wedge, 1991b, p.6). “The Act should be amended to provide full disclosure of the complaint” “A copy of the written complaint, the identity of the complainant and a copy of the investigators report prior to requiring a response from the nurse” (Wedge, 1991b, p.9).
lawyers and courts blamed the RNABC for the disciplinary problems and advocated strongly for the RNABC to implement changes in their disciplinary process. At the same time, the RNABC acted and failed to act in a way that blocked meaningful change. The reasons for this failure to change were not evident in the data. An understanding of these reasons is critical in understanding how to move forward from the present juncture. Suggestions for research to assess this omission will be addressed in the section on future research.

The Future of the College of Nurses under the Health Professions Act

The process which is proposed by the provincial government for streamlining health professions disciplines in British Columbia, including Registered Nurses, involves establishing a College for each regulated profession under the Health Professions Act (HPA). The Health Professions Council (HPC), appointed by the Government of British Columbia under the Health Professions Act, R.S.B.C. 1996, c.183, was asked to provide advice and recommendations to the Minister of Health Planning regarding the regulation of health professions. The HPC voiced concerns specific to the Investigation and Inquiry process of the RNABC in its recommendations. I have summarized the HPC's concerns below, because they have the potential to shed some light, and/or add alternative opinions on the process, as well as, provide insight on future development. The process for the review commenced on April 24, 1995, when the Council Chair of the HPA met with representatives of the RNABC. A summary of the concerns and opinions of the parties have been excerpted from the final report dated October 5, 2001.

The Council has some concern about the fact that the Nurses (Registered) Act (NRA) does not clearly provide for a separation between the regulatory and professional functions of the nursing profession, and it requested that the RNABC address this issue in its submissions (Seaton et al., 1999).
lawyers and courts blamed the RNABC for the disciplinary problems and advocated strongly for the RNABC to implement changes in their disciplinary process. At the same time, the RNABC acted and failed to act in a way that blocked meaningful change. The reasons for this failure to change were not evident in the data. An understanding of these reasons is critical in understanding how to move forward from the present juncture. Suggestions for research to assess this omission will be addressed in the section on future research.

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The Council has some concern about the fact that the Nurses (Registered) Act (NRA) does not clearly provide for a separation between the regulatory and professional functions of the nursing profession, and it requested that the RNABC address this issue in its submissions (Seaton et al., 1999).
It was the Council’s view that there are several points upon which the current complaints and discipline process is not consistent with the core principles of professionals. In the Seaton report (1999) commissioned by the Provincial government to assess the functioning of the health professions, concerns were expressed by the Health Professions Council and BCNU that the disciplinary process which was being used was not in accordance with the principles of fairness and natural justice enshrined in self-regulating professions. There were also concerns about bias, independent decision-making and a clear separation between investigation and adjudication. Other concerns deal with the process of disclosure and privacy issues. At the completion of the submissions:

The Health Professions Council recommends to the Minister of Health and Minister Responsible for Seniors that the Nurses [Registered] Act be repealed and the profession of registered nursing be designated under the Health Professions Act (Seaton, 1999).

What this means for registered nursing in B.C. is that nurses would no longer have their own Act. The practice of nursing would be regulated under the Health Professions Act and all aspects of the administration of a self-regulated profession would now be under the legislative framework of HPA. What this specifically means for nurses is B.C. remains to be seen. As I understand the Act, an 18-month transition period will commence in October, 2003. This transition period is aimed at forming a BOD and committees, and rewriting rules and regulations for nurses which will conform to the HPA. The HPA has a disciplinary process in place, and members of the RNABC/College of Nurses, who had a complaints filed against them would follow the procedures set out in the HPA. Under the Health Professions Act a structure exists which is substantially identical to the RNABC disciplinary process.
The determining factors regarding the mandate for procedural fairness will depend upon the bylaws/rules created by the College of Nurses under the Act. The College of Midwives, for example, has a bylaw, which includes a provision for mediation. In cases where mediation is deemed appropriate and agreed upon by the member and the complainant under s.64 (2), "Following a recommendation under subsection (1), the inquiry committee shall appoint a mediator who is acceptable to the complainant and the registrant" ("Health Professions Act, SBC c.50 and The Midwives Regulations, B.C. Reg. 103/95,"). The only other difference noted between the RNABC rules and the College of Midwives bylaws is the inclusion of a member of the public on the three-person inquiry committee, rather than requiring all panel members to be members of the profession ("Health Professions Act, S.B.C. c.50 and The Midwives Regulations, B.C. Reg. 103/95,").

