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

AND IN THE MATTER OF: **A hearing into the conduct of Shahid Shams, CRNM #138111**

DECISION

College of Registered Nurses of Manitoba

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Important note regarding redactions in this document:

In compliance with Council Policy GP-11, the College of Registered Nurses of Manitoba redacted the names of individuals not directly involved in the hearing and to protect the identity of the firm and the health region involved and the five community agencies that provided letters of support.

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DECISION

Discipline Panel Members:	Michele Groff, Panel Chair Jennifer Berscheid, Panel Member Michelle Prange, Panel Member Joanna Knowlton, Panel Member
Counsel to the Investigation Committee:	William G. Haight Duboff Edwards Haight & Schachter
Counsel to Shahid Shams:	Bill Gange Gange Collins
Counsel to the Panel:	Gordon A. McKinnon Thompson Dorfman Sweatman LLP

Introduction

1. On June 8, 2020, a panel of the Discipline Committee (the "Panel") of the College of Registered Nurses of Manitoba ("the College") held a hearing into the charges against Shahid Shams (the "Member"), a member of the College.
2. At the commencement of the hearing, it was agreed that the Notice of Hearing had been properly served and the time limits set forth in paragraph 34 of the Act had been met.
3. No objections were raised as to the composition of the Panel and the Panel proceeded to hear the matter.The
4. Member appeared at the hearing with legal counsel and pled guilty to professional misconduct. The charges related to displaying a lack of knowledge or a lack of skill or judgment in the practice of nursing were stayed.
5. The Panel then heard submissions from counsel for the College, as well as counsel for the Member, respecting the background facts giving rise to the matters raised in the Notice of Hearing and the appropriate disposition of the matter.
6. After hearing submissions of counsel, the Panel adjourned to consider the matter.

Facts

The following facts are not in dispute:

1. The Member graduated in about 2000 with a Bachelor of Nursing and subsequently obtained a Master of Nursing.
2. The Member has been a registered nurse since 2000 and an RN/Nurse Practitioner since about 2007, practicing in various clinical settings.
3. A firm called [redacted] was contracted by the [redacted] a health region to provide community health services supporting clients to live in the community. The Member provided services for [redacted] the firm by performing house calls for some clients under the care of [redacted] the health region
4. In late 2017 and early 2018, the Member, at the request of [redacted] the firm created and signed at least 25 letters utilizing his RN/Nurse Practitioner designation to provide a professional nursing opinion regarding the care needs of 25 clients under [redacted] the health region
5. Twenty-five letters were identical.
6. The letters opined on the care needs of the 25 individuals indicating:
    a) their care needs had changed,
    b) they now required 24/7 supervision and care,
    c) their current living arrangements were not safe, and
    d) they required alternative accommodations.
7. The Member reported to the College's Investigator that [redacted] the firm had represented to the Member that the letters were required because:

a) the individuals were responsible for the leases of the apartments in which they lived,

b) due to budget cuts, the [redacted] health region intended to move the individuals to a different care provider and different premises, and

c) the letters would allow the individuals to terminate their leases without penalty.

8. The Member accepted these alleged representations without further investigation. He did not ask to see the leases to corroborate the information given to him by [redacted] the firm. Many of these representations turned out to be incorrect.

9. The Member was not the treating Nurse Practitioner for the individuals in question.

10. The only information the Member reviewed relating to the individuals was a paper file provided to him by [redacted] the firm which contained nothing more than the individuals' diagnosis. He also relied on what [redacted] the firm told him about the client's needs. He did not physically meet with these individuals nor did he conduct nursing assessments.

11. The Member provided the letters to [redacted] the firm. He did not provide the letters to the individuals or their representatives.

12. The Member was paid by [redacted] the firm for the time he spent on site, travel time and the time to write the letters. The payment was for 10 hours at $67.50 per hour.

Disposition

1. The Panel is satisfied that the facts submitted constitute professional misconduct, as alleged in the Notice of Hearing and, accordingly, the Member is guilty of professional misconduct, as charged.

2. After considering the submissions of counsel with respect to discipline, the Panel makes the following Order:

    1. The Member's registration be suspended for one month commencing July 1, 2020 and concluding on July 31, 2020, and

    2. The Member shall pay costs to the College in the amount of $5,000 on or before August 31, 2020.

Reasons

The Panel considers the foregoing disposition to be appropriate for the following reasons:

1. The fundamental purpose of sentencing for professional misconduct is to ensure the public is protected from acts of professional misconduct.

