



IMPROVING PATIENT SAFETY THROUGH NURSE COLLECTIVE BARGAINING

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Abstract

Nursing workload and time worked are two key working conditions tied to the risk of adverse events and medical error. In Canada at the provincial level, these issues, which I call “patient safety issues”, are raised, negotiated and ultimately resolved within collective bargaining structures that are based on traditional “Wagnerist” labour law theory. I reviewed the results of decisions on patient safety issues within fifteen years of nurse collective bargaining in six of the thirteen provinces/territories. My findings are that patient safety issues of workload are inadequately addressed in nurse collective agreements, but at the same time these agreements contained strong patient safety-driven protections relating to time-worked issues of scheduling, hours of work and overtime. I further conclude that these limitations can be attributed to a series of trends in the process of nurse collective bargaining that tended to limit the ability of nurses’ unions to push for patient safety protections and more generally to marginalize patient safety issues in the bargaining process in favour of more traditional economic issues. To overcome these problems, I propose that patient safety issues in nursing be decided instead in locally-based “patient safety committees” instead of in the current traditional labour law model.

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INTRODUCTION, LITERATURE REVIEW AND OUTLINE

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Overview of Thesis

To improve decision-making on patient safety-related nursing issues, I recommend the following reforms to the provincial legal frameworks for nurse collective bargaining:

- a) All nursing employment issues related to nursing workload or time worked (hereinafter called “patient safety issues”) will be removed from the current nurse collective bargaining structures.
- b) Patient safety issues will instead be decided in locally-based “patient safety committees”.
- c) These “patient safety committees” would function like traditional collective bargaining, but incorporate participation by patient representatives and an emphasis on the use of evidence.
- d) There will be no right to strike or lock out in any dispute that arises in a patient safety committee. Disputes within the patient safety committee will be resolved by an adjudication process based on interest arbitration on the Ontario model but with significant modifications. Specifically:
 - i. Disputes would be decided by a tripartite panel of arbitrators from a standing roster of adjudicators. This standing roster will be comprised partly of existing labour arbitrators but also experts in nursing, health policy, and patient safety.
 - ii. Arbitrators would be required to apply more criteria, and ones based on patient safety-related evidence. Current criteria such as “ability to pay” are too broad and are seldom applied by arbitrators; they should be replaced with more specific factors such as “impact on the risk of adverse events”
 - iii. The arbitration process should be open to public view and include representatives of patients.

- iv. Arbitrators must give detailed, intelligible reasons, and their awards must be subject to review or appeal.
- e) Terms on nursing workload or time worked resulting from patient safety committees will take the form of regulation or by-law, and be enforceable through a system of consensual grievance arbitration similar to that found in nurse collective agreements.

I arrive at this programme of law reform after critiquing how patient safety issues are raised, negotiated and resolved within the current labour law model for nurses. My two-pronged critique is:

- (a) that the current outcomes of that model as embodied in nurse collective agreements do not provide sufficient protections against excessive nursing workload or time worked; and
- (b) trends in how patient safety issues are negotiated in nurse collective bargaining show that it is a poor process for the resolution of patient safety issues.

I elaborate on this argument below in my Chapter Outline. Before doing so, I will first show how this study is unique within the existing health policy literature on nursing and collective bargaining.

Glossary of Terms

Before embarking on a review of the literature surrounding this topic, it may be helpful for scholars outside labour law for me to give a brief glossary of common terms and concepts that will be discussed later.

“Employer” and “employee” are well-understood concepts and definitions. The hallmark of employment contracts is the exchange of wages for work, and specifically for the voluntary subordination of the employee to the wishes of the employer. It is a fundamentally hierarchical relationship.

“Employment law” is (a) the common law of employment, and (b) statutes regulating an array of matters. These include employment standards, health and safety, human rights and workers’ compensation statutes. They also include the collective bargaining statutes I discuss in Chapter 3. Constitutional law also plays a central role in labour and employment law, both in the division of powers over employment between the federal and provincial levels of government¹, and in the freedom of association guarantee found in section 2(d) of the *Charter*.² Where the employer is considered part of “government” to which the *Charter* applies³, *Charter* rights such as equality (section 15) have also been advanced in labour law forums such as grievance arbitration or labour relations boards.⁴

“Labour law” is considered the subset of employment law focused on providing employees a protected right to form unions and require their employers to negotiate exclusively with those unions. Labour law is primarily provincial in nature, although there is a separate labour law scheme for federally-regulated employers. Labour law at the provincial level consists of the general collective bargaining statutes applicable to private

¹ Labour and employment law are not explicitly mentioned in the constitutional division of powers between the federal and provincial levels of government in Canada. Rather, it has been held by a series of Supreme Court of Canada decisions that employment and labour relations fall primarily under the property and civil rights jurisdiction under section 92(13) of the *Constitution Act, 1867* (U.K.), 30 & 31 Victoria, c. 3. The federal government may only legislate in the labour relations field in relation to employers that are tied to another head of federal power such that they are a federal business, work or undertaking. For an extensive discussion of the federal-provincial division of powers in labour law, see G. Adams, *Canadian Labour Law* (Aurora, Ont.: Canada Law Book, current: loose-leaf updated), Part 2, Chapter III at paras. 3.50 – 3.130.