From this, it can be suggested that there is nothing within the structure of the disciplinary processes of the Health Professions Council, with the possible exception of the Mediation clause of the Midwives Act and the inclusion of a member of the public on the inquiry committee, which will ensure improved procedural fairness. This is despite that fact that the Seaton report emphasised concerns regarding procedural fairness in the RNABC disciplinary process and the HPC was supposed to address these concerns by structuring the Health Professions Act.

In addition, the people most likely to be considered qualified to sit on the Board of the College of Nurses and the Inquiry Committee are those who have some experience in this area. Therefore, there seems to be a considerable risk that the suggested solution to the problems of lack of procedural fairness in the RNABC disciplinary process will not be addressed by the proposed changes. Rather the old problems are likely to reappear within the
new structure, which will differ only in name. The overall result may be a further delay in addressing the underlying issues, rather than using this opportunity to expedite effective change. A factor which may mitigate this risk is that the Health Professions Council has acknowledged in writing that the RNABC process is procedurally unfair. This acknowledgement, combined with the supervisory role HPC must play to the new College of Nurses may function to limit the reappearance of past concerns. In the meanwhile the reality that we will be left with is that nursing status as a self regulating profession will pass through a period of flux. This flux echoes the ongoing power dynamics over healthcare and nursing autonomy that have been seen in past struggles. Because of the complex dynamics it is possible that the new disciplinary process under the HPA will fail to demonstrate the expected progress in terms of fairness. The outcome is unclear and will be determined by the evolution of political struggles in the future and thus it is imperative that nurses pay attention to the evolving dynamics as they occur.

- The British Columbia Nurses Union should continue to be mandated to “promote the economic welfare” of nurses in the Province. This would include such activities as contract negotiations, workplace representation and the legal support of nurses undergoing disciplinary action.

- The Registered Nurses Association, which after having its Act repealed, will adopt a position of advocacy and education for nurses and that membership of the Association will become voluntary.

- The new College of Nurses will be an administrative organization whose mandate will be regulation of the Profession of Registered Nurses and will include the mandate to protect the public from unsafe nursing practice and thus the disciplinary role.
A Preferred Future

Based on my historical analysis of the nursing disciplinary process in B.C., I have created the following recommendations in consideration of the three organizations coming into existence. The recommendations are based on the aforementioned roles and structures, which were suggested for the three associations/organizations by the RNABC (Registered Nurses Association of British Columbia, 2003b). The new College will be in a position to write rules for the administration of Registered Nursing under the Health Professions Act.

The historical inquiry which I have undertaken has illuminated the lack of general lack of knowledge and understanding of the professional disciplinary process by registered, graduate and student nurses in British Columbia. Thus, I recommend that:

1. The Association (or future College) needs to produce a handbook for nurses to identify issues of professional conduct. Definitions of terms, and commonly used language, procedures, rules and regulations, as well as resources available should be included in the guide, which should be provided free of charge to all practicing nurses and updated annually.

