ALBERTA COLLEGE OF PHARMACY

IN THE MATTER OF
THE HEALTH PROFESSIONS ACT

AND IN THE MATTER OF A HEARING
REGARDING THE CONDUCT OF

MICHELE MENZIES
Registration number: 8682

DECISION OF THE HEARING TRIBUNAL

March 2, 2021

I. INTRODUCTION

The Hearing Tribunal held a hearing into the conduct of Michele Menzies ("Ms. Menzies") on February 4, 2020. In attendance on behalf of the Hearing Tribunal were Jennifer Teichroeb, pharmacy technician and chair; Rhonda Bodnarchuk, pharmacy technician; Kelly Boparai, pharmacy technician; and Dave Rolfe, public member. Jason Kully was present and acted as independent legal counsel to the Hearing Tribunal.

The hearing took place by way of video conference. The hearing was held under the terms of Part 4 of the *Health Professions Act* ("HPA").

In attendance at the hearing were Aman Costigan and Raymond Chen, legal counsel representing the Complaints Director of the Alberta College of Pharmacy ("the "College"); James Krempien, the Complaints Director of the College; Ms. Menzies, the investigated member; and Alexis Moulton, legal counsel representing Ms. Menzies.

Margaret Morley, Hearing Director, was also present. Ms. Morley did not participate in the hearing but was available to assist in administering the virtual hearing.

There were no objections to the composition of the Hearing Tribunal or the jurisdiction of the Hearing Tribunal to proceed with a hearing.

II. ALLEGATIONS

The Hearing Tribunal held a hearing to inquire into the following allegations with respect to Ms. Menzies, as set out in the Notice of Hearing, included in the "Hearing Documents" entered as Exhibit 1:

IT IS ALLEGED THAT, between April 11, 2018 and April 2, 2020, while you were a registered Alberta pharmacy technician employed by Alberta Health Services, you:

1. Displayed a pattern of lack of knowledge or a lack of skill or judgment in the provision of pharmacy technician services when you practiced at the Tom Baker Cancer Centre between April 11, 2018 and September 17, 2019, including when you:

    a. pulled an incorrect drug supply on April 11, 2018 when you prepared market supply Rituxan® SC for a clinical trial patient instead of the trial supplied Rituxan® SC,
    b. prepared four times the intended dose of Temodal® for a patient on November 29, 2018,
    c. pulled an incorrect drug supply on February 13, 2019 when you prepared the wrong number of vials and the incorrect dosage of pembrolizumab for a clinical trial patient,

d. prepared an incorrect drug supply on April 3, 2019 when you used a market supply and not a patient specific supply of Compassionate Program medication,
e. left a preparation of azacitadine at room temperature on July 23, 2019 after it was prepared such that it expired before it could be checked and so had to be remade,
f. made an incorrect entry in an accountability log for a clinical trial patient on August 6, 2019 such that the number of vials remaining was found to be mismatched,
g. entered an incorrect preparation date on a patient label for intravenous irinotecan 20 mg/ml on August 21, 2019, and
h. entered an incorrect dose on a patient prescription on September 17, 2019 when you entered Venetoclax 10 mg oral tablet instead of Venetoclax 100 mg oral tablet.

2. Repeatedly displayed a lack of knowledge or a lack of skill or judgment in the provision of pharmacy technician services when you were in training and practicing as a pharmacy technician at Central Production between November 26, 2019 to December 16, 2019 and March 23, 2020 to April 2, 2020, and you made numerous errors in training and ultimately were unable to retain the information required to perform the job.

3. Failed to take responsibility for maintaining a high standard of professional competence and for improvement of professional knowledge and skill, including when you:

    a. relied on other health professionals to catch your errors,
    b. failed to recognize or acknowledge that your inability to retain information and maintain focus was creating an ongoing risk of errors and possible risk to patients, and
    c. declined the Operation Manager at Central Production's offer of additional support.

IT IS ALLEGED THAT your conduct in these matters:

a. created the potential for patient harm, and
b. failed to exercise the professional and ethical judgment expected and required of an Alberta pharmacy technician.

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

- Standards 1 and 7 and sub-standards 1.1, 1.2, 7.1 and 7.14 of the Standards of Practice for Pharmacists and Pharmacy Technicians and
- Principles 1(1), 9(1, 2, 3, 5 and 6) and 11(1, 3 and 4) of the ACP Code of Ethics.

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)(i) and 1(1)(pp)(ii) of the *Health Professions Act*.