² *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 (“*Charter*”); *Health Services and Support -- Facilities Subsector Bargaining Assn. v. British Columbia*, 2007 SCC 27, [2007] 2 S.C.R. 391; *Ontario (Attorney General) v. Fraser*, 2011 SCC 20, [2011] 2 S.C.R. 3; *Saskatchewan Federation of Labour v. Saskatchewan*, 2015 SCC 4.

³ *Charter*, *supra* note 2, s. 32; *McKinney v. University of Guelph*, [1990] 3 S.C.R. 229, *Harrison v. University of British Columbia*, [1990] 3 S.C.R. 451, *Stoffman v. Vancouver General Hospital*, [1990] 3 S.C.R. 483, *Douglas/Kwantlen Faculty Assn. v. Douglas College*, [1990] 3 S.C.R. 570.

⁴ *R. v. Mills* [1986] 1 S.C.R. 863; *Weber v. Ontario Hydro* [1995] 2 S.C.R. 929 (whether labour arbitrator court of competent jurisdiction).

employers, any special statutes governing collective bargaining in public or other sectors, and the various regulations under these statutes. It also consists of the accumulated decisions of provincial labour relations boards in the many proceedings in which they are asked to enforce, apply or interpret the collective bargaining statute.

“Labour relations board” or “labour board” means the tribunal set up in each province to police the collective bargaining scheme enacted under the collective bargaining statute. These boards consist of a chair and a number of vice-chairs, and receive complaints from both employers and unions alleging various infringements of the statute. Common hearings by labour boards include complaints by unions that the employer has unfairly discouraged its employees from supporting the union, that the employer has retaliated against one or more workers for trying to organize a union, or has refused to bargain in good faith. Employers also commonly apply to labour boards to restrict or postpone strike activity they consider unlawful, and in other cases complain that a union has unfairly pressured its employees to support the union.

“Union” or “trade union” is an unincorporated entity that seeks to be “certified” under the labour relations statute as the “bargaining agent” for a group of employees called a “bargaining unit”. “Certification” is the act of the provincial labour relations board granting a union an exclusive right to represent employees in a given bargaining unit in their dealings with their employer. A union typically becomes certified after a majority secret ballot of the group of employees. Once a union is certified, the employer has a legal obligation to recognize the union’s exclusive bargaining rights and to negotiate with the union in good faith toward a collective agreement.

“Collective agreements” are not employment contracts. In a unionized workplace, the employment contract for each employee covered by the union is determined in a single “collective agreement” that is negotiated between the union and the employer. The employer does not bargain with employees individually; it may only bargain with the union. The resulting collective agreements set uniform terms and conditions of work for all employees covered by the union that negotiated them. Collective agreements cannot be enforced in courts, nor may a union go on strike during a collective agreement’s term. Instead, any disputes about the enforcement or interpretation of the collective agreement are funneled into a system of private arbitration called “grievance arbitration”.

“Grievance arbitration” is the legal procedure set up by collective agreements for the handling of complaints by either party that the other has breached the collective agreement in some way. Neither party may sue in court on the collective agreement. Rather, where an employee considers that a right of an employee under the collective agreement has been breached, the union brings that “grievance” to the employer. If the parties cannot agree, an independent tribunal called a “grievance arbitrator” or a “rights arbitrator” is appointed by the parties to hear the dispute and render a decision called an “arbitral award” or just an “award”. The arbitrator’s award is a binding judgment on the parties.

“Interest arbitration” is different from grievance arbitration because interest arbitrators write the terms of collective agreements for the parties themselves, whereas grievance arbitrators only interpret, apply and enforce those terms. As Chapter 3 will explain, Ontario uses interest arbitration in its hospital sector labour disputes, including those with nurses’ unions.

“Strike” means a cessation or interruption of work by a group of employees represented by a union undertaken for the purpose of attaining terms and conditions of employment. A “lock out” is akin to a strike by the employer: the employer shuts down operations and stops paying the workers as a means of applying pressure. Strikes are closely regulated by collective bargaining statutes: they are prohibited during the life of a collective agreement, and there are usually many legal conditions a union must meet before it can commence a strike that is lawful.