   The data I have retrieved reveals that despite requests for information (disclosure) not all documents are generally provided to nurses or their representing council and I recommend that:

2. Nurses who are cited for professional misconduct must be provided with the letter of complaint and all documentary evidence, in whatever form, which is or has been in the care control and custody of the College of Nurses or its legal council (Previously this function was under the auspices of the RNABC).
The data revealed in Chapter 4 indicates that currently only one law firm is retained by BCNU on behalf of nurses to address professional conduct inquiry related matters. It seems therefore that:

3. **BCNU needs to reassess the LEAP program, and make independent legal counsel available to nurses by providing a list of BCNU-approved counsels.**

Chapter 4 addresses some of the issues regarding professional practice insurance and discusses some of the issues which may develop in regards to insurance coverage with the inclusion of Advanced Practice Nursing, reserved acts, and a shift in organizational structure. There is also a suggestion from the proposed legislation for Advanced Practice Nursing that increased responsibilities maybe transferred to nursing including such tasks as prescribing medications, ordering laboratory tests and managing deliveries, which I suspect will carry added responsibilities and may make nurses more vulnerable to malpractice claims. This leads me to believe that:

4. **The LEAP program may not be sufficiently able to handle this, due to financial limitations, and nurses may have to be prepared to purchase independent insurance coverage as a top-up. This issue should be addressed in the handbook described in recommendation number one.**

And

5. **The Association should consider top-up insurance being available to nurses working in high litigation areas, such as obstetrics, neurology and Advanced Practicing nursing.**

Through my inquiry it has been evident to me that nurses cited by the Association are not actively involved in their own hearings. As well, in my historical review I have not seen any
situations where nurses were advocates for nurses cited, which, to me, seems counter to the self-regulatory and self-advocacy role of the profession. Therefore I recommend that:

6. The RNABC, in collaboration with BCNU, should develop an advocacy program (either voluntarily or pay for service) to assist nurses who are under review by the College. One suggestion is that this should be based on peer support from other nurses.

Historically, nurses have been asked to provide RNABC with statements concerning actions which are being investigated. This process would be reasonable, if nurses were aware of their legal rights to refuse to comply with the Associations requests until such time as they had been advised by legal counsel or if nurses were able to access trained advocate, early in the investigatory process. Because of this, I suggest that:

7. Initial communication with the disciplinary body should not take place until an advocate for the nurse is in place.

Due to the increasing costs of disciplinary hearings which were discussed in Chapter 5, as well as concerns regarding the potential loss of self-regulatory status by individual nurses, as well as the Associations/Colleges. I suggest that advocacy programs would strengthen nursing self-regulation for nurses by nurses without putting individual nurses at risk and create a process fair to nurses while still enabling the Association/College to be seen to be protecting the public. I suggest that:

8. A program of professional review, such as the Consensual Resolution Process should take place prior to a formal hearing. At this point in the process, legal counsel should not be involved and there should be no record of this process in cases where a resolution is achieved. If the matter is not resolved in this informal process, evidence discovered during the process should not be admissible before the hearing board. This
process would be similar to non-admissible evidence in a settlement conference or in family matters before a family court counsellor.

Currently in B.C. nurses are not able to readily access practice advice. Nurse practice advisors are only available Monday to Friday, 9 a.m. to 5 p.m. As my research has suggested, nurses generally do not have a sound knowledge of the legal system, their rights and obligations. Based on what I have observed in the past, I anticipate that nurses in future will often require consultation. Therefore it is my suggestion that:

9. The Association needs a 24-hour, 7-day per week toll-free number, staffed by nurses who can advise nurses who encounter professional practice concerns. This could be achieved logistically by including information of nursing discipline in the manual used by nurses staffing the Tele-health phone line.

Many professional disciplinary inquiries that were reviewed revolved around ethical issues, professional practice concerns and legal issues. There is also evidence a lack of ability among nurses to apply nursing codes of ethics and standards to their practice. Therefore, I recommend that:

10. All education institutions must develop a mandatory course in the area of professional practice, ethics, regulations and legal issues, or strengthen existing programs in these areas.

From my data I have learned that a greater percentage of nurses cited by the professional disciplinary issues were not trained in Canada, illuminating a potential area of focus for education. From this, it is my suggestion that:

11. All foreign-trained nurses must be provided with the opportunity to take a course, to ensure that they are on an even footing with Canadian trained nurses in
terms of training in issues of ethics and professional practice. This course should the

course content I have flagged in recommendation ten.