Ms. Costigan advised that the parties had agreed to amend allegation 1(c) and 1(d). She advised that the revised allegations stated:

> c. performed the final check that resulted in four times the intended dose of Temodal® for a patient on November 29, 2018; and
>
> d. pulled a drug from an incorrect drug supply on February 13, 2019, which was then not caught by another technician who was responsible for performing the final check which resulted in the wrong number of vials and incorrect dosage of pembrolizumab for a clinical trial patient.

The Hearing Tribunal accepted these revisions to the allegations in the Notice of Hearing.

The hearing proceeded by Admission of Unprofessional Conduct, an Agreed Statement of Facts, and a Joint Submission on Sanction. Through the Admission of Unprofessional Conduct, Ms. Menzies admitted the allegations set out above and as amended by the parties agreement.

III. EVIDENCE

The hearing proceeded by way of an Agreed Statement of Facts and other agreed exhibits, including an Admission of Unprofessional Conduct. No witnesses were called to testify.

The following exhibits were entered by agreement of the parties:

Exhibit 1: Hearing Documents, which included the Notice of Hearing, an Agreed Statement of Facts and an Admission of Unprofessional Conduct
Exhibit 2: Investigation Records

Agreed Statement of Facts:

The Agreed Statement of Facts provided by the parties' states:

1. At all relevant times, Michele Menzies was a registered member of the Alberta College of Pharmacy and employed as a pharmacy technician with Alberta Health Services ("AHS").

2. On April 8, 2020, the Complaints Director received an email of complaint from [the] Pharmacy Manager with AHS, Tom Baker Cancer Centre (Investigation Report, Tab 1). In his email, [he] described the following concerns about the practice of Ms. Menzies:

a. Ms. Menzies was involved in "numerous medication errors" while employed as a pharmacy technician at the Tom Baker Cancer Centre,

b. AHS provided Ms. Menzies with additional training and support, but Ms. Menzies continued to "put patients at risk due to her inability to perform her required role",

c. Ms. Menzies continued to have performance-based issues after accepting another position with AHS at Central Production, and these issues prompted a discussion proposing that Ms. Menzies return to her role at the Tom Baker Cancer Centre, and

d. Ms. Menzies' inability to meet the practice standards of a pharmacy technician presented a "serious risk of harm or death" to the patients at the Tom Baker Cancer Centre.

3. Based on [his] complaint, the Complaints Director appointed himself and Ms. Jennifer Mosher as investigators and an investigation into the conduct of Ms. Menzies commenced. This investigation resulted in this complaint being referred to a hearing.

Facts Supporting Allegation 1

4. On May 6, 2020, the Complaints Director received emails from [the complainant] attaching documentation relating to Ms. Menzies' performance as a pharmacy technician at the Tom Baker Cancer Centre (Investigation Report, Tab 12). The documentation indicated that Ms. Menzies:

a. pulled an incorrect drug supply on April 11, 2018 when she prepared market supply Rituxan® SC for a clinical trial patient instead of the trial supplied Rituxan® SC (Investigation Report, Tab 12, pages 45 to 46),

b. performed the final check that resulted in four times the intended dose of Temodal® for a patient on November 29, 2018 (Investigation Report, Tab 12, page 47),

c. pulled a drug from an incorrect drug supply on February 13, 2019, which was then not caught by another technician who was responsible for performing the final check which resulted in the wrong number of vials and incorrect dosage of pembrolizumab for a clinical trial patient (Investigation Report, Tab 12, pages 49-53, 95-104),

d. prepared an incorrect drug supply on April 3, 2019 when she used a market supply and not a patient specific supply of Compassionate Program medication (Investigation Report, Tab 12, pages 56-69, 105-112),

e. left a preparation of azacitadine at room temperature on July 23, 2019 after it was prepared such that it expired before it could be checked and so had to be remade (Investigation Report, Tab 12, pages 70-72),

f. made an incorrect entry in an accountability log for a clinical trial patient on August 6, 2019 such that the number of vials remaining was found to be mismatched (Investigation Report, Tab 12, pages 74-78, 113-128),

g. entered an incorrect preparation date on a patient label for intravenous irinotecan 20 mg/ml on August 21, 2019 (Investigation Report, Tab 12, pages 79-89, 129-140), and

h. entered an incorrect dose on a patient prescription on September 17, 2019 when she entered Venetoclax 10 mg oral tablet instead of Venetoclax 100 mg oral tablet (Investigation Report, Tab 12, pages 90-93, 141-153).