The Absence of Labour Law in Health Policy Discourse

This thesis fills an important gap in the existing literature and makes a unique contribution to the existing field of health law and policy. There have been no studies of labour law’s impact on health care policy decision-making in Canada, but a great many on a subject - nursing and nurse working conditions – conceptually adjacent to labour law. There has been an enormous literature on nursing working conditions, the nursing shortage, and the merits of various policy choices in what has become known as the “health human resources” (HHR) field. Within this literature, there is a vast amount of research focused on the relationships between nurse working conditions and the prevalence of medical errors: much of this literature is reviewed in Chapters 1 and 2. However, apart from a few US studies none of it looks at the background labour law structures that play a key role in shaping decision-making on issues affecting nurse working conditions.⁵

⁵ A small number of studies of the impact of nurses’ unions on patient health outcomes have emerged from the U.S. These include a line of studies published by U.S. researchers Joan Seago and Michael Ash which drew links between the presence of nurses’ unions in hospitals and the prevalence of adverse patient outcomes such as heart attacks: M. Ash, & J. Seago, “Registered Nurse Unions and Patient Outcomes” (2002) 32:3 *Journal of Nursing Administration* 143-151; M. Ash & J. Seago, “The Effect of Registered Nurses’ Unions on Heart-Attack Mortality”

This thesis also fills an important gap in the literature as it blends what are normally strict compartments of scholarship -- labour law and health law and policy. To a certain extent this absence of attention to labour law among Canadian health policy scholars is attributable to the common habit among all legal scholars to rigidly compartmentalize social and economic issues and phenomena. Labour law, for instance, is (at least in the Wagnerist mind) best designed, administered, enforced and written about by “experts” in industrial relations and collective bargaining. Similarly, health law and policy has developed an expertise of its own, in which analysts remain confined to traditional subjects within health policy and do not often extend their analysis into areas thought to be exclusively the domain of other groups of experts. Thus, even as institutions from a field outside health policy, such as labour law, can be shown to have important influence on decision-making and outcomes within health policy, a traditional reluctance to venture outside traditional boundaries of expertise can restrain commentary on those institutions.

This reluctance to cross the barriers erected by the concepts of expertise and specialization is unfortunate. Labour law as it operates in the health sector ought to be a focus of health policy, because it sets the environment in which important policy questions about the health care workforce are decided. Spending on the incomes of doctors, nurses and all other health care providers and others working in the health care system comprises a large part of public health care budgets. As well, the working conditions in

(2004) 57:3 *Industrial and Labor Relations Review* 422-461, online at http://courses.umass.edu/econ340/AshSeago_ilrr.pdf. More recently, a 2014 study by Ash *et. al.* found that unionized hospitals in California had lower mortality than non-union by a 6.8% margin. However, there have been no such studies in Canada: M. Ash *et. al.*, “What do Health Care Unions do?: A Response to Manthous” (2014) 52:5 *Medical Care* 393-397; see also C. Manthous, “Labor Unions in Medicine: The Intersection of Patient Advocacy and Self-advocacy” (2014) 52:5 *Medical Care* 387–392; and A. Dube *et. al.*, “Nurse Unions and Patient Outcomes” (Bonn, Germany: Institute for the Study of Labor, Discussion Paper No. 8259, 2014), online at <http://ftp.iza.org/dp8259.pdf>.

which doctors, nurses and others provide health services affect the quality and – as I focus on here – safety – of care. Decisions on these issues are very often made in collective bargaining, which is an institution designed and created by labour law. Thus, looking more closely at labour law would be a natural extension of health policy’s already extensive interest in the employment issues of health professionals, most notably nurses, who have bargained through their unions with governments for many decades within distinctly Wagnerist legal models (as will be outlined in more detail in the third chapter) of collective bargaining. This thesis, then, strives to bridge an important gap in the scholarship by transcending the divide between labour law and health law. It explores how the labour law model for nursing affects how nursing issues I define as having a significant public interest dimension are raised and decided. Because labour law and the collective bargaining structures for nurses that have emerged under it are an important forum of decision-making on “patient safety” issues as I define them in Chapter 2, it is important to look closely at how this particular forum of decision making operates.

[The Traditional Labour Law Approach to Health Care Collective Bargaining](#)

The literature on Canadian labour law is extensive, but almost all of it to date proceeds from the traditional North American theory of labour law model to which I will refer often in this thesis: “Wagnerism”. Wagnerism is embraced and explained in many key works of Canadian labour law scholarship.⁶ The 1980 book *Reconcilable Differences*⁷ by Harvard professor Paul Weiler is a leading example, as is the National

⁶ H. Arthurs, “National Traditions in Labor Law Scholarship: The Canadian Case” (2002) 23:3 *Comp.Lab.L.& Pol’y J.* 645-678.

⁷ P. Weiler, *Reconcilable Differences: New Directions in Canadian Labour Law* (Toronto: Carswell, 1980).

Casebook Group which has published and updated the *Labour Law: Cases, Materials and Commentary* text for Canadian law schools for more than 45 years.⁸

As Chapter 3 explains, Wagnerism sees the main functions of labour law as remedying the inequality of bargaining power between workers and employers, social justice in the employment context, protection of associational activities, and stable labour relations. Much of the scholarship on labour law in health care, then, has focused on how to adapt the “Wagner” model of collective bargaining rights and duties to the context of a publicly-funded essential service.