Currently the practice of the RNABC is to publish the name of a member who has been
found guilty of professional misconduct, and has had his/her membership stricken from the
Association. In the Consensual Resolution (established in 1997) and the established formal
Inquiry process, (which took place from 1975-1996, and is still available to day) as soon as a
decision has been rendered the nurse’s name is made public regardless of to whether an
appeal is commenced. I have illuminated in my research that there is a need to balance the
right of the nurses with the mandate of the Association to protect the public, thus I suggest
that:

13. Nurses who are found guilty of misconduct should not have their names be made
public until all appeal avenues have been exhausted.149

And

14. Nurses who are guilty of misconduct due to alcohol abuse, drug addiction and
mental illness, should not have their names made public, unless a hearing in the
Supreme Court of British Columbia has been held, and the member has been
determined fit to deal with the allegations alleged.

During my research it became evident that many nurses were charged with actions that
were several years old. The difficulty that this presents is multi-fold. The nurse may not
remember the incident, witness may not be available, and documentation may be difficult to
retrieve. Also, there as evidence of actions which took place years prior (which were not

149 In my case my name was published in several local newspapers, on the television news, and letters were
sent to educational institutes that I had attended, as well as notification in the BC Gazette. The problem was
that after my successful appeal, in the Supreme Court of British Columbia, the RNABC did not place a
retraction in the papers.
brought to the nurses' attention at the time) being entered in evidence in an attempt by the Association to show a pattern of carelessness. Further, it is important to facilitate an expedient process to bring resolution to the disciplinary matters. The emotional stress and financial consequences for all parties is significant and an expedient and fair process is necessary to resolve matters related to professional conduct. I therefore recommend that:

15. Nurses must be notified in writing immediately of a complaint being lodged. If the complaint is found to be substantiated, the matter must be commenced within 60 days or as soon as the investigation process is complete.

And

16. Guidance needs to be sought in regards to establishing time frames or Statutes of Limitations for the Nursing Disciplinary Inquiry Process.

These recommendations above have stemmed from the data which I have analysed in my thesis, as well as the case law which I have reviewed, my personal experience with the Professional Conduct Inquiry Committee of the RNABC, the Board of Directors and the Supreme Court of British Columbia.

Future Disciplinary Inquiry

As I indicated at the outset of this chapter, during my research, I also identified a number of areas where further research would be helpful to illuminate aspects of the nursing disciplinary process. The failure of the RNABC to address institutional issues in many cases

150 This time line has been used as suggested by the report entitled Legal Aid Ontario- Quality Assurance Programs “Better Quality Practices- Outline of Complaints Guidelines and Procedures, dated November 27, 2001. (Wigginsworth v. Her Majesty the Queen) Available at www.walnet.org/csis/reports/junger_inquiry/chapter_8.html (p.6).

151 Limitation Act, RSBC 1996. Chapter 266. This Act currently addresses the issue of medical malpractice. Section 8 (b) reads against a medical practitioner, based on professional negligence or malpractice, after the expiration of 6 years from the date on which the right to do so arose, or ....". This does not however address a statute of limitation regarding professional misconduct.
of nursing discipline suggests that there may be pressures being placed on nurses to discipline individual nurses rather than risk liabilities for the health care institutions. My own case provides some indications of this issue. For instance in my case a release of liability for the hospital was signed by the patient (one of the complainant’s in my case), and a risk analysis was carried out by the hospital involved. These could be seen as elements of a strategy of “scapegoating”, to which the RNABC was party (see Appendix I). Another example of this dynamic of “scapegoating” is the case of Susan Nelles which was discussed in Chapter 4. If it is true that individual nurses are disciplined to address institutional issues, it will be critical that the BCNU and the RNABC and/or the College of Nurses are able to open up a dialogue regarding staffing issues (which falls under the mandate of BCNU) education (which falls under the mandate of the Professional body), and resource issues (which must be negotiated with the employing institutions). This will prevent the dynamic of infighting among nursing bodies which currently impedes progress. If the two associations were able work more proactively together they would be able to strengthen nursing as a healthy self-regulating profession within a turbulent healthcare environment.