Facts Supporting Allegation 2

5. On May 11, 2020, Ms. Mosher received the following documentation from the Pharmacy Operations Manager at Central Production, regarding Ms. Menzies' performance as a pharmacy technician at Central Production:

   a. a document named "Michele Menzies feedback summary", which contained comments from [the manager] and Ms. Menzies' trainers between November 26, 2019 to December 16, 2019 and March 23, 2020 to April 2, 2020. [the manager] and Ms. Menzies' trainers noted numerous errors Ms. Menzies made during training and Ms. Menzies' inability to retain the information required to perform the job (Investigation Report, Tab 15, pages 329 to 332); and

   b. *Trainee Feedback Forms* and additional written feedback provided by Ms. Menzies' trainers, which listed numerous errors Ms. Menzies made during training (Investigation Report, Tab 15, pages 333 to 348).

Facts Supporting Allegation 3

6. On May 11, 2020, Ms. Mosher received Ms. Menzies' written response to the complaint (Investigation Report, Tab 14), which included:

   a. Ms. Menzies' recollection of the August 6, 2019 error, where she noted that there was "no extra help", "[no one] to ask for help" and that she asked the pharmacist on duty for confirmation that she had the right drug (Investigation Report, Tab 14, page 220); and

b. Ms. Menzies' recollection of the August 21, 2019 error, where she noted that she felt "that a technician should not final check a completed IV order if they have checked 1 of the preps at the hood" (Investigation Report, Tab 14, page 222).

7. On May 28, 2020, Ms. Mosher had a phone conversation with [the complainant and [the] Pharmacy Operations Manager at the Tom Baker Cancer Centre (Investigation Report, Tab 20). [They] provided the following information:

   a. [The Pharmacy Operations Manager] supervised technicians, including Ms. Menzies, at the Tom Baker Cancer Centre. [The Pharmacy Operations Manager] reported to [the Complainant],

   b. The practice environment at the Tom Baker Cancer Centre was such that all processes were standardized with policies and procedures that were considered the "most involved in the province" to ensure that tasks were completed the "same way every time",

   c. Clinical trial orders were a big component of pharmacy practice at the Tom Baker Cancer Centre. The consequences of an incorrect medication or dose were considered "extremely serious", with the potential of the patient being removed from the trial, and the facility being cited for the error and "pulled from the trial", and

   d. [The Complainant] re-iterated the statement from his complaint that Ms. Menzies posed a "serious risk of harm or death".

8. On May 28, 2020, Ms. Mosher had a phone conversation with [the Operations Manager at Central Production](Investigation Report, Tab 21) [who] indicated that:

   a. As Operations Manager at Central Production [she] was provided feedback from Ms. Menzies' trainers during her training period at Central Production,

   b. Ms. Menzies received three weeks of training where the typical expectation for this same training was four day of training. Ms. Menzies' trainers observed that Ms. Menzies was not able to retain the information that she was given by her trainers and was not able to "be on her own",

   c. She offered additional support to Ms. Menzies. Ms. Menzies declined additional support saying that she was having trouble retaining the information, and

   d. She felt that Ms. Menzies' retention issues "would not allow her to perform" in the role.

9. On June 3, 2020, Ms. Mosher had a phone conversation with Ms. Menzies (Investigation Report, Tab 23). Ms. Menzies indicated that:

    a. When working at the Tom Baker Cancer Centre:

        i. She reported directly to [the Pharmacy Operations Manager who] reported directly to [the Complainant].

        ii. She acknowledged the drug errors in question were made by her. While she considered these drug errors "serious", she indicated that there were procedures in place to catch drug errors before they left the pharmacy.

        iii. She did not feel there were enough supports (i.e. pharmacy staff) in place to avoid making these drug errors.

        iv. She felt that the education provided to her to improve her performance was not helpful as "these were things she already knew".

    b. Upon her transfer to Central Production:

        i. She was trained by several pharmacy technicians who reported to [the Operations Manager at Central Production].

        ii. The expectation of the trainers was to complete the training for each position in 2-3 days, but Ms. Menzies did not feel that 2-3 days was adequate as she was coming from a different facility which required a different skill set.

        iii. Ms. Menzies was "not comfortable" and "not ready" to work on her own.

10. At the time of these events, Ms. Menzies was experiencing mental health issues. It is agreed by the parties that Ms. Menzies has been seeking help for her mental health issues and continues to do so.

11. Ms. Menzies has received legal advice prior to signing this Agreed Statement of Facts and understands that the Hearing Tribunal may use this Agreed Statement of Facts as proof of the allegations set out in the Notice of Hearing.

The exhibits referred to in the Agreed Statements of Facts or referred to in other parts of the decision have not been reproduced but are part of the record of proceedings.

