Who Will Be Culpable?

A registered nurse of questionable professional competence, with a dodgy employment record, a history of mental illness and substance abuse, remains employed and ultimately murders eight vulnerable seniors, attempts to murder four others, and assaults another two over the course of a decade. At least those are the ones for which Elizabeth Wettlaufer offered a confession. Like most nurses and citizens, I was horrified by the revelation of multiple homicides at the hand of one of us. How could such a confluence of incompetence, mental illness and addiction, and willful murder go undetected for so long by so many?

Notwithstanding that she is serving eight concurrent life sentences, Elizabeth Wettlaufer provided her own insights as to what system changes would have limited her capacity to kill: a) better controls on drugs such as insulin, b) better visibility and monitoring of activities within medication rooms, c) active mental health follow-up for persons/health care givers like herself, and d) provision of advocates for seniors with dementia (Dubinski 2018). Albeit all reasonable and actionable suggestions from the mind of a serial killer but let's be honest, a much higher bar of accountability, actions and preventive measures are being expected from our profession.

A Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System was called after her sentencing. The inquiry's mandate is: "to inquire into the events which led to the offences committed by Elizabeth Wettlaufer, the circumstances and contributing factors allowing these events to occur, including the effect, if any, of relevant policies, procedures, practices and accountability and oversight mechanisms. The inquiry is also directed to inquire into other relevant matters that the Commissioner considers necessary to avoid similar tragedies." The inquiry will deliver its final report in both official languages on July 31, 2019. But even before those deliberations have been completed, it is prudent for the profession to reflect upon this travesty of oversights and inaction and potential malfeasance. Furthermore, it is incumbent on all of us to consider the constituents of culpability in this case and as leaders to determine what we must do differently in the months ahead. Besides Wettlaufer, who else should be held culpable and who will be held culpable? And ultimately, what pending actions and directives will ensure that such a tragedy never happens again?

Early findings of the investigation suggested that her substandard performance and misdemeanors were protected by the union, her firings not sufficiently investigated by the regulatory college, and that overall the vulnerability of long-term care residents was further compounded by high nurse-patient ratios and staff shortages. Even worse some of the existing regulations hindered the college and union from doing the right thing. Two years after her conviction, is it possible to know whether a nurse is under

investigation? Is it possible to know if a nurse has been fired for incompetence? Do employers have the information they need to protect the public with an acceptable degree of certainty as to a nurse's competence?

In this issue, our authors provide perspectives on some of our regulatory issues including a critical commentary on the British Columbia experience of regulator amalgamation and the need for the engagement of all nurses in self-regulation, and the potential benefits of Canadian nursing adopting a model of mandatory reporting of professional incompetence such as that employed in Australia.

Mildon's (2018) commentary provides perhaps the most thoughtful, multi-faceted view of the issues and challenges associated with being a self-regulating profession. Bringing her rich experience from a multiplicity of leadership roles in different sectors, professional organizations and 2 provincial jurisdictions, she also boldly highlights the troubling aspects arising from the lack of collaboration among our professional associations, regulators and unions and the loss of "a platform for shared and collegial discussion and a willingness to make decisions that consider the best interest of patients and the profession as a whole" (p. 36). Further she offers her views on the need for enhanced partnerships between regulators and employers to ensure that practice concerns are addressed expediently in the best interest of all concerned.

Duncan and Whyte (2018) offer a critical commentary on the amalgamation of British Columbia's nurse regulators and argue that a strong public safety mandate can only be met if registrants are fully engaged in the purpose and process of self-regulation. Leslie and Nelson (2018) compare the mandatory reporting regimes of Canada and Australia and examine the development and reform of mandatory reporting. They suggest that Canadian policymakers and nurse leaders should consider advocating for more comprehensive mandatory reporting to improve public confidence in regulation and protect the public. Tarjan (2018) suggests that the assurance of safe care is not the sole responsibility of the professional regulator. In her view, beginning with educational programs, it needs to be reinforced in all care delivery systems by legislators, regulators and unions. And she states: "nothing will surpass individual professionals' moral and ethical commitment to the delivery of ethical, safe care to their clients" (p. 21).

