

**IN THE MATTER OF AN ARBITRATION**

**BETWEEN:**

**West Lincoln Memorial Hospital**

**-and-**

**Ontario Nurses' Association**

**Union Grievance Re: Palliative Care Nurse**

**Lorne Slotnick, Arbitrator**

**Representing the Union – Claudia Vicencio**

**Representing the Employer – Jane Gooding**

**Hearing – Grimsby, Ont., April 23, Oct. 5 and 8, and Nov. 17, 2009**

## **A W A R D**

In this grievance, the union seeks a ruling that a new classification of Palliative Care Nurse has been created and also seeks a new wage rate for the classification.

The employer is a 60-bed hospital in Grimsby, Ont., serving the western part of the Niagara Peninsula. The union represents about 130 registered nurses at the hospital, who are covered by a central collective agreement and some local appendices. Under the local provisions, all members of the bargaining fall under the single classification of Registered Nurse, with differences in pay rates tied only to years of experience. However, the union argues in this case that the hospital has, in effect, created a new classification of Palliative Care Nurse, and seeks recognition of it. The hospital says the employee in this position performs a job that has not changed significantly since it was created more than a decade ago, and that her job is comparable to that of many other nurses who work in specialized areas.

The union relies on the following language in the central collective agreement:

19.08 (a) When a classification in the bargaining unit is established by the Hospital or the Hospital makes a substantial change in the job content of an existing classification which in reality causes such classification to become a new classification, the Hospital shall advise the Union of such new or changed classification and the rate of pay established....If the matter is not resolved in the Grievance Procedure, it may be referred to Arbitration in accordance with Article 7, it being understood that any Arbitration Board shall be limited to establishing an appropriate rate based on the relationship existing amongst other nursing classifications within the Hospital and the duties and responsibilities involved.

Any change in the rate established by the Hospital either through meetings with the Union or by a Board of Arbitration shall be made retroactive to the time at which the new or changed classification was first filled.

The parties agreed that I would first determine whether a new classification has been created, and, if necessary, deal with the wage rate at a later hearing.

Palliative care, a term coined in the 1970s, aims to relieve suffering and improve the quality of life for patients who are dying, and their families. At West Lincoln Memorial Hospital, a nurse was first assigned to palliative care functions in the late 1990s for about five hours a week as part of a broader team. The evidence indicated that in 1999, a part-time 10-hour-per-week palliative care nurse position was posted and filled. By the time the nurse filling that position left in 2003, the position was up to 16 hours weekly. The job was posted and filled in 2003 as Palliative Care Resource Nurse and was still part-time. It remained within the sole classification in the bargaining unit. The next year, the hospital began participating in an externally funded study of the need for and effectiveness of palliative care in the West Niagara area. As part of this project, the hospital hired an advanced practice nurse who was excluded from the bargaining unit and who conducted research as well as provided palliative care. The union, which had not raised any concerns about the palliative care position that had been included within the bargaining unit, filed a grievance in 2006 challenging the exclusion of the advanced practice nurse. However, the union withdrew that grievance in 2007 after an assurance by the hospital that when the research project was over, it would be hiring a full-time palliative care nurse within the bargaining unit (the position at issue in this grievance.) Meanwhile, the part-time bargaining unit palliative care nurse had been laid off in 2006.

But the evidence indicated that the research project had demonstrated the need for a full-time palliative care nurse, and the hospital posted that position in the summer of 2007.

The nurse hired, Mary Catherine Rilett, is currently the incumbent.

While Ms. Rilett is employed by the hospital, she works as part of a group called the Niagara West Palliative Care Team. This team, which is a partnership of the hospital and the local Community Care Access Centre, consists of Ms. Rilett, a physician who specializes in palliative care, a bereavement support person, a psycho-spiritual counsellor and a case manager. Ms. Rilett is the only full-time member of the team. There is no question that Ms. Rilett's job is unique among the nurses at the hospital, partly because of her particular patient group and partly because she works as part of the team described above and follows patients through various care settings including their own homes and nursing homes, as well as the hospital. The question before me, however, is not whether the position is unique but whether the circumstances fall under Article 19.08 (a) of the collective agreement as a situation where the employer has made "a substantial change in the job content of an existing classification which in reality causes such classification to become a new classification." The union argues that Ms. Rilett's job has changed both qualitatively and quantitatively from the old part-time palliative care position, and now carries a level of skill, specialization, responsibility and autonomy that distinguishes it from the Registered Nurse classification occupied by all the other nurses at the hospital. The hospital responds that with the exception of being full-time, the current position is essentially the same as the position that existed before 2006, and does not warrant a status

different from that of many other nurses in the hospital who are specialists in one aspect of patient care.