Admission of Unprofessional Conduct:

In the Admission of Unprofessional Conduct, Ms. Menzies admitted the allegations set out in the Notice of Hearing as amended at the hearing. Ms. Menzies also agreed and acknowledged that her conduct created the potential for patient harm and failed to exercise the professional and ethical judgment expected and required of an Alberta pharmacy technician. Ms. Menzies further agreed and acknowledged that her conduct breached Standards 1 and 7 and sub-standards 1.1, 1.2, 7.1 and 7.14 of the Standards of Practice for Pharmacists and Pharmacy Technicians; and Principles 1(1), 9(1, 2, 3, 5 and 6) and 11 (1, 3 and 4) of the College's Code of Ethics.

Ms. Menzies further admitted that her conduct constitutes "unprofessional conduct" as defined in sections 1(1)(pp)(i) and 1(1)(pp)(ii) of the HPA.

Investigation Report

The parties submitted investigation documents by agreement. Many of the investigation documents were referenced in the Agreed Statement of Facts.

IV. SUBMISSIONS

Ms. Costigan made submissions on behalf of the College. Ms. Costigan reviewed the allegations in the Notice of Hearing and then reviewed the Agreed Statement of Facts, the Investigation Records, and the Admission of Unprofessional Conduct. She provided the following submissions with respect to these documents and the hearing:

- The Agreed Statement of Facts provided the factual foundation and support needed to find that the allegations had been established. It included cross-references to the Investigation Records where the Tribunal could find the documents that supported each of the items.
- Tab 12 of the Investigation Records was important because it was all of the documents sent over by [the complainant] when he was asked for substantiating documents.
- Tab 15 was another important document. It provided documents that [the manager] provided for Central Production and related to Allegation 2.
- Ms. Menzies had made an admission of unprofessional conduct to all the allegations pursuant to s. 70 of the HPA.
- The Hearing Tribunal's task was to review the evidence and make a decision as to whether to accept the admission in whole or in part. The Tribunal needed to be satisfied that the evidence put forward supported the admission.
- Ms. Menzies admitted that her conduct constituted unprofessional conduct pursuant to s. 1(1)(pp)(i) of the HPA, as well as s. 1(1)(pp)(ii) as she admitted to breaching Standards of Practice 1 and 7,

specifically Sub-standards 1.1, 1.2, 7.1 and 7.14 , and Principles 1, 9, and 11 of the Code of Ethics.

- There was sufficient evidence in the Agreed Statement of Facts and in the documents to support the admissions. It was for the Hearing Tribunal to make findings of fact that the allegations were proven on a balance of probabilities and that the conduct constituted unprofessional conduct.

On behalf of Ms. Menzies, Ms. Moulton advised she did not have anything to add other than Ms. Menzies was completely willing to acknowledge and agree to the facts and the admissions.

After caucusing, the Hearing Tribunal advised the parties that it was of the view that Sub-standard 7.2 of the Standards of Practice had also been breached. After a short caucus, Ms. Moulton advised that Ms. Menzies was prepared to admit to breaching this sub-standard in relation to Allegation 1(e).

V. FINDINGS

The Hearing Tribunal accepted Ms. Menzies' admission of unprofessional conduct and concluded the allegations set out in the Notice of Hearing, as amended at the hearing, were proven on a balance of probabilities and that the conduct constituted unprofessional conduct as defined in the HPA.

In determining that the allegations were proven, and that Ms. Menzies' admission should be accepted, the Hearing Tribunal carefully considered the Agreed Statement of Facts entered into by the parties, the Admission of Unprofessional Conduct, and the Investigation Records.

The reasons for the Hearing Tribunal's findings that the allegations in the Notice of Hearing, as amended, are factually proven on a balance of probabilities are as follows.

Ms. Menzies acknowledged and admitted that she engaged in the conduct as alleged in Allegation 1 (as amended), Allegation 2, and Allegation 3. In addition, the evidence demonstrated the allegations were proven.

With respect to Allegation 1, the Tom Baker Cancer Centre maintained contemporaneous documents of the errors made by Ms. Menzies between April 11, 2018 and April 2, 2020. These documents included notes to file identifying the concerns that were discovered, emails and memos summarizing meetings that occurred with Ms. Menzies regarding her errors, accountability logs, patient labels, and patient prescriptions. The Tribunal reviewed these documents and concluded they demonstrated that Ms. Menzies committed the errors on the dates alleged and that the errors displayed a lack of knowledge, skill, or judgment in the provision of pharmacy technician services.

