Edited to remove identifying third party information

ALBERTA COLLEGE OF PHARMACISTS

IN THE MATTER OF
THE HEALTH PROFESSIONS ACT

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF

CURTIS CROUGH
Registration number 3412

DECISION OF THE HEARING TRIBUNAL

October 11, 2016

I. INTRODUCTION

The Hearing Tribunal held a hearing into the conduct of Curtis Crough. In attendance on behalf of the Hearing Tribunal were Kevin Kowalchuk, Chairperson and Pharmacist, Rakhee Patel, Pharmacist, Carin Jensen, Pharmacist, Peter Kawalilak Public Member.

The hearing took place on August 23, 2016 at the offices of the Alberta College of Pharmacists. The hearing was held under the terms of Part 4 of the *Health Professions Act*.

In attendance at the hearing were James Krempien, Complaints Director for the College and David Jardine, legal counsel for the Complaints Director and Gregory Sim, legal counsel for the Hearing Tribunal. Mr. Crough also attended in person but did not have legal counsel present. Mr. Crough confirmed that he was aware of his right to legal representation and that he intended to represent himself.

There were no objections to the composition of the Hearing Tribunal, the timeliness of service of the Notice of Hearing or any other objections to the jurisdiction of the Hearing Tribunal to proceed with a hearing.

II. ALLEGATIONS

The Allegations, which appeared in the Notice of Hearing, are as follows:

1. You admitted to injecting multiple patients over the past number of unspecified years since 2007, while at the same time not having the required authorization, training, and at time, the CPR/First Aid certification required to do so as a licensed pharmacist.

2. The Alberta College of Pharmacists' registration records for you demonstrate that you have never applied for, nor received, authorization to administer medication by injection.

3. The requirement to only inject after being granted authorization by the Alberta College of Pharmacists, and the need to be in full compliance with the regulatory framework, has been communicated and re-communicated to pharmacists on a regular and frequent basis and you have admitted that you were aware of these requirements.

4. You had a positive, regulatory obligation to the Alberta College of Pharmacists to ensure that you obtained and maintained the required authorization prior to injecting any patient, and you failed to do so.

5. You had an ethical obligation to your patients and the public to obtain and maintain the required authorization prior to injecting any patient, and you failed to do so.

6. You had an obligation to create and maintain the applicable administration records pertaining to your patient injections, and you failed to do so.

7. You practiced outside your authorized scope of practice and failed to create or maintain the required records of care and by doing so you have called into question the trust placed in you as a member of a self-regulating profession.

Based on these facts, it is alleged that your conduct in these matters:

a. undermined the integrity of the profession;

b. was contrary to accepted pharmacist practice and ethical standards;

c. placed your patients at risk; and

d. showed a serious disregard of your duties as a pharmacist to your patients, the Alberta College of Pharmacists and to the public which relies upon the integrity and competence of pharmacists as members of a self-regulating profession.

IT IS ALLEGED THAT your conduct constitutes a breach of the following statutes, regulations, and standards governing the practice of pharmacy:

- Standards 1, 16, 17, 18, and Appendix A, including subsections 1.1, 1.2, 1.7(b), 1.7(d)(i), and 2.1(e) of the Standards of Practice for Pharmacists and Pharmacy Technicians;

- Principles 1 (1, 7), 5(6) and 10(1, 2) of the ACP Code of Ethics Bylaw;

- Subsections 16(5) (a and b) of the Pharmacists and Pharmacy Technicians Profession Regulation; and

- Sections 1(1)(pp)(ii), 1(1)(pp)(iii) and 1(1)(pp)(xii) of the *Health Professions Act*;

and that your conduct set out above and the breach of some or all of these provisions constitutes unprofessional conduct pursuant to the provisions of sections 1(1)(pp)(ii), 1(1)(pp)(iii) and 1(1)(pp)(xii) of the *Health Professions Act*.

III. PRELIMINARY MATTERS

Neither of the parties applied to close the hearing, or any part of it to the public. Mr. Jardine did request on behalf of the parties that the Hearing Tribunal's written decision omit the names of any patients and replace them with initials. The Hearing Tribunal has replaced patient names with initials in this decision.