Ms. Rilett gave detailed evidence about her job as palliative care nurse. I also received in evidence the posting for the job from 2007 and a job description from 2008. Ms. Rilett has been working in palliative care since 1992, and applied as an external candidate for the position in 2007. There is no doubt from the evidence that she is an expert in that field. She is certified as a hospice and palliative care nurse under the standards set by a national body, the Canadian Hospice Palliative Care Association. As noted above, in her current position she functions as part of a team that provides support to physicians and nurses at the hospital, at long-term care facilities and in the community. Patients are referred to the team by family doctors, by long-term care facilities, through the hospital or by the Community Care Access Centre. Once referred, the team follows the patient no matter where the patient is located, to ensure continuity and consistency. She described herself as the “hub of the team,” saying she co-ordinates who will visit the patient once there is a referral. However, the team does not take over care of the patient, but rather assesses needs and provides information to the front-line care providers, such as primary care nurses and physicians. One of the key roles is assisting in navigating the patient through the various parts of the health care system. Ms. Rilett said some of her time is also spent educating health care providers on aspects of palliative care. Along with several doctors, including the palliative care team doctor, Ms. Rilett rotates through an on-call schedule covering nights and weekends, so that calls can be taken when patients – some of whom are at home – have a problem. Ms. Rilett said she reports to

both Joyce Smith, a clinical manager at the hospital, and to Denise Marshall, the physician who is part of the palliative care team.

Asked what differentiates her from a hospital staff nurse, Ms. Rilett replied that hospital nurses are involved in primary care, implementing the patient's care plan, including administering medications and monitoring the patient's physical status, while she assesses and reassesses the care plan, determining where the goals of care can be met, following the patient from location to location, and often conferring with their family doctors. By knowing the patients and their families, she said, she can help ensure better continuity and comprehensiveness of care is delivered by the primary care providers. She also said he has a higher degree of autonomy than a hospital staff nurse, working mainly with Dr. Marshall rather than any supervisor at the hospital.

Ms. Rilett agreed the job description for her position prepared by the hospital and dated January, 2008, is an accurate representation of her job, and includes all aspects except for the on-call schedule. She acknowledged that many of the duties listed in the job description would be common to all nurses, although she said some items listed – such as “act as patient advocate and encourage others to be receptive to patient needs” – are areas of emphasis for her job, and others – such as following patients in their homes, and promoting palliative care in the hospital and community – are unique to her position.

On cross-examination, Ms. Rilett was shown a 2003 job description from when the palliative care position was part-time. She agreed the duties and responsibilities listed

and the experience required were essentially the same as her current position. The job summary for that position states that “the Palliative Care Resource Nurse is responsible for assessing referred patients and working together with the interdisciplinary teams in planning care to meet the identified needs of patients and families. The Palliative Care Nurse acts as a resource to physicians, nursing staff, other health professionals, community agencies and institutions. The Palliative Care Resource Nurse fulfills an important co-ordinating role for the West Lincoln Palliative Care Team. In addition, the Palliative Care Resource Nurse participates in education, research and public relations.”

I also heard evidence from the president of the ONA bargaining unit at West Lincoln, Louann Waugh, who is a nurse in the hospital’s emergency room and described her duties. Her job is clearly quite different from Ms. Rilett’s. Asked about her involvement in palliative care, she said she would assist in referring a patient to the palliative care team if the team were not already involved with that patient. She said she was not familiar with the standards of palliative care practice and does not follow patients beyond the emergency room where she works. She agreed that many nurses have a unique and specialized body of knowledge, such as obstetrics or operating room procedures.