A subspecialty of Wagnerist literature thus emerged focused on “government employee” or “public sector” collective bargaining. The idea of unions and collective bargaining by public employees gained most of its traction when governments across North America expanded their activities in all areas of social and economic life in the second half of the 20th century. In the U.S., the classic early opponents of this extension were Yale Law School professors Harry Wellington, Ralph Winter and Clyde Summers.⁹ Wellington, Winter and Summers all argued that extending unions and collective bargaining to government employees would have a number of harms. Wellington and Winter argued that, while unions in the private sector must calibrate their demands against the reasonable capacity of the employer to pay for them, and must account in their bargaining tactics for the impact of available non-union labour, competition, and technological change, public sector unions have no incentives toward self-restraint in their

⁸ D. Beatty, “Labour Law in a Nutshell: The Influence of a National Casebook” (1996) 75 *Can.Bar Rev.* 35-67.

⁹ H. Wellington & R. Winter, “The Limits of Collective Bargaining in Public Employment” (1969) 78 *Yale L.J.* 1107; C. Summers, “Public Employee Bargaining: A Political Perspective” (1974) 83 *Yale L.J.* 1156-1200; C. Summers, “Public Sector Bargaining: Problems of Governmental Decisionmaking” (1975). *Faculty Scholarship Series*, Paper 3911, online at http://digitalcommons.law.yale.edu/fss_papers/3911.

bargaining demands because, quite simply, the government is never going to go out of business. Wellington and Winter further argued that inequality of bargaining power between employers and employees did not exist in the same way in the public sector because of the unique nature of the political forces that drove management decisions in public administration. In their view, it is a mistake to equate non-profit, monopoly public employers with for-profit competitive employers.¹⁰

In his articles, Professor Summers posited a tension between citizens on one hand and public employees on the other. He argued that one of the effects of extending collective bargaining to public employees would be to give public employees special rights in the political process over ordinary citizens. Public (or government) employees have, he argued, privileged access to power, and often receive priority in budgeting decisions because of this. He also said that public sector unions have their exclusive bargaining rights guaranteed by law, and often use this power to advance and entrench their political interests outside the bargaining process. Summers thus warned that unions can in effect become the brokers of power and access to public services. This happens, he argued, because unions often forge strategic alliances with beneficiaries of a public service, alliances based on a narrow coincidence of interest. The union's interest in the continued employment of its members coincides with the user group's interest in continued public provision of the service. Where this occurs, governments are hard pressed to respond to the political sympathy created by the union's highlighting of the plight of the user group

¹⁰ Wellington & Winter, "The Limits of Collective Bargaining in Public Employment", *supra* note 9 at 1111.

The result is that groups who are not strategically aligned with the unions suffer a political voice disadvantage relative to those who are aligned.¹¹

Summers argued that the government as employer must adhere to a sacred internal decision-making process – the democratic process - not found in the private sector context. How governments arrive at decisions – and what those decisions are – are of vital interest, are the essence of democracy. Private employers, on the other hand, are free to act as rigidly or as loosely as they wish, accounting to shareholders primarily. Thus, governments' decisions in collective bargaining – where it exists – are inherently political questions. “The notion that we can or should insulate public employee bargaining from the political process”, wrote Summers, “... is a delusion of reality and a denigration of democratic government.”¹² Summers concluded by arguing that governments must bring more transparency to negotiations, work harder to marshal public support for their positions, and institute mechanisms to hold politicians accountable for the choices they make in collective bargaining.

These American critics of collective bargaining in the public sector predicted that collective bargaining by public or government employees is essentially a political competition for resources between citizens (as payers via taxes and users of government services by need) and public sector workers. They predicted that public employee unions will – absent the usual checks and balances in the private sector labour relations context - push governments to increase tax rates or cut service levels. That is, said these scholars, governments will relent and concede to union demands, no matter how lavish,

¹¹ Summers, “Public Employee Bargaining: A Political Perspective”, *supra* note 9 at 1180-1181.

¹² Summers, “Public Sector Bargaining: Problems of Governmental Decisionmaking”, *supra* note 9 at 673.

because of the unusual political pressures brought to bear on them by the unions. The net effect of giving collective bargaining to public employees, in the eyes of these critics, was to give them special rights in the political process over ordinary citizens. Through their unions, public employees will have privileged access to power, and thus receive priority in budgeting decisions.

The basic parameters of the debate about unions in public employment had thus been set by the time collective bargaining began to penetrate Canadian health care. As publicly funded hospital and medical insurance evolved at different times in each province, so too did the collective bargaining structures in each province's health care system. Thus, along with public education, health care in Canada became an arena for conflict between public sector unions and governments. Throughout the 1960s and 1970s, a series of touchstone strikes in health care and education quickly drew attention to the tremendously political nature of public sector collective bargaining and to the risk to public safety and welfare caused by labour conflicts in these sectors.¹³ In Canada, then, the issue for labour lawyers in health care was how to adapt the Wagnerist labour law model to a sector in which work stoppages could jeopardize public safety. As explained below, this singular focus on protecting patients from unsafe care during strikes or lockouts became the dominant theme of labour law literature in Canadian health care.