With respect to Allegation 2, Central Production maintained documents regarding Ms. Menzies' performance as a pharmacy technician while she was in training. The document titled "Michele Menzies feedback summary" contained comments from Ms. Menzies' trainers between November 26, 2019 to December 16, 2019 and March 23, 2020 to April 2, 2020. The comments demonstrate that Ms. Menzies made many errors during her training, including: she required assistance to complete TPN labeling and had trouble retaining the information, she forgot to write up site orders or wrote site orders wrong, she put interim doses and site orders in the wrong bins, she wrote incorrect labels, she did not prioritize tasks properly, she sent in extra vials, she was not able to meet timelines, she used incorrect worksheets, she was not concerned about wastage, and she was unsure of drug amounts and vial sizes. Many more errors were also identified in this document and the Tribunal does not intend to repeat them all. In addition, there were *Trainee Feedback Forms* and further written feedback for Ms. Menzies which demonstrated that Ms. Menzies did not learn from her errors, was extremely slow in understanding the processes needed to complete tasks, made wrong calculations for the amount and volume of drug needed, and made many other errors. The feedback demonstrated that Ms. Menzies did not meet expectations. After reviewing these contemporaneous accounts of Ms. Menzies' performance, the Tribunal found that the evidence demonstrated Ms. Menzies made numerous errors in training between November 26, 2019 to December 16, 2019 and between March 23, 2020 to April 2, 2020 and that she did not retain the information required to perform the job.

For Allegation 3, Ms. Menzies' written response to the College and her conversations with investigators indicated that she relied on other health care professionals to check her work and to confirm that she was doing things properly. Ms. Menzies acknowledged to the College that she made "serious" drug errors but stated that there were procedures in place to catch the errors. At the same time, the evidence indicated she felt that the education provided to her to improve her performance was not helpful because they were things she already knew. In addition, the Pharmacy Operations Manager at Central Production, provided evidence that Ms. Menzies declined additional support on the basis that she was having trouble retaining information. The evidence, including Ms. Menzies own admissions to the College, demonstrated that Ms. Menzies failed to take responsibility for maintaining a high standard of professional competence and for improvement of her knowledge and skill.

The Tribunal observed that the evidence indicates that Ms. Menzies was experiencing mental health issues during the relevant time period. Nonetheless, she continued to attempt to perform her duties even though she could not maintain focus and was creating an ongoing risk of errors and possible risk to patients.

In summary, Ms. Menzies committed a number of serious errors over a long period of time. She was unable to demonstrate the necessary skills and was unable to perform her position in a timely and accurate manner. She had on-going errors and a lack of consistency in performance. She failed to demonstrate competency in the practice of the profession.

The reasons for the Hearing Tribunal's findings that the proven conduct amounts to unprofessional conduct are as follows.

Allegations 1, 2 and 3 demonstrate a lack of knowledge or a lack of skill or judgment in the provision of pharmacy technician services. They also demonstrate a failure to take responsibility for maintaining professional competence and the improvement of knowledge and skill.

This was not an isolated incident or a single mistake. Ms. Menzies repeated her conduct and was routinely unable to meet the minimum standards and expectations of a pharmacy technician.

Ms. Menzies was given several opportunities to improve her performance and received appropriate and timely educational support and training. Nonetheless, she continued to make serious drug errors that jeopardized the safety of the patients at the Tom Baker Cancer Centre.

Ms. Menzies did not demonstrate competence in the provision of pharmacy technician services. Ms. Menzies' conduct demonstrates a failure to perform the basic skills required of a pharmacy technician. Her repeated drug errors and documentation errors demonstrate a lack of knowledge, skill, and judgment with regards to her practice and demonstrate inadequacies with her understanding of the proper role of a pharmacy technician. Ms. Menzies' repeated errors posed a risk of harm or death and were very serious.

Despite being aware of her errors and failure to meet the minimum standards, Ms. Menzies did not take responsibility for her own conduct and relied on others. Accordingly, Ms. Menzies failed to exercise the professional and ethical judgment expected of a regulated pharmacy technician.

Ms. Menzies breached Standards 1.1 and 1.2 of the Standards of Practice as she failed to act professionally and failed to demonstrate the knowledge, judgment and skills required as a professional. She also breached Standards 7.1, 7.2 and 7.14 of the Standards of Practice as she failed to fill prescriptions correctly, failed to use appropriate dispensing procedures, and failed to properly complete the final checks when dispensing a drug.

Ms. Menzies breached Principle 1(1) of the Code of Ethics as her repeated failures were not actions in the best interest of the patients. She also breached Principle 9 as she failed to ensure that she was competent. Specifically, Ms. Menzies breached Principle 9 (1, 2, 3, 5, and 6) as she failed to improve her level of professional knowledge and skill, failed to take responsibility for maintaining a high standard of confidence, failed to evaluate her practice and assume responsibility for improvement, ailed to keep informed about new pharmaceutical knowledge, failed to respond constructively to appraisals and reviews and did not undertaking further training as necessary, and failed to limit her practice to her personal competence.