Another union witness, Sharon Wintermute, is a charge nurse on the medical-surgical floor, known as C Ward. She said this ward has some palliative care patients, who she says are generally more time-consuming for nurses since the whole family is often involved. In the case of palliative care patients who have been involved with the team, she said, Ms. Rilett comes every morning and visits, and together with Dr. Marshall

advises the hospital staff on a plan. If the patient has not been involved with the palliative care team, she said, the hospital suggests to the family doctor that Dr. Marshall see the patient, and Ms. Rilett also gets involved. Ms. Wintermute added that where a palliative care patient or their family is in distress she has called Ms. Rilett or Dr. Marshall for advice, since they know more about the patient and the family than the bedside nurses do. This differs from the practice with other patients, where nurses are simply following the doctor's orders. She described Ms. Rilett as a specialist in palliative care, whereas other nurses may just know the basics. Like Ms. Waugh, she acknowledged that many nurses in the hospital, her included, have specialized knowledge in other areas. The main difference, she said, is that a nurse on the C Ward would contact a physician if they saw something wrong with a patient, whereas Ms. Rilett actually formulates a care plan, then contacts Dr. Marshall or the family doctor to get those orders.

Ms. Smith, the hospital's clinical manager for inpatient and complex continuing care, gave evidence for the hospital. She has been a nurse since 1975 and has been in her current position, which includes responsibility for palliative care, since 2005. Her evidence indicated she is familiar with the job duties of a wide range of nurses. Ms. Smith's portrayal of the palliative care nurse job did not differ markedly from Mr. Rilett's, and conformed to the job description that both agreed was an accurate reflection of the position. Many of those duties, she said, are common to all nurses, including ongoing assessment of patients, team meetings, sharing of information and knowledge, and acting as a patient advocate. However, she agreed that Ms. Rilett has specialized knowledge and certification, which she said is also true of nurses in the intensive care

unit, emergency department, obstetrics department and other areas of the hospital. She agreed that one difference between Ms. Rilett and other nurses is that Ms. Rilett follows patients beyond the hospital.

Ms. Smith said that when the research project was over in 2007 and the hospital decided to post the job for which Ms. Rilett successfully applied, the idea was that the job would have the same scope as it had had previously when it was a part-time position. The difference, she said, is that the research project had demonstrated that a full-time position was necessary. For that reason, the job postings from 2003 and 2007 are virtually the same, she said, and the nurses who held the position when it was part-time could do the job as it exists now. Aside from the move to full-time status, the only difference in the job is the on-call schedule, she said.

Ms. Smith also described the job of the geriatric nurse, which reports to her and which she characterized as a position similar to the palliative care nurse. I also received in evidence the job description for this position, which is dated December, 2000. Ms. Smith said patients are referred to the geriatric nurse and she conducts a full assessment, including visits to home or to a long-term care facility, in preparation for an appointment with the geriatrician who is at the hospital one day monthly. Both the geriatric nurse and the palliative care nurse conduct assessments, collaborate with a specialist and with the family doctor, perform much of their work outside the hospital, work largely autonomously and promote their services in the community.

The parties referred me to a number of relevant arbitration decisions, but there seems to be no disagreement about the applicable test in this matter, which was set out in a case referred to by both sides, *Re Nurses' Association Joseph Brant Memorial Hospital and Joseph Brant Memorial Hospital* (1972) 24 L.A.C. 104 (Hinnegan). In that case, dealing with similar language, the arbitration board said, (at page 112):

...in order to constitute a changed occupational classification ... there must be more than a mere change, addition to, or subtraction from the actual job content of a classification. Rather, there must be a substantial, qualitative change in the actual function performed by the employees in the classification. The employees' basic job function, subject of course to the *de minimis* principle, must have changed in fact even if not in name.

The union also drew my attention to *Re St. Joseph's General Hospital, Elliot Lake* [2008] O.L.A.A. No. 866 (Randall), in which the arbitrator found that the jobs performed by the two grievors had changed substantially over the years and that the duties performed by them were greater than those of other nurses at the hospital; *Re Victoria Hospital Corporation and Ontario Nurses' Association*, (1980) unreported (Carter); and *Re Selkirk and District General Hospital and Canadian Union of Public Employees, Local 1601* [1993] M.G.A.D. No. 9 (Hamilton), which notes that a gradual accretion to duties can, in time, constitute a substantial change.