IV. EVIDENCE

The evidence presented at the hearing consisted of:

- Notice of Hearing, Notice to Attend and Notice to Produce dated June 1, 2016 (exhibit 1),
- Record of Decision dated May 3, 2016 (exhibit 2),
- Investigation Report dated April 14, 2016 (exhibit 3), and
- Examination of a single witness, Mr. James Krempien, Complaints Director respecting his findings outlined in the Record of Decision (exhibit 2) and his investigation results outlined in the Investigation Report (exhibit 3).

Mr. Jardine called Mr. Krempien as the only witness. Mr. Krempien gave the following key evidence:

- Mr. Krempien became aware of this matter on March 4, 2016 when contacted by the Dr. Kerr, Dean of the Faculty of Pharmacy. Dr. Kerr reported that a 4th year pharmacy student completing a practicum had observed Mr. Crough administering injections without authorization from the College.
- Dr. Kerr subsequently suggested to the student, Xx Xxxx that he make a formal complaint to the College as he had directly observed Mr. Crough's conduct. Xx Xxxxx made the formal complaint on March 7, 2016.
- Mr. Krempien conducted an investigation including a review of Mr. Crough's registration records at the College. Mr. Krempien noted that Mr. Crough had never applied for or received authorization from the College to administer medications by injection.
- Mr. Krempien also explained that the College had published information to its regulated members about the need for authorization to administer medications by injection and how to become authorized since 2007.
- Mr. Krempien sought and obtained Mr. Crough's written response to the complaint. Mr. Crough acknowledged he was not authorized to administer injections but he indicated that he did not believe he had placed any of his patients at risk. Mr. Crough provided photographs of the pharmacy's injection room showing an anaphylaxis reaction kit and protocol, vital signs monitoring equipment and forms to document adverse reactions.
- Mr. Crough's written response included an acknowledgment that he had injected two patients with Zostavax on March 3, 2016 and that he would

stop administering injections until he had completed the College's requirements.

- Mr. Krempien also interviewed Mr. Crough. Mr. Crough acknowledged that none of the pharmacy staff were authorized to provide injections at this time. He also verbally acknowledged that he had injected two patients, [redacted] and [redacted] with Zostavax as alleged in the complaint and that he injected another patient, [redacted] with vitamin B12. Mr. Crough acknowledged that he may also have assisted a patient with an epi pen during an allergic reaction.
- Mr. Crough acknowledged to Mr. Krempien that his CPR/ALS certifications had lapsed.
- Mr. Krempien noted that Mr. Crough had apparently provided the injections as a favour for long term pharmacy patients. He had never billed Alberta Health or any third party insurers for providing injection services.
- Mr. Krempien also noted that Mr. Crough had no records of any of the injections he had administered and so there was no evidence of any adverse reactions or patient harm either.
- Mr. Krempien indicated he had also interviewed the other pharmacy staff. A pharmacy assistant, Sheena Mercer, advised Mr. Krempien that she had booked [redacted] and [redacted]'s appointments for their Zostavax injections with Mr. Crough. Mr. Mercer also confirmed she was aware of Mr. Crough injecting [redacted] with vitamin B12 although she said she did not directly observe the injection.
- Mr. Krempien concluded his investigation having identified two main concerns. First, Mr. Crough had been administering medications by injection without authorization or having completed the prerequisite education to obtain the authorization. Mr. Krempien also noted that Mr. Crough did not have current CPR/ALS certifications.
- Second, Mr. Krempien noted that Mr. Crough did not have records of having administered medications by injection so the College had no firm idea of the scope of Mr. Crough's conduct.

Mr. Crough admitted that the allegations in the Notice of Hearing were accurate and declined to testify.

V. SUBMISSIONS

Mr. Jardine submitted that in order to find the allegation proven the Hearing Tribunal must be satisfied of the factual matters alleged and that the facts, if proven, constitute unprofessional conduct by Mr. Crough. Mr. Jardine said that between Mr. Krempien's evidence and Mr. Crough's lack of challenge to the allegations, they should be found proven.