In addition, Ms. Menzies failed to demonstrate responsibility for herself and breached Principle 11 (1, 3 and 4) as she did not seek help for personal problems that might affect the provision of service, did not practice only when fit and competent to do so,

and did not promptly declare any circumstances that may have called into question her fitness to practice.

VI. SUBMISSIONS ON SANCTIONS

After the Hearing Tribunal deliberated, the Tribunal advised the parties that it accepted the Admission of Unprofessional Conduct by Ms. Menzies and determined that the conduct admitted to constituted unprofessional conduct. The Hearing Tribunal invited the parties to make submissions with respect to sanctions.

A Joint Submission on Sanction, which was entered as Exhibit 3, was proposed by Ms. Costigan and Ms. Moulton. Ms. Costigan indicated the parties were jointly proposing a number of sanctions. The first was that Ms. Menzies would undertake to not work in a pharmacy or provide direct or indirect pharmacy services for patients until conditions were placed on her practice permit that required her to practice under the direct supervision of a pharmacy technician or pharmacist acceptable to the Complaints Director for a minimum of one year from the date of the Tribunal's decision or until such time as Ms. Menzies' direct supervisor provided a report, satisfactory to the Complaints Director, confirming that Ms. Menzies met the minimum entry to practice standards related to exercising good judgment and skilled practice, whichever was later. Ms. Menzies had to provide a copy of the Tribunal's decision to any individual responsible for her direct supervision. The second sanction was that Ms. Menzies had to provide a copy of the decision to every pharmacy employer and every licensee of every pharmacy in which she is hired for a period of three years. The last order was that Ms. Menzies would pay the costs of the investigation and hearing up to a maximum of $7,000 within 24 months of receiving the Tribunal's decision.

Ms. Costigan submitted:

- A joint submission on penalty is not binding but a Tribunal should give serious consideration to it. Hard work was put into it and there was give and take between the parties. Deference should be given.
- In addition, the case law states that unless the Hearing Tribunal thinks the joint submission is contrary to the public interest or clearly unreasonable, then it should not just be set aside.
- If a joint submission is rejected, the parties must be allowed to make further submissions or even decide to withdraw and proceed to a contested hearing before a panel.
- The decision on sanction should reflect sentencing principles as they applied to the facts of the particular case. The goals of the discipline process include protection of the public, demonstration of integrity of the profession, fairness to the member, and deterrence of the conduct in question, both specific to the member and generally to the profession at large. Deterrence is a fundamental purpose as it ensures that the public is protected from similar acts of unprofessional conduct occurring in the future.
- The Tribunal should take into account the non-exclusive factors from the case of *Jaswal v the Newfoundland Medical Board* as the factors are often considered by panels in the assessment of appropriate sanctions.

- With respect to the nature and gravity of the proven allegations, the allegations were serious. Many, if not all, of the patients at the Tom Baker Cancer Clinic are in a vulnerable patient population and their medical conditions are not minor or self-limiting. Any drug errors or incidents they encounter could delay or disrupt their treatment and result in real and tragic harm. While all registered pharmacists and pharmacy technicians are required to demonstrate a knowledgeable and skilled approach, this is even more important in servicing patients from a vulnerable population, such as those receiving cancer treatment. Ms. Menzies' conduct could have created the potential for patient harm that jeopardized the safety of patients and the validity of clinical trials.
- With respect to the age and experience of the offending member, Ms. Menzies had been a pharmacy technician for almost 30 years. Ms. Menzies was not a new practitioner and her conduct cannot be excused based on a lack of experience.
- Ms. Menzies was a long-time employee of Alberta Health Services and was provided with several opportunities to improve her performance and received appropriate and timely educational support and training.
- There were three previous notices about Ms. Menzies' conduct to the College, but those notices were resolved with the agreement of the parties. There were no other complaints or findings of unprofessional conduct against Ms. Menzies.
- The three allegations involve several different events and different patients over approximately a two-year period. Allegation 1 had 8 particulars so the number of times the errors and events occurred was significant. This was not a onetime error.
- Ms. Menzies' role in acknowledging what occurred was a mitigating factor. She admitted to all of the allegations and took responsibility for her conduct. Her willingness to agree to the admissions provides considerable support to the College that the orders will be all that are needed and that more punitive sanctions are not required. Ms. Menzies and her legal counsel were cooperative throughout. This removed the need to have a longer hearing and to call witnesses.
- Addressing specific and general deterrence, the Complaints Director accepted that Ms. Menzies had taken the events seriously and, that by admitting her conduct was unprofessional and entering into a Joint Submission, she was taking the necessary steps to ensure the conduct did not arise again in the future. The direct supervision condition for a minimum period of one year will ensure what happened does not happen again and will provide evidence that Ms. Menzies had the requisite skill and judgment to practice as a pharmacy technician. The direct supervision requirement is robust and will protect patients, the public and Ms. Menzies.
- In addition, Ms. Menzies will have to provide a copy of the Hearing Tribunal's written decision to anyone responsible for her direct supervision before practicing and will have to provide a copy of that decision to every pharmacy employer and licensee in which she is hired for a period of three years, which is not an insignificant amount of time.