Other authors highlight factors that may be addressed by nurse leaders to optimize the nursing impact on clinical outcomes. Specifically, D'Sa et al. (2018) revealed an associated 3.3 hour increase in nursing sick time for every 10 hours of nursing overtime worked in critical care units. Their findings suggest that hospitals and nurse managers should monitor collective and individual paid and unpaid hours in order to impose appropriate limits and mitigate the potential risks of inordinately excessive overtime hours to patients and staff. Wettlaufer, like many other long-term care home staff, also often worked excessive over time and double shifts, compounding an already compromised mental state. Such gruelling work patterns in many care settings have been shown time and time again to put nurses at risk not to mention the quality and safety of their patients.

Lopez and Freeman (2018) posit that our understanding of leadership is incomplete without also understanding followership; they suggest that without the following role, there is no leadership role. Defining the concept, they discuss different styles and explain the importance of the role to nursing and proffer recommendations to guide followership integration into practice. Relative to the discussion of effective regulation, the leader-follower dyad likely also has merit in supporting the creation of work cultures that contribute to transparency and better communication of concerns regarding the practice of others.

And finally, Landry and her colleagues (2018) describe a journey to creating a 'culture of kindness' in their organization, describing the results to date for employees and patients. One might surmise that engendering a culture of kindness might also go a long way to foster effective followership with positive consequences for staff and patients. In sum, there is much for our nursing family, leaders and followers, to consider in the context of being a self-regulating profession today and into the future. The very least of which should be to not let hubris stand in the way of doing the right things right TOGETHER.

Lynn M. Nagle, PhD, RN, FAAN
Adjunct Professor
University of Toronto
University of New Brunswick
Western University

References

Dubinski, K. 2018. "Five Things Nurse Elizabeth Wettlaufer Suggests Might Have Stopped her Killing." CBC News, August. Retrieved November 16, 2018. <https://www.cbc.ca/news/canada/london/long-term-care-inquiry-elizabeth-wettlaufer-what-could-have-stopped-you-1.4776403>.

Duncan, S.M. and N.B. Whyte. 2018. "British Columbia's One Nursing Regulator: A Critical Commentary on the Amalgamation Process." *Canadian Journal of Nursing Leadership* 31(3): 24–33. doi:10.12927/cjnl.2018.25680.

D'Sa V. M., J. Ploeg, A. Fisher, N. Akhtar-Danesh and G. Peachey. 2018. "Potential Dangers of Nursing Overtime in Critical Care." *Canadian Journal of Nursing Leadership* 31(3): 48–60. doi:10.12927/cjnl.2018.25677.

Landry, S., K. Bisson, C. Cook and L. Morrison. 2018. "How a Culture of Kindness Can Improve Patient Outcomes and Five Ways to Get There." *Canadian Journal of Nursing Leadership* 31(3): 42–47. doi:10.12927/cjnl.2018.25678.

Leslie, K. and S. Nelson. 2018. "Mandatory Reporting of Health Professional Incompetence and Incapacity: Is it Time to Adopt the Australian Regime? *Canadian Journal of Nursing Leadership* 31(3): 8–19. doi:10.12927/cjnl.2018.25682.

Lopez, S. and M. Freeman. 2018. "Refocusing Nursing's Lens on Followership." *Canadian Journal of Nursing Leadership* 31(3): 61–70. doi:10.12927/cjnl.2018.25676.

Mildon, B. 2018. "Regulation and the Nursing Profession: A Personal Commentary." *Canadian Journal of Nursing Leadership* 31(3): 34–41. doi:10.12927/cjnl.2018.25679.

Tarjan, R. 2018. "Will Mandatory Reporting of Health Professional Misconduct, Incompetence or Incapacity Make Patients Safer?" Canadian Journal of Nursing Leadership 31(3): 20–22. doi:10.12927/cjnl.2018.25681.