2. The Member acknowledges the College's mandate to protect the public.

3. The Member has filed strong letters of support from five community agencies who identify an adverse impact to their clients if the Member was unable to provide service for a lengthy period of time. These community agencies include:

a) [redacted],

b) [redacted],

c) [redacted],

d) [redacted], and

e) [redacted].

4. The Member submits that given the strong support described in paragraph 3 above, the public is best protected by allowing the Member to continue to serve his clients without interruption.

5. Counsel for the Investigation Committee submits that the five agencies noted in paragraph 3 are not the public as a whole. He submits that it is the interests of the public as a whole that must be protected.

6. The Panel has concluded that its obligation is to protect the public as a whole. The public as a whole must have confidence that the nursing profession will maintain its obligation to them through its Standards of Practice and Code of Ethics.

7. The Panel has concluded that by providing one standardized nursing opinion for 25 individuals with whom he had no therapeutic nursing relationship, the Member:

   – demonstrated a lack of critical inquiry in planning for the needs of the individuals,
   – failed to follow one of the basic tenants of the nursing process by not conducting individualized assessments,
   – failed to investigate the impact of the letters on the individuals in question,
   – relied upon minimal clinical information,
   – involved himself in financial matters that were outside the scope of his professional knowledge and training,
   – accepted unreliable information without proper inquiry, and
   – failed to identify that he was not the nurse practitioner for the individuals in question.

8. The Panel has further concluded that the matters noted in the previous paragraph demonstrate that the Member has failed to act with honesty and integrity.

9. The Panel has concluded that the Member failed to meet the following Standards of Practice:

   a) Standard I, indicator 5

   b) Standard II, indicator 8

   c) Standard IV, indicators 23 and 26

10. The Panel has also concluded that the Member failed to meet his obligations under Value G, Responsibility 2 of the Canadian Nursing Association Code of Ethics.

11. The Member works in situations where he is often the sole practitioner available, frequently servicing a vulnerable population. As per the expectations for all members, it is essential that the Member consistently adhere to the Standards of Practice and meet his ethical obligations.

12. The Member has a prior conviction which was presented to the Panel and filed as Exhibit 5. The prior conviction involved the Member billing and documenting under a physician's name for services that the Member had actually performed in his role as a Nurse Practitioner. The Member had represented that the work had been done by a physician when he knew that was not true. The mitigating factor in that situation was the fact that the Member was under the direction of the physician who told him this practice was acceptable. However, it was clearly an issue involving the Member's integrity.

13. The Member relies upon the following statement in the Notice of Decision and Reasons of the Complaints Investigation Committee[1]:

> "The committee considered a censure as a way to resolve the matter, however upon review of the member's discipline history, the committee learned that the member had a previous finding of professional misconduct for similar conduct."

14. The Member relies upon this statement as support for his submission that a reprimand and a fine would be an appropriate resolution of this matter.

15. Counsel for the Investigation Committee points to the following paragraph in the Notice of Decision and Reasons of the Complaints Investigation Committee which states:

> "The committee cannot understand how a RN(NP), running a private healthcare business, who has already been disciplined for similar conduct, continues to display a lack of judgment, insight and integrity for repeated conduct less than two years after a finding of professional misconduct knowing that he was reprimanded, charged with costs and a fine and completed coursework on ethics."

16. The Panel is not bound by either of these comments

17. The Panel is satisfied that the conduct of the Member in the current case is similar to the previous conviction in that it involves a lack of integrity and a breach of ethical standards and the standards of practice on the part of the Member. In both situations the Member was asked to do something and he complied. He failed to consider his ethical obligations and professional standards of practice. The panel is of the view that the current matter is more serious than the prior matter because it also involves issues of inadequate professional practice.

18. In the circumstances, and following the principles of progressive discipline, the penalty should be at the higher end of the range.

19. After considering the case authorities provided by counsel and the submissions of both parties, the panel concludes that a suspension of one month is warranted in the circumstances of this case.

20. Given the member's cooperation in the investigation, costs will be limited to $5000. DATED at Winnipeg, Manitoba, the 16th day of June 2020.

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[1] Under the Regulated Health Professions Act, which came into force effective May 31, 2018, the Investigation Committee became the Complaints Investigation Committee. This change is of no consequence to the issues in this case and the names are be used interchangeably in this decision.