In many of the cases that I reviewed nurses had apparently been asked to function outside their area of preparation. Research which analyses the pressures on nurses to work outside their areas of expertise, beyond their physical capacities for patient care, and/or without adequate resources to monitor their patients’ conditions, must be integrated with analysis of the discipline of individual nurses. This research will present a number of difficult ethical and logistical issues for the investigators; however, it is only through such integrative research that true solutions may be tendered for the disciplinary process. These solutions could then be built upon the comprehension the complex dynamic of forces at work in nurses’
organizational contexts. At the same time, this integrative research will function to determine accountability.

If there are pressures exerted on the RNABC to pursue individual nurses for institutional problems, this does not excuse the Association's actions. BCNU needs to provide better advocacy for nurses in ensuring adequate staffing levels, their focus on condemning the RNABC could be seen as a way of avoiding their own responsibility in cases. In the United States, information on staffing levels is beginning to be included in disciplinary hearings (Green et al. 1995; Le Duke, 2001; Lewallen & McMullan, 2001). The failure of BCNU to adequately support nurses cited by the Association further acts to enable the injustice. Finally, individual nurses also have a responsibility in this situation. We have the responsibility to educate ourselves and our peers regarding discipline and its interactions with issues of stress, ethics, staffing levels, and professional recognition.

If all of the actors in the process begin to collaborate and take responsibility for their respective roles in the problem, there is a possibility that the future will hold a disciplinary process which helps the Province of British Columbia to sanction nurses appropriately and rehabilitate nurses in an effective manner. Such a process could provide a model for nursing discipline elsewhere in Canada and abroad.
Appendix 1

In February 1996, I was found guilty by the RNABC's Professional Conduct Committee of incompetence, breach of "all the standards of practice in the Province of British Columbia" ("Milner v. Registered Nurses Association of British Columbia Vancouver (unreported) Registered Nurses Association, dated February 14, 1996,") conduct contrary to the ethical standards of nursing, and a breach of the Nurses (Registered) Act, R.S.B.C. 1996 c. 302. I appealed the decision to the Board of Directors (BOD) of the RNABC, who upheld the Committee's decision in August of 1997.

On February 19, 1996, following a lengthy disciplinary hearing, the Professional Conduct Committee of the Registered Nurses Association of British Columbia ("RNABC") found the appellant, Cynthia Milner ("the Member") guilty of incompetence and having acted contrary to the ethical standards of the nursing profession and in breach of the Registered Nurses Act ("the Act"). On December 23, 1996, following a sentencing hearing, the Professional Conduct Committee terminated her membership in the RNABC. The decisions were the subject of an appeal heard by the Board of Directors of the RNABC. By way of decision dated August 28, 1997, the Board of Directors upheld the findings of the Professional Conduct Committee. This proceeding is a judicial review of those decisions brought pursuant to s. 45 of the Act ("Milner v. Registered Nurses Association of British Columbia Vancouver, A972468 (unreported), Vancouver, B.C., December 9," 199, p.1).

On September 18, 1997, I appealed to the Supreme Court of British Columbia and on December 9th 1999, The Honourable Madam Justice Boyd reversed the findings of the RNABC and stated the RNABC could retry the matter ("Milner v. Registered Nurses' Association of British Columbia Vancouver, A972468 (unreported), Vancouver, B.C., December 9, 1999,").

Madam Justice Boyd's decision was largely based on the fact that information potentially
important to my case that was in the possession of the RNABC and/or its legal counsel was either not disclosed, or were not disclosed in a timely fashion. This prevented me from being able to make "full answer and defence" of my case.

In the final result, I am satisfied the Member has established there is a reasonable possibility that had the information noted been disclosed either at all or in a more timely fashion, her counsel could have pursued lines of inquiry with witnesses or opportunities to garner additional evidence and that those efforts may have produced a different result. To this degree, I am satisfied the Member is at least entitled to an order for the lesser remedy - that is a new hearing ("Milner v. Registered Nurses' Association of British Columbia Vancouver, A972468 (unreported), Vancouver, B.C., December 9, 1999," para 11).