Mr. Jardine argued that in 2007 pharmacists' scope of practice was expanded creating further opportunities for pharmacists. Along with these expanded opportunities came

corresponding responsibilities. Pharmacists wanting to pursue their expanded scope of practice were required to complete additional training and obtain authorizations to ensure patient safety. These requirements were set by the profession for the profession, so compliance with them is an ethical obligation for all Alberta pharmacists. The statutory authorities also make it clear that maintaining records is vital so that regulators can monitor pharmacists' compliance and ensure patient safety. Mr. Crough did not comply with these obligations.

Mr. Jardine also explained that unprofessional conduct was defined by the *Health Professions Act* to include a contravention of the *Health Professions Act*, a code of ethics or standards of practice, a contravention of another enactment that applies to the pharmacy profession and conduct that harms the integrity of the pharmacy profession, citing the *Health Professions Act* section 1(1)(pp)(ii), (iii) and (xii). Mr. Jardine also referred the Hearing Tribunal to several principles from the College's Code of Ethics, the Standards of Practice for Pharmacists and Pharmacy Technicians ("Standards of Practice") and the Pharmacists and Pharmacy Technicians Profession Regulation, Alta. Reg. 129/2006 as amended.

Mr. Jardine concluded that Mr. Crough had deliberately administered injections to patients when he knew he was neither trained, nor authorized to do so. Mr. Jardine said this breached Mr. Crough's ethical obligations as a professional pharmacist and was unprofessional conduct.

Mr. Crough reiterated his admission of the allegations. He further admitted that he needed to meet the requisite standards and made no other submissions.

VI. FINDINGS

Weighing the evidence and arguments presented by the Complaints Director and the admissions from Mr. Crough, the Hearing Tribunal finds the allegations factually proven. After deliberations, the Hearing Tribunal determined that Mr. Crough's conduct also constituted unprofessional conduct as alleged.

In determining whether unprofessional conduct occurred the statutes, regulations, and standards governing the practice of pharmacy were considered. The Hearing Tribunal's reason for its findings are:

1. Mr. Crough admitted to injecting multiple patients over the past number of unspecified years since 2007, while at the same time not having the required authorization, training, and at time, the CPR/First Aid certification required to do so as a licensed pharmacist.

   The Pharmacists and Pharmacy Technicians Profession Regulation, Alta. Reg. 129/2006 provides at section 16(5) that a clinical pharmacist is

authorized to perform, within the practice of pharmacists and in accordance with the Standards of Practice, the restricted activity of administering anything by an invasive procedure on body tissue below the dermis or the mucous membrane for the purpose of administering subcutaneous or intramuscular injections if the clinical pharmacist

(a) has provided evidence satisfactory to the Registrar of having successfully completed the Council requirements for the administration of injections, and
(b) has received notification from the Registrar that the authorization is indicated on the clinical pharmacist register.

The College's Standards of Practice in turn provide at standard 1.7(b) that a pharmacist must only engage in restricted activities that the pharmacist is authorized and competent to perform and that are applicable to the pharmacist's practice. Standard 1.7(d)(i) provides that a pharmacist must be aware of the circumstances in which they pharmacist should refer the patient to another appropriately qualified regulated health professional, including when the pharmacist does not have the training, experience or skills necessary to address the patient's needs.

The College's Code of Ethics similarly provides at principle 1(1) that pharmacists must act in the best interests of each patient and at principle 5(6) recognize their limitations and when indicated, refer their patients to other health professionals whose expertise can address the patient's needs.

There is a regulatory obligation to ensure that all pharmacists obtain and maintain the required authorization prior to injecting any patient, and this was not done. The evidence was that Mr. Crough had injected at least several patients without the required authorization, contrary to the Regulation and the Standards of Practice. It was also clear from the evidence that Mr. Crough lacked up-to-date CPR/ALS certifications that might be necessary in the event that a patient suffered an adverse reaction.