- Ms. Menzies is responsible to pay costs up to $7,000. While this amount is low, it was done intentionally in the specific circumstances. A lower cost amount was warranted because of Ms. Menzies' full admission, her cooperation, and her financial circumstances.
- In terms of general deterrence, the Complaints Director believed other members of the profession would see that this conduct would not be tolerated, and the sanctions would send a message that there are consequences for this conduct.
- With respect to maintaining the public's confidence in the integrity of the profession, the public needs to see that there are consequences if a member fails to meet the requirements of a self-regulating profession.
- With respect to the degree to which the conduct was regarded as conduct that would fall outside the range of permitted conduct, the errors made were serious and were clearly outside of the range of what is acceptable.
- Looking at the range of sentences in other similar cases, the parties did not find any past decisions that were factually similar.
- The joint submission met the sentencing principles, as well as the public interest test. It will ensure specific deterrence with respect to Ms. Menzies, and it met the principles of general deterrence to tell the profession that the conduct was serious and would attract serious consequences. It protects the public and the integrity of the profession.

Ms. Moulton submitted:

- The parties worked hard to come to a Joint Submission on Sanction.
- Ms. Menzies started practicing as a pharmacy technician about 25 years ago and had not been the subject of any investigations into unprofessional conduct prior. She had been working at the Tom Baker Centre for 22 years and had a significant degree of relationships built up in that time.
- The sanctions would protect the public.
- Ms. Menzies acknowledged her conduct was serious and that it was unprofessional.
- Ms. Menzies recognized that some of the issues that she was dealing with on a personal level created an environment that impacted her ability to do her job. The Tribunal could be confident that Ms. Menzies sought and continues to seek professional treatment for some of the issues that were going on in her personal life for the relevant two-year period of time.
- The sanctions are sufficiently strict enough for Ms. Menzies and other members of the profession to know that anyone who commits the conduct will be sanctioned.
- Ms. Menzies was fully cooperative with the entirety of the investigation, was remorseful about her conduct, and had agreed to the conduct.
- Ms. Menzies recognized that in that two-year period of time, between April of 2018 and April of 2020, she was not conducting her job in accordance with the requirements and had taken steps to address that. She continues to use the skills and approaches she has learned in her personal treatment. She is now aware of her mistakes and how to address them going forward.

- Ms. Menzies is hopeful that she can put this traumatic, embarrassing, regretful and uncharacteristic fact scenario behind her so that she can continue to have a career in a profession that she enjoys very much
- Ms. Menzies was experiencing a fragile mental condition during the two years brought on by personal life circumstances, as well as serious health issues faced by her mother, where she was the primary caregiver.
- She appreciates that this process has been brought to her attention and will work hard to make sure that these sorts of mistakes and conduct does not happen again in the future.
- The jointly proposed sanctions acknowledge the seriousness of the offences and address the purpose of sanctions and take into account the *Jaswal* factors.

VI. FINDINGS AND ORDERS

After carefully considering the Joint Submission on Sanction, the facts of Mr. Menzies' case, and the submissions by the parties, the Hearing Tribunal accepted the Joint Submission on Sanction.

The Hearing Tribunal acknowledged that deference should be provided to Joint Submissions on Sanction and that the Hearing Tribunal ought not to depart from the Joint Submission unless the proposed sanctions would bring the administration of justice into disrepute or would otherwise be contrary to the public interest.

The Tribunal considered the orders that were jointly proposed in light of the factors discussed in the *Jaswal* decision and the purposes of sanctions. It found that the orders were appropriate.