The most significant finding from my case for nurses both in the province and throughout Canada (as well as for all other self-regulated professions) was that a legal precedent had been set. The failure to disclose evidence in the proceedings resulted in a breach of natural justice, as the disclosure of documents did not allow my counsel to adequately prepare for the hearing, plan a defence and to call or cross-examine witnesses, to defend the Citation.

In the end result, however, there are various matters which do squarely raise the issue of whether the late disclosure or non-disclosure of various documents have prejudiced the Member’s ability to make full answer and defence...

---

1 Examples of documents which were not disclosed (an estimated 500) and were only obtained through a request under the Freedom of Information and Protection of Privacy Act included:

1. All of the investigator’s notes which included considerable amounts of exculpatory evidence.
2. A letter from the admitting emergency room nurse, which confirmed my version of the facts at patient admission.
3. The nurse’s notes from the case room, which confirmed a fetal heart rate on admission.
4. The release of liability signed by the patient and a risk analysis commissioned by the hospital which showed a strategic approach to the management of my case by the hospital. The release of liability, signed while the patient was under the influence of sedatives, stated that if the patient released the hospital of all liability, the hospital would agree to pursue me. A complaint was then written by the hospital to the RNABC.
5. Correspondence between the hospital and the RNABC and counsel for the RNABC and the doctors involved in the case, indicating collaboration.
However, cumulatively, I believe the late disclosure or non-disclosure of these items has indeed had a significant effect on the overall conduct of the Member's defence to the Citation... ("Milner v. Registered Nurses' Association of British Columbia Vancouver, A972468 (unreported), Vancouver, B.C., December 9, 1999," p.99)

Disclosure is a matter dealt with by section [s.] 7 of the Canadian Charter of Rights and Freedoms, the section which concerns Life, Liberty and Security of the person. The precedent stated that in cases where the right to practice a profession and earn a livelihood is at stake, disclosure of evidence must be to the same legal standard as that used in criminal proceedings. In February 2000, the RNABC informed me by way of a letter that they were not going to retry my case and the matter was closed, costs were awarded in my favour, and my application for re-registration was processed.
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<td>Arrival of nursing in Canada- Jesuit missionaries</td>
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<td></td>
<td>1738</td>
<td>Early Nursing sisters arriving from Europe-first Canadian order of nurses founded</td>
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<td></td>
<td>1874</td>
<td>First training school- Mack Training School-St.Catherine’s Ontario</td>
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<td></td>
<td>1886</td>
<td>First hospital establish in BC</td>
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<td></td>
<td>1889</td>
<td>Royal hospital (now Royal Jubilee Hospital, Victoria) graduated first class of nurses</td>
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<td>Late 1880s</td>
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<td>Movement towards formal organization of nurses</td>
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<td></td>
<td>1912</td>
<td>GNABC established</td>
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<td></td>
<td>1918</td>
<td>First Nurses Act legislated</td>
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<td></td>
<td>1935</td>
<td>GNABC becomes RNABC</td>
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<td></td>
<td>Late 1940s</td>
<td>Codes of Ethics officially adopted</td>
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<td></td>
<td>1966</td>
<td><em>Medical Care Act</em> established</td>
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Appendix III

Professions

Proposed and recently approved amendments to bylaws, rules and regulations for each of the regulated health professions can be viewed by clicking on the profession in the table below. Notice of these amendments to all professional regulatory bodies is required by statute and by ministry policy (available at [http://www.healthplanning.gov.bc.ca/leg/](http://www.healthplanning.gov.bc.ca/leg/) accessed January 10, 2004).

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<td>Emergency Medical Assisting</td>
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<td>Hearing Aid Dispensing</td>
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<td>Licensed Practical Nursing</td>
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<td>February 05, 2002</td>
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<td>Traditional Chinese Medicine and Acupuncture</td>
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Last Revised: January 08, 2004
RNABC PROFESSIONAL CONDUCT REVIEW PROCESS
Appendix IV
Appendix V

Helpful References for hisorical work, and professional disciplinary issues:


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Helpful References for historical work, and professional disciplinary issues:


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