2. The Alberta College of Pharmacists' registration records for Mr. Crough demonstrate that he has never applied for, nor received, authorization to administer medication by injection.

   The evidence of the College's registration records demonstrates that there were no applications for authorization for Mr. Crough.

3. The requirement to only inject after being granted authorization by the Alberta College of Pharmacists, and the need to be in full compliance with the regulatory framework, has been communicated and re-communicated to pharmacists on a regular and frequent basis and Mr. Crough admitted that he was aware of these requirements.

The evidence presented demonstrated examples of multiple communications by the College to all pharmacists since 2007.

4. Mr. Crough had a positive, regulatory obligation to the Alberta College of Pharmacists to ensure that he obtained and maintained the required authorization prior to injecting any patient, and he failed to do so.

   The profession has set up requirements to show that pharmacists could do this correctly and responsibly. There is clearly an ethical aspect in that and an obligation that was proven to have not occurred in this case. This is contrary to accepted pharmacist practice and ethical standards.

5. Mr. Crough had an ethical obligation to his patients and the public to obtain and maintain the required authorization prior to injecting any patient, and he failed to do so.

   As noted above, the profession has set up requirements to show that pharmacists could do this correctly and responsibly to the public as well. There is clearly an ethical aspect in that and an obligation that was proven to have not occurred in this case. It is contrary to accepted pharmacist practice and ethical standards.

6. Mr. Crough had an obligation to create and maintain the applicable administration records pertaining to his patient injections, and he failed to do so.

   The College's standard 18 provides that a pharmacist must create and maintain patient records for pharmacist services provided by that pharmacist. Standard 18.2 provides that a pharmacist who administers a drug must ensure that an appropriate entry is made in the patient's record

   It is clear in the Standards of Practice that when a pharmacist provides a treatment, and particularly when the pharmacist is actively administering a treatment, it is mandatory to maintain records. Records are important for the reason if there is an emergency that arises, but they are also a very important aspect of being able to monitor compliance. In this case the College does not know precisely how many times, and there are no records. It is as if those injections never happened. This behavior has potentially placed patients at risk.

7. Mr. Crough practiced outside his authorized scope of practice and failed to create or maintain the required records of care and by doing so he has called into question the trust placed in him as a member of a self-regulating profession.

> Any self-regulating profession has its obligation to regulate its members, but it can't be standing over its members. Each member has to take the responsibility to uphold this principle and govern oneself accordingly to the statute, regulations, standards of practice and code of ethics. Mr. Crough showed a serious disregard of his duties as a pharmacist to his patients, the Alberta College of Pharmacists and to the public which relies upon the integrity and competence of pharmacists as members of a self-regulating profession. This behavior undermines the integrity of the profession.

When considering the allegations as a whole, the Hearing Tribunal finds that deliberately administering an injection that Mr. Crough knew he was not authorized to do, that he knew he did not have the requirements to do, and contrary to the Regulation, the Standards of Practice and the Code of Ethics is a serious matter. It is a serious matter because of potential risk to patients, and because it goes against the implicit understanding of self-regulation and Mr. Crough's obligation as a professional pharmacist.

VII. SUBMISSIONS ON ORDERS

Given the Hearing Tribunal's findings, the admissions by Mr. Crough and the absence of any challenge to the evidence presented, Mr. Jardine suggested that the following penalties would be appropriate:

- Costs of the hearing.
- A reprimand by the Hearing Tribunal.
- A fine of $2,000 in respect of Mr. Crough's failure to create and maintain the applicable administration records pertaining to patient injections.
- A fine of $2,000 in respect of Mr. Crough's unauthorized practice and the failure to obtain and maintain the required authorization prior to injecting any patient.
- An order from the Hearing Tribunal that directs Mr. Crough as the licensee and owner of his pharmacy to ensure that there are no further injections provided at his pharmacy unless they are provided by a pharmacist who is properly authorized to do so and who has ensured that all of the other safe guards and requirements for the practice and dispensing of injections are met.