¹³ For example, a 1964 labour dispute at a hospital in Trenton, Ontario triggered the legislative removal of the strike mechanism from hospital collective bargaining in Ontario the following year: see D. Johnston & I. McKenna, "Public Interest Disputes and Compulsory Arbitration: A Case Study of Hospitals in Ontario" (1975) 7:3 *Ottawa L. Rev.* 503; B. Adell *et. al.*, "The System of Labour Dispute Resolution in Ontario Hospitals and Its Application at Kingston General Hospital", in T. Hanami & R. Blanpain eds., *Industrial Conflict Resolution in Market Economies* (New York: Kluwer, 1987) 45, and A. Kruger, "Collective Bargaining in Ontario Public Hospitals" (1985) 40:1 *Relations Industrielles* 48.

The starting idea was that fairness required that all employees be treated equally regardless of the identity of their employer, which in turn meant that public sector workers, including those in the health care system, should have access to a model of labour law faithful to the fundamental precepts of Wagnerism but also one that accommodates the unique differences in public sector employment identified by Wellington, Winter and Summers.

Some writers focused on the problems caused by the sheer number of different unions in the health care sector.¹⁴ The remedy suggested by labour law scholars for the multiplication of unions in health care was to create and impose a smaller number of standard, fixed bargaining units divided along broad occupational lines. Provincial governments in Canada, at varying times and by different means, followed this recommendation and imposed standard bargaining units in health care.¹⁵ Under the standardized model, then, one bargaining unit is assigned for registered nurses (but in most cases not licensed practical nurses), another unit gathers in all other employees in other health professions, and another unit is for non-professional support staff (cleaners, cooks, laundry employees).

Other labour law scholars focused on the health care bargaining structure, asking whether collective bargaining should take place on a single-employer basis, as is the norm in the Wagner model, or on a multi-employer or sector-wide basis in which a council

¹⁴ See e.g. Johnston & McKenna, "Public Interest Disputes and Compulsory Arbitration", *supra* note 13, and for the evolution of bargaining unit structures in the British Columbia health care system, see J. Dorsey, "B.C.'s Health Sector Collective Bargaining Restructuring: An Unfolding Story" (1997) 5 *Can.Lab. & Emp.L.J.* 85.

¹⁵ See e.g. the fixed bargaining units prescribed by legislation in Alberta: *Regional Health Authority Collective Bargaining Regulation*, A. Reg. 80/2003, s. 2.

of local unions negotiates with an association of employers in that sector.¹⁶ The problem identified by labour law observers was the instability and lack of cost control created when health care (or other public sector) collective bargaining happened on a localized basis. As unions penetrated Canadian hospitals, it soon became clear that they could gain tactical advantages by coordinating bargaining between local hospitals. Provincial governments were passive funders of hospitals, and had a limited role if any at the collective bargaining table. The result was an escalation in the bargaining strength of nurses' unions and others in health care. Another consequence was an increased risk of instability in labour relations from one hospital to the next.¹⁷

Of most interest to labour law scholars focused on health care, however, has been the thorny issue of dispute resolution, and specifically how to reconcile the use of the strike mechanism with the need to protect the public from interruptions of "essential" health and social services such as police, fire departments, emergency first responders, and many if not most of those who work in the health care sector. The core problem is maintaining free collective bargaining without exposing the public – and patients specifically - to harm in the event of a labour dispute. On one hand, as Chapter 3 explains more fully, the right to strike is sacrosanct in the Wagner model of collective bargaining; on the other, work stoppages can cause real and irreparable harms to the public. This

¹⁶ See *e.g.* Dorsey, "B.C.'s Health Sector Collective Bargaining Restructuring", *supra* note 14.

¹⁷ Union strength in health care increased under local-by-local bargaining because each union local used gains won by other locals of the same union in different communities as precedents for yet more gains, which are then in turn used as precedents by other locals, leading to a rapid escalation of union demands. See Johnston & McKenna, "Public Interest Disputes and Compulsory Arbitration", *supra* note 13; Adell *et. al.*, "The System of Labour Dispute Resolution in Ontario Hospitals and Its Application at Kingston General Hospital", *supra* note 13; and L. Haiven, "Industrial Relations in Health Care: Regulation, Conflict and Transition to the 'Wellness Model'," ch. 11 in G. Swimmer & M. Thompson eds, *Public Sector Collective Bargaining in Canada: Beginning of the End or End of the Beginning* (Kingston, Ont.: IRC Press, 1995) 236-271 at 240.

issue has garnered by far the most interest in the literature on health sector collective bargaining, in part because of the frequency it arises in real life: almost every round of collective bargaining in the health care or other public sectors can turn into a pitched battle of wills between unions and governments in which the threatened or actual use of the strike, and threatened or actual legislation to outlaw it, come to dominate the debate and crowd out all other considerations.