Pharmacy technicians must provide competent care as their actions impact the health and safety of members of the public. Ms. Menzies failed to provide such competent and safe care and her conduct was serious. The patients at the Tom Baker Cancer Clinic are in a vulnerable patient population. Drug errors or incidents can delay or disrupt their treatment and result in real and tragic harm. Ms. Menzies' conduct created the potential for patient harm and jeopardized the validity of clinical trials. Ms. Menzies' conduct was also not an isolated incident but a pattern of misconduct over a two-year period. Her conduct was significant as there were several different events and different patients. If members of the public were aware of Ms. Menzies' conduct, they may not pursue required care or have serious reservations about doing so.

Ms. Menzies was an experienced pharmacy technician, with almost 30 years of experience, so a lack of experience did not excuse her behavior. Ms. Menzies was also provided with several opportunities to improve her performance and received appropriate and timely educational support and training. Nonetheless, she failed to meet the expectations of a pharmacy technician. The Tribunal considered this to be an aggravating factor.

The absence of any previous finding of unprofessional conduct against Ms. Menzies and her acknowledgement of what occurred were mitigating factors to be considered against the serious and repeated conduct.

There is a need to ensure that Ms. Menzies, as well as other members of the profession, is aware that this conduct will not be tolerated. The sanction imposed must deter future conduct of this nature and maintain the public's confidence in the integrity of the profession.

In this case, the orders and the requirements imposed on Ms. Menzies will serve as an appropriate deterrent to Ms. Menzies. It will also demonstrate to other members of the profession and the public that the College will take appropriate action if a member fails to demonstrate competency in the profession.

The direct supervision and requirement to provide a copy of the Tribunal's decision to her employers will ensure there is appropriate oversight, deter Ms. Menzies from engaging in similar conduct, and will minimize the possibility of a recurrence of the actions, thereby protecting the public. Direct supervision of Ms. Menzies' work for a period of at least one year is robust and will provide reasonable protection for the public. The extent of the supervision will demonstrate that Ms. Menzies will be able to build trust from her co-workers that she is able to meet her professional responsibilities as a pharmacy technician. It will ensure the conduct does not happen again and will protect patients, the public, and Ms. Menzies. The obligation to disclose the Hearing Tribunal's decision will serve a similar purpose as her employers will be aware of her previous actions and will be put on notice to ensure Ms. Menzies meets the required standards.

The deterrent effect of the sanctions is balanced with the rehabilitation of Ms. Menzies. She is provided a means to return to practice in a rehabilitative manner.

It is appropriate that Ms. Menzies be responsible for costs of the hearing and investigation, as it was her conduct that necessitated the proceedings. Nonetheless, the cap on the total costs payable was appropriate given the circumstances, including her cooperation, her financial circumstances, and the fact that she was experiencing mental health issues during the time of the conduct.

In conclusion, the Hearing Tribunal agreed that the proposed orders were appropriate having regard to the factors that are relevant in assessing sanction in the professional discipline context. Specifically, the sanctions would deter Ms. Menzies and the profession at large from similar unprofessional conduct in the future. They also serve the public's interest and uphold the integrity of the profession.

ORDERS:

In light of the above, the Hearing Tribunal makes the following orders under section 82 of the HPA:

1. Ms. Menzies shall provide an undertaking that she will not work in a pharmacy or provide direct or indirect services for patients until such time as the following conditions are placed on her practice permit:

    a. Ms. Menzies shall practice under the direct supervision of a pharmacy technician or pharmacist acceptable to the Complaints Director, for a minimum of one year from the date of the Hearing Tribunal's decision in this matter or until such time as Ms. Menzies' direct supervisor provides a report satisfactory to the Complaints Director confirming that Ms. Menzies meets the minimum entry to practice standards for a pharmacy technician related to exercising good judgment and skilled practice, whichever is later. The direct supervisor providing the report must have directly supervised Ms. Menzies for a minimum of six months; and

    b. Ms. Menzies shall provide a copy of the Hearing Tribunal's written decision in this matter to any individual responsible for her direct supervision under Order 1(a) prior to practicing.

2. Ms. Menzies shall provide a copy of the Hearing Tribunal's written decision in this matter to every pharmacy employer and every licensee of every pharmacy in which she is hired for a period of three years, beginning on the date Ms. Menzies receives a copy of the Hearing Tribunal's written decision in this matter.

3. Ms. Menzies shall pay the full costs of the investigation and hearing to a maximum of $7,000 within 24 months of receiving a copy of the Hearing Tribunal's written decision in this matter, on a payment schedule acceptable to the Hearings Director.

Signed on behalf of the hearing tribunal by the Chair on March 2, 2021

Per: Jennifer Teichroeb
Jennifer Teichroeb (Mar 2, 2021 10:54 MST)

Jennifer Teichroeb