Mr. Jardine explained that in weighing the proposed sanctions, the Hearing Tribunal would have to balance the protection of the public interest with fairness to Mr. Crough. Mr. Jardine argued that within this balancing exercise, the Hearing Tribunal should consider several factors. The first was the nature and gravity of Mr. Crough's conduct. Mr. Jardine said that Mr. Crough's conduct was serious in that any failure to comply with the profession's own rules was serious but acknowledged the conduct was not at the most serious end of the spectrum.

Mr. Jardine also argued that the Tribunal should consider Mr. Crough's age and experience. In this case Mr. Crough is a senior, experienced pharmacist so there is no evidence of a lack of experience that might serve as a mitigating factor.

Mr. Jardine said that Mr. Crough's lack of any discipline history was also a factor to take into account. There was no suggestion Mr. Crough had any previous findings of unprofessional conduct and his otherwise unblemished professional record was a mitigating factor.

Mr. Jardine explained the Tribunal could consider whether the patients were particularly vulnerable but in this case there was no suggestion that they were.

Mr. Jardine offered that Mr. Crough's conduct was proven to have occurred several times, but he went on to explain that part of the Complaints Director's concern was the lack of records and information about the scope of the problem. The Hearing Tribunal took note that Mr. Crough's own lack of records exacerbated the difficulties in assessing the scope of his unprofessional conduct.

Mr. Jardine said that Mr. Crough was cooperative throughout, including at the hearing. Mr. Crough readily admitted the allegations and avoided the need for a complicated hearing, but his own lack of records would have been the main complicating factor.

Mr. Jardine said there was no evidence of Mr. Crough having suffered financial or other penalties as a result of the allegations having been made. The Tribunal therefore did not consider there were any reasons to impose a lesser sanction than proposed.

Mr. Jardine said the Tribunal could consider the need for the penalties to deter Mr. Crough from similar unprofessional conduct in the future, but also, given the novelty of the conduct, to deter others in the profession from exceeding their scopes of practice without authority. It would be important for other pharmacists to understand the seriousness of doing so.

Mr. Jardine also mentioned the need for the penalties to maintain public confidence in the profession. He explained that it was important for the Tribunal to impose sanctions that the public would view as sufficiently severe.

Mr. Jardine commented that Mr. Crough's conduct was clearly outside his authorized scope of practice so there was no question his conduct was unauthorized.

Lastly Mr. Jardine explained that this was the first case of a pharmacist administering injections without authorization so there were no similar cases to which to compare.

Mr. Crough choose not to make any submission on the appropriate penalties.

VIII. ORDERS

After deliberations, the Hearing Tribunal agreed that the penalties suggested by Mr. Jardine were appropriate with the exception of the number and amounts of the fines requested. The Hearing Tribunal took into account:

- The seriousness of deliberately administering an injection when not authorized to perform and breaching the regulation and a number of standards and ethical obligations.
- The seriousness of not creating and maintaining appropriate records of care.
- Mr. Crough's cooperation and the fact that he was forthcoming during the investigation.
- Mr. Crough's willingness to acknowledge the seriousness of his actions
- No evidence of financial gain.
- The number of injections administered to a restricted number of patients versus a widespread implementation initiative such as flu vaccinations.

Mr. Crough's willingness to acknowledge his actions, the lack of evidence of financial gain and the restricted number of patients involved versus widespread implementation were considerations in determining the appropriateness of the orders.

Accordingly, the Hearing Tribunal makes the following orders:

1. Mr. Crough shall pay the costs of the investigation and hearing on a payment schedule satisfactory to the Hearings Director.

2. This decision shall serve as a written reprimand for Mr. Crough.

3. Mr. Crough shall pay a Fine of $2,000 on a payment schedule to be determined by the Hearings Director.

4. An order that directs Mr. Crough as the licensee and owner of his pharmacy to ensure that there are no further injections provided at his pharmacy unless they are provided by a pharmacist who is properly authorized to do so and who has ensured that all of the safe guards and requirements for the practice and dispensing of injections are met.

Signed on behalf of the Hearing Tribunal by the Chair

Dated: October 11, 2016

Per: _____[Kevin Kowalchuk]_____