In 1967, Professor Harry Arthurs was among the first scholars in Canada to write about what came to be known as the “essential services” issue.¹⁸ Arthurs noted that, unlike in the U.S., Canadian legislatures had accepted the expansion of the Wagner model of collective bargaining to the public sector, and by doing so raised the essential services question:

The general trend in public employment, then, is to discard the constitutional and political mythology of sovereign immunity. This new and realistic approach, however, has its price. For the first time it has become necessary to distinguish general governmental functions from those whose continued operation is essential to the health, safety and well-being of the community. Some means had to be found for identifying these essential functions, and for giving due weight to their special characteristics in the settlement of disputes.¹⁹

In *Reconcilable Differences*, Professor Paul Weiler aptly described the policy dilemma in “essential services” sectors. Weiler called this problem the “perennial issue in governmental collective bargaining”, adding that “[i]n my experience, debates about public employee strikes tend to degenerate into sloganeering.”²⁰ On interest arbitration, he stated:

Advocacy of binding arbitration is now de rigueur across a wide spectrum of opinion among politicians and pundits. They consider arbitration not a painful necessity, but a

¹⁸ H. Arthurs, “Public Interest Labor Disputes in Canada” (1967) 17:1 *Buff. L.Rev.* 39-64.

¹⁹ *Ibid.* at 45.

²⁰ Weiler, *Reconcilable Differences*, *supra* note 7 at 218.

positive virtue. On the one hand, public employees will not be treated as second-class citizens, left to the not-so-tender mercies of their employers. Even better, the rival positions of governments and unions will be appraised on their merits, in a rational judicial forum, rather than settled by crude economic warfare whose fall-out is largely felt by innocent members of the general public.²¹

Later, Professor Weiler appealed to the core Wagnerist values of voluntarism and bargaining equality in explaining the claims for interest arbitration further:

If we pull all the teeth of a union by requiring provision of imperative public safety services, such that any remaining strike option does not afford the union significant bargaining leverage, then I believe the union should have access to arbitration at its option.²²

This passage was cited by the Supreme Court of Canada in its 2015 decision enshrining the right to strike as a constitutionally protected activity, in support of its holding that, for any restrictions on the right to strike to even have a chance to be saved under section 1, the government must offer interest arbitration as an alternative.²³ However, Weiler ultimately concluded that the replacement of the right to strike with interest arbitration created disincentives to voluntary settlement of disputes. He argued:

Theory predicts and experience confirms that the prospect of binding arbitration has a dampening, though not a chilling effect on earlier negotiations. Over a period of time the parties become habituated to third-party intervention. The ready availability of arbitration makes them more and more inclined to use it.²⁴

The most recent, comprehensive and systematic study of the “essential services” problem was by Professors Bernard Adell, Michel Grant and Allen Ponak.²⁵ The authors studied three different models of dispute resolution used in essential service sectors

²¹ *Ibid.* at 224.

²² *Ibid.* at 237.

²³ *Saskatchewan Federation of Labour v. Saskatchewan*, *supra* note 2.

²⁴ Weiler, *Reconcilable Differences*, *supra* note 7 at 229.

²⁵ B. Adell *et. al.*, *Strikes in Essential Services* (Kingston, Ont.: IRC Press, Queen’s University, 2001); see also B. Adell, “Regulating Strikes in Essential (and Other) Services after the ‘New Trilogy’” (2013) 17:2 *Can.Lab.& Emp.L.J. Online*.

(including health care): the “no-strike” model, the “unfettered strike” model, and the “designation” model. They evaluated them against four criteria:

- a) How well they maintained the provision of services essential to public health and safety;
- b) The extent to which negotiations over which services will be maintained in the event of a work stoppage negatively affect the “efficiency” of the main collective bargaining process;
- c) How well the dispute resolution model encourages settlement (i.e. does it encourage voluntary settlement or lead to dependence on third party intervention to resolve disputes); and
- d) Whether the outcomes of bargaining are acceptable to employers, employees and the public.²⁶

The authors concluded that the “unfettered strike” model has the advantage of encouraging settlements; however, under this model the unions have greatest power to determine essential service levels and this potentially gives them enhanced bargaining strength.²⁷ They found that the “no-strike” (arbitration) model was really only popular in Ontario, concluding that “[l]abour relations for hospital nurses in Ontario have been much more stable than in jurisdictions where they are governed by other dispute resolution models.”²⁸ Outside Ontario, resistance to arbitration remained strong, especially in Alberta, found the authors. Finally, they determined that the “designation” model does the best at protecting essential services, where the parties negotiate essential service levels and disputes over essential services are resolved by a third party applying objective principles of essentiality. On the criterion of collective bargaining efficiency, the unfettered strike model is the best, and the designation worst. Interest arbitration eliminates the need

²⁶ *Ibid.* at 150-160.

²⁷ *Ibid.* at 188-189.

