Grey Areas
A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION
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Regulating Disruptive Behaviour

by Richard Steinecke
April 2014 - No. 185

What is the role of regulators when their members are disruptive? That question sparked a lot of debate at a conference of regulators held earlier this month.

Graeme Keirstead, chief legal counsel for the College of Physicians and Surgeons of British Columbia, described a range of behaviours that have caused significant concerns in the two professions he has been involved in regulating: physicians and lawyers. One category, which he called aggressive behaviours, includes yelling, foul and abusive language, threatening gestures, public criticism of co-workers, insults and shaming of others and intimidation.

Another category involves passive-aggressive behaviour such as the cold shoulder treatment, condescending language, impatience with questions, malicious gossip, discriminatory slurs often called "jokes" and sarcasm.

Keirstead clarified that regulators should not be worried about a single episode where a person had a bad day. No one is perfect and expecting absolute harmony is unrealistic. It is persistent disruptive behaviour that might attract the attention of regulators.

Some regulators have already taken action in this area. For example, guidelines have been issued by the College of Physicians and Surgeons of Ontario and the College of Physicians of Alberta. Other regulators, like the College of Nurses of Ontario, have published a similar guideline on conflict prevention and management. These documents reflect an initial strategy of identifying the issue, describing expectations and offering practical suggestions for dealing with disruptive behaviour when it does occur. There has also been quite a push in recent years among the regulators of lawyers to foster civility among practitioners.

Keirstead also gave some examples where the regulator had to deal with disruptive behaviour at the more serious end of the spectrum, particularly where the behaviour was "actionable" in the sense that other legal duties were breached. Of heightened concern would include harassment on a ground protected by the applicable Human Rights Code (e.g., sex, race) or conduct that put the mental or physical safety of people at risk (i.e., contrary to occupational health legislation). In one case the outcome of the complaint included:

- the practitioner issuing a letter of apology,
- a formal written reprimand,
- counselling with a psychiatrist,
- visits by a supervisor to the practitioner's office,
- connecting the practitioner with a mentor,
- professional development in ethics, professionalism and boundaries, and
- reports to the regulator.

Keirstead also identified cases that went to formal disciplinary hearings.

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Keirstead indicated that there may be significant consequences for co-workers and clients and other victims of such behaviour, particularly where it was ongoing. These consequences ranged from poor morale, absenteeism, turnover and ultimately financial cost to the workplace.

Keirstead pointed out that the intervention strategy for disruptive behaviour encompassed quite a range. Less severe options might include everything from informal meetings, to coaching, counselling and, where there is a medical condition contributing to the conduct, treatment. Keirstead acknowledged that the complaints and discipline process was an exceedingly blunt instrument for addressing such behaviour; generally it could be more effectively handled in the workplace.

It is interesting to note that the courts have struggled with the issue of when disruptive behaviour crosses the line to become professional misconduct. Sometimes courts have said that "bad manners" is not professional misconduct: *Li v. College of Pharmacists of British Columbia* (1994), 116 D.L.R. (4th) 606 (BCCA).

However, in numerous other cases the courts have indeed characterized rude and disruptive behaviour as professional misconduct: *Przysuski v. College of Opticians of Ontario* (1996), 133 D.L.R. (4th) 280 ((Gen. Div.) Div. Ct.) (rudeness can constitute professional misconduct); *C. (K.) v. College of Physical Therapists of Alberta* (1998), 157 D.L.R. (4th) 31 (Alta.C.A.) (rudeness to non-patients can constitute misconduct); *Bermel v. Registered Psychiatric Nurses Assn. of Manitoba* (2001), 159 Man. R. (2d) 33 (Q.B.) (pattern of rough, intolerant and aggressive verbal and physical behaviour is serious misconduct and can warrant revocation); *Fox v. Registered Nurses Assn. of Nova Scotia* (2002), 209 N.S.R. (2d) 342 (C.A.), leave to appeal to S.C.C. refused 220 N.S.R. (2d) 400*n*, 320 N.R. 187*n* (rude and abusive conduct towards patients, including breach of confidentiality, can warrant revocation); *Carr v. Nova Scotia Board of Dispensing Opticians* (2006), 239 N.S.R. (2d) 370, (S.C.) (inappropriate attitude and language to clients is professional misconduct)

There was lively discussion during and after the presentation. Some argued that it was inappropriate for regulators to become involved in disruptive behaviour unless it crossed into illegal territory (e.g., human rights harassment). The view of some was that regulators have no business dealing with difficult personal interactions.

There was also concern that the regulator would end up becoming embroiled in employee / management disputes that could consume resources in a manner similar to the advertising complaints that enmesh some regulators. Concern was also expressed that regulators tended to support management in these disputes (although others countered that regulators reasonably have a reduced role when a practitioner is acting in a management capacity as opposed to acting during the course of practising the profession).

In addition, there were concerns that the complaints and discipline process could be used by disruptive professionals as one more tool with which to vex their colleagues.

Keirstead stated that the anecdotal evidence available to him suggested that regulators who addressed this issue explicitly through guidelines actually reduced the number of complaints about such behaviour. Raising awareness about the issue may alter behaviour and empower people to respond directly to the difficult practitioner rather than simply resulting in increased complaints to the regulator.

The three guidelines referred to above may be found at: www.cpso.on.ca, www.cpsa.ab.ca and www.cno.org.