The employer referred to *Re Hopital Regional de Sudbury Regional Hospital and Ontario Nurses' Association* (2008) unreported (Surdykowski), in which the arbitrator found that the main classification of registered nurse at that hospital was "populated by a diverse group of nurses with a broad spectrum of qualifications, certifications, skills and duties

and responsibilities.” (at parag. 34) The arbitrator in that case also says that in deciding cases under the language of 19.08 (a), “quantitative factors may be significant, but generally qualitative changes (including the changes in the focus or emphasis in job functions) tend to be more important.” Other cases referred to by the employer were *Re Toronto Western Hospital and Canadian Union of Public Employees* (1989) unreported (Marcotte); *Re Ottawa Hospital and Ontario Public Service Employees Union* (2003) 120 L.A.C. (4th) 21 (Kaplan), where the arbitrator concluded that only the methods of performing the job had changed, not the job itself; and *Re Hamilton Health Sciences and Canadian Union of Public Employees, Local 4800* [2005] O.L.A.A. No 118 (Carrier).

The union argues that the job that Ms. Rilett performs is substantially different from that performed by the part-time incumbents before 2006, since the current position is both the successor to the advanced practice nurse that was excluded from the bargaining unit for several years and product of the research study conducted by that nurse. In particular, the union says, the constant liaison with family doctors in the community could not have been performed by the previous incumbents before the research study made the service well known. Moreover, the palliative care nurse’s job differs substantially from that of other hospital nurses in a number of different ways, including the specialized body of knowledge, the high level of responsibility as a leader of the team, the high level of interaction with patients’ families, the increased level of autonomy in scheduling and the substantially different working conditions involving large amounts of time spent outside the hospital. Finally, while the union acknowledges the existing registered nurse

classification includes a broad range of jobs, it says the palliative care nurse position differs enough that it should not be part of that classification.

The employer responds that there is little aside from the hours of work that distinguishes the current full-time palliative care nurse position from its part-time predecessor. The employer points to the evidence that a wide range of skills and responsibilities is encompassed in the one classification of registered nurse in this collective agreement, including the position of geriatric nurse, which is most similar to the position at issue here. Differences between the palliative care nurse's job and that of other nurses are inherently linked to the patient group served, the employer says.

### **Decision**

While previous decisions applying the words of Article 19.08 (a) similar language are instructive, those decisions revolve around their particular facts, as this one must. As noted by some of the arbitrators in the awards cited above, the task here is not to decide whether there should be a new classification. That is a matter for the union and employer to discuss in bargaining, if one of the parties believes a separate classification is warranted. In a grievance arbitration under 19.08, the sole question is whether there has already been enough change that a new classification has, in reality, been created.

In assessing whether there has been “substantial change in the job content of an existing classification which in reality causes such classification to become a new classification,”

to use the words of Article 19.08 (a), there are two points of comparison relevant to this case: first, whether the job of palliative care nurse has itself changed substantially; and second, if that is the case, whether those changes have created a job that no longer is within the scope of the classification of registered nurse as used in the collective agreement. To succeed, the union must establish both points.

Despite a strong and well-framed argument, and despite demonstrating some important recent changes in the job of palliative care nurse, I have concluded that the union has fallen short of establishing that the position is, in reality, no longer part of the registered nurse classification. In reaching this conclusion, I give significant weight to the following facts:

First, I find it particularly important that the parties have only one job classification – that of registered nurse – for all of the approximately 130 employees in this bargaining unit. This is indicative of a strong presumption that, for the purpose of labour relations, this employer and the union have been guided by the view that a nurse is a nurse is a nurse. This does not mean that nurses are interchangeable. Clearly they are not: the evidence indicates that nurses within this single classification work in a variety of areas such as obstetrics, operating rooms, the intensive care unit, etc., where they have specialized knowledge and may require specific certifications; a nurse from one area of the hospital would not necessarily be capable of performing the job of a nurse in another area of the hospital. Yet despite these widely differing jobs, all the nurses are in the same classification under the collective agreement. Given the apparent intention not to create a

hierarchy of nurses and given the broad range of jobs under the umbrella of registered nurse classification, the union in my view bears a heavy burden in establishing that the job of palliative care nurse falls outside the sole existing classification.