²⁸ *Ibid.* at 189.

to negotiate essential services but it slows down bargaining.²⁹ On the criterion of voluntary settlement, the authors found that, if the essentiality of the services in question is low, the unfettered strike model is best, and if it is high, the designation model is best, because under an unfettered strike model, if the essentiality is high there is likely to be legislative ad hoc intervention to end the dispute.³⁰ And on the criterion of acceptability of outcomes, views of the no-strike model varied from Alberta, where the UNA and other health care unions reject it, to Ontario where the ONA were happy with the system as it has worked to date.³¹

As the foregoing shows, the vast bulk of the literature on health care collective bargaining has focused on trying to adapt the Wagner Act model of labour law to a specific context: a publicly funded, monopoly essential service, the lack of which poses a significant patient safety risk. The task of the labour law literature has been to ask how the traditional Wagnerist aims of voluntarism, associational freedom, bargaining equality and industrial peace can be achieved in this context. This limited vision of patient safety, however, did not inquire more broadly on the patient safety impacts of the outcomes of collective bargaining disputes, in the form of collective agreement terms that shape the nursing workplace in which adverse events arise. There is room in the literature for a study of the labour law structures for nurses from a non-traditional standpoint: the interaction between those structures and the interests of patients. In this study, I am concerned with patient safety not only during strikes and lockouts, but always. Thus, I am asking how the outcomes of nurse collective bargaining on patient safety-related issues

²⁹ *Ibid.* at 195-196.

³⁰ *Ibid.* at 197.

³¹ *Ibid.* at 199.

– decisions which often arose from disputes – affect the prospects for improving patient safety.

Scope of Study

In this study, I focus on collective bargaining by nurses. In Canada, nurses comprise a large part of the total health care workforce. By 2012, it was estimated that more than 365,000 nurses of all classifications are working in Canada, an 8 per cent growth since 2008, a pace that exceeds the rate of growth in the Canadian labour force generally.³² Approximately 292,883 of these are registered nurses, although many licensed practical nurses (LPNs) (or “registered practical nurses” in Ontario) also work in the system.³³ In most provinces, nurses may also now undertake additional training to be licensed as “nurse practitioners” or “extended certificate” nurses.³⁴ These nurses may perform diagnoses and write prescriptions for a range of common ailments. The number of nurse practitioners has increased steadily since 2010, from 2,554 in 2010 to more than 4,300 in 2015.³⁵ Nursing also has many sub-specialties, including emergency treatment, surgery, maternity, community care, palliative care, psychiatry, occupational health, and oncology.

³² Canadian Institute for Health Information (“CIHI”), *Registered Nurses, 2012: Summary Report*, online at <https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC2385&lang=en> (the “2012 Nurses Report”) at 3; Canadian Federation of Nurses’ Unions, “Nursing Workforce Backgrounder” (2013), online at http://nursesunions.ca/sites/default/files/2013.backgrounder.nursing_workforce.e.pdf.

³³ *Ibid.* at 3.

³⁴ The number of Nurse Practitioners doubled from 1,344 to 2,777 between 2007 and 2011: see CIHI, *Regulated Nurses: Canadian Trends, 2007 to 2011*, online at http://www.cihi.ca/cihi-ext-portal/internet/en/document/spending+and+health+workforce/workforce/nurses/ADVISORY_10JAN13 (the “2007-2011 Report”) at 3.

³⁵ Canadian Nurses Association, *2010 Workforce Profile of Nurse Practitioners in Canada*, online at https://cna-aiic.ca/~media/cna/page-content/pdf-en/2010_np_profiles_e.pdf; CIHI, *Regulated Nurses, 2015* at 10, online at https://secure.cihi.ca/free_products/Nursing_Report_2015_en.pdf.

Why do I restrict my focus to nurses? Collective bargaining occurs with many occupational groups in health care; there are almost as many different bargaining relationships as there are health professions. There are many different providers in the health care system, each represented by a union or professional association. Issues of patient safety surely involve all providers, from physicians to nurses to non-licensed support staff. In my view, nurses are the most representative of these for study, for several reasons. First, nurses are, by their numbers, the largest of the regulated health professions. As of 2011, 42.7% of health professionals in Canada were nurses (including LPNs, RNs and Nurse Practitioners); 10.3% were doctors. Nurses comprised almost as large a portion as all other non-physician health professions combined (47%).³⁶ Nurses are also by far the largest group of regulated health professionals to provide their services through the traditional employment relationship.³⁷ Because employment is their primary mode of engagement with the health care system, nurses are also the largest health profession to have employment terms and conditions of work determined through the traditional Wagnerist labour law model.

Like all regulated health professions, nurses are governed by provincial self-regulatory bodies called Colleges. Nurses must obtain licensure from provincial nursing

³⁶ CIHI, *Canada's Health Care Providers, 1997 to 2011 - A Reference Guide: Overview and Methodological Notes*, Table 3, "Number of Health Personnel, 1997 and 2011, and Regulatory Environment for Selected Groups of Health Professionals, Canada, 2012" at 9; and Figure 2, "Distribution of Health Personnel in Canada, 1997 and 2011" at 11, online at <https://secure.cihi.ca/estore/productFamily.htm?pf=PFC2161&lang=en&media=0>.