Second, the evidence indicates that at least one position within the classification of registered nurse – the geriatric nurse – has many similarities to the palliative care nurse. The union's case on the palliative care nurse is largely based on the high level of responsibility and autonomy of the palliative care nurse, as well as the position's distinct working conditions, but it appears that the geriatric nurse works in a similar environment with similar duties and responsibilities. This position has existed for at least nine years, and Ms. Smith's evidence was that the geriatric nurse works large amounts of time outside the hospital, receives referrals of patients, performs assessments, collaborates with the geriatrician and outside agencies, works with the patient's family and promotes the service in the community. Ms. Smith testified that, like the palliative care nurse, the geriatric nurse is given great autonomy, for example, to schedule her own activities during her time at work. Much of Ms. Smith's evidence was confirmed by the 2000 job description for the geriatric nurse position. The union requested that I draw an adverse inference from the hospital's failure to call evidence from the incumbent in this job; however, the hospital did produce its evidence regarding this position, through Ms. Smith and the job description, and if the union wanted to contradict that evidence, it was incumbent upon the union, not the employer, to bring evidence from the incumbent. It did not do so. My conclusion on this point is that the classification of registered nurse under this collective agreement has for many years been broad enough to include a

position with many similarities to the palliative care nurse and with no complaint from the union.

Third, while the palliative care nurse clearly possesses a high level of skill and specialization, this fact alone does not distinguish Ms. Rilett or her job from that of many other nurses at the hospital. The fact that Ms. Rilett has certification in her specialty and sits on committees, for example, does not differentiate her from many other nurses in the registered nurse classification in the collective agreement. While there are clearly some differences between her job and those of the other nurses, those are largely a function of the different patient groups served. For example, Ms. Rilett's higher level of interaction with patients' families can be seen as part of the territory in dealing with palliative patients. In my view, many of the other specialized nurses could also argue that their area of specialization makes their job different from any other, but this in itself is not sufficient to say that a new classification has been created.

Fourth, while there have been some changes to the palliative nurse position in its new full-time form, I find it difficult to conclude that those changes qualify as "substantial" in the sense that that concept has been interpreted in the case law. Here again, the job descriptions are telling. The 2003 job description – from before the research project and when the job was part-time – notes the palliative care nurse's role as part of an interdisciplinary team and her participation in education and public relations. It specifies that the nurse is to advocate for the patient in all care settings, advise hospital staff where there are difficult issues related to palliative patients and follow some patients in their

homes. In summary, while there has been some rewriting and rearranging, the 2008 job description is unchanged in substance from the 2003 document. In her evidence, Ms. Rilett agreed the job descriptions were similar and that the 2003 document is an accurate description of her current job. She agreed that both provide a comprehensive picture of the job, except that neither mentions the on-call aspect. The on-call schedule, under which she is available to take calls on some evenings and weekends, splitting that duty with several doctors, is a change in the job from prior to when Ms. Rilett was hired. Added to that, of course, is the change in the position from part-time to full-time. I accept that a change from part-time to full-time hours for a position is an important one and can amount to a qualitative change in some circumstances. Here, in my view, the union has demonstrated that the change was accompanied by some increased responsibility because the palliative care team structure has become more formalized as a result of the research project. Ms. Rilett described herself as the hub of the team, and given that she is the only full-time member, I do not doubt that characterization. But this does not amount to a qualitative change in job function. The basic job function, to use the phrase from the *Joseph Brant* case cited above, has not changed. The union also argues that Ms. Rilett essentially performs the duties of the advanced practice nurse who was excluded from the bargaining unit for several years; however, that position appeared to differ little from the job as it has existed throughout, with the exception of a significant research component, which is not part of Ms. Rilett's position and which required an incumbent with a master's degree.

To summarize, while there have been some changes to the palliative care position, the union has not demonstrated that these amount to a substantial change in the content of the job, nor has the union demonstrated that the palliative care position is outside the scope of the one classification of registered nurse in this collective agreement. As noted above, the arbitrator has no mandate to consider whether a new classification ought to be created – that is an issue for the parties to discuss in bargaining, if they wish – but only to consider whether that new classification has, in fact, already been created. I have concluded that the registered nurse classification in this collective agreement is broad enough to include the palliative care nurse position.

For these reasons, the grievance is dismissed.



---

Lorne Slotnick, Arbitrator

December 15, 2009