³⁷ A small but growing number of nurses, mostly nurse practitioners (or "extended class" nurses), work as independent contractors with doctors and others as part of primary health care teams. See D. Way *et. al.*, "Implementation Strategies: 'Collaboration in Primary Care – Family Doctors & Nurse Practitioners Delivering Shared Care'", Discussion Paper for the Ontario College of Family Physicians (Toronto: OCFP, 2000), online at <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.458.383&rep=rep1&type=pdf>.

regulatory Colleges³⁸, creatures of statute³⁹ which prescribe numerous clinical practice and ethical guidelines⁴⁰ with which all nurses must comply or face disciplinary sanctions.⁴¹ Colleges also set certification requirements for licensed practical nurses and nurse practitioners. Under provincial nursing legislation, only duly-licensed registered nurses (or their lawful delegates) may perform certain treatment procedures called “controlled acts”⁴² Other legal constraints on nurses include duties under consent-to-treatment and substitute decision-making legislation, which governs the provision of medical treatment to patients lacking decision-making capacity.⁴³ Similarly, nurses also have duties under health information privacy legislation to safeguard patient information.⁴⁴ For example, Ontario’s *Personal Health Information Protection Act* requires that nurses (and all other health providers) obtain consent from patients before the collection, use or disclosure of

³⁸ See e.g. College of Nurses of Ontario, online at <http://www.cno.org/>; College of Registered Nurses of British Columbia, online at <https://www.crnbc.ca/Pages/Default.aspx>; Saskatchewan Registered Nurses’ Association, online at <http://www.srna.org/>.

³⁹ **Ontario:** *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, *Nursing Act, 1991*, S.O. 1991, c. 32; **British Columbia:** *Health Professions Act*, R.S.B.C. 1996, c. 183; *Nurses (Registered) and Nurse Practitioners Regulation*, B.C. Reg. 284/2008; **Saskatchewan:** *Registered Nurses Act, 1988*, S.S. 1988-89, c. R-12.2.

⁴⁰ Canadian Nurses Association, *Code of Ethics for Registered Nurses* (2008 Centennial Edition), online at <https://www.cna-aicc.ca/~media/cna/files/en/codeofethics.pdf>; College of Registered Nurses of Nova Scotia, “Code of Ethics for Registered Nurses”, online at <http://crnns.ca/practice-standards/code-of-ethics/>; College of Registered Nurses of Nova Scotia, “Standards of Practice for Registered Nurses” (Effective January 16, 2012), online at <http://crnns.ca/wp-content/uploads/2015/02/RNStandards.pdf>.

⁴¹ See, e.g., Ontario: *Nursing Act, 1991 – Professional Misconduct Regulation*, O.Reg. 799/93, online at <http://www.cno.org/en/learn-about-standards-guidelines/standards-and-guidelines/>.

⁴² See, e.g., Ontario: *Nursing Act, 1991*, *supra* note 39, ss. 3-5, and *Regulated Health Professions Act, 1991*, *supra* note 39, s. 27 (controlled acts) and s. 28 (delegation).

⁴³ All health providers must comply with provincial legislation governing consent to treatment and substitute decision-making by patients lacking capacity. See e.g. (Ontario) *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, *Substitute Decisions Act, 1992*, S.O. 1992, c. 30; (B.C.) *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181; (Manitoba) *Health Care Directives Act, The*, C.C.S.M., c. H27; (Nova Scotia) *Personal Directives Act*, S.N.S. 2008, c. 8.

⁴⁴ Health information privacy legislation now exists in many provinces. See (Ontario) *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sch. A; (B.C.) *Personal Information Protection Act*, S.B.C. 2003, c. 63; (Manitoba) *Personal Health Information Act*, C.C.S.M., c P33.5; (N.S.) *Personal Health Information Act*, S.N.S. 2010, c. 41.

their health information other than in the course of medical treatment.⁴⁵ And where an adverse event occurs during treatment in which nurses were involved, patients often sue the nurses involved as co-defendants with the other staff and facilities who participated in treatment.⁴⁶ Thus, in addition to their obligations as employees of hospitals and other health facilities, nurses are bound by many other legal rules and institutions.

Unlike physicians and some other health professionals who bill provincial insurance plans on a fee-for-service basis, most nurses in practice are salaried employees of public health care employers. Despite the shift in the health care system from hospital-based to community-based care, hospitals are still the leading employers of nurses (about 61% as of 2012)⁴⁷, while other common nurse employers include (in descending proportions) nursing homes, long-term care facilities, home care firms, and independent health facilities.⁴⁸ As well, most nurses (approximately 60%) still work in full-time positions.⁴⁹

Consequently, as employed health professions, nurses are covered by extensive and entrenched labour relations structures. This is due largely to the hospital-centered origins of the Canadian system. After hospitals in each province became funded predominantly by provincial governments, they became, like all public sector employers, ripe targets for unionization beginning in the late 1960s and early 1970s. Before long, the

⁴⁵ *Personal Health Information Protection Act, 2004*, *supra* note 44, s. 29.

⁴⁶ For a good overview of the tort law system applicable to nurses and hospitals, see J. Morris *et. al.*, *Canadian Nurses and the Law* (Toronto: Butterworths, 1999) ch. 9, "Nursing Malpractice" at 151-188. See *e.g. Fisher v. Attack*, 2008 ONCA 759, [2008] O.J. No. 4481, 62 C.C.L.T. (3d) 1, where the Court of Appeal ordered a new trial in a case brought against a hospital and several nurses for damages arising from asphyxia to a newborn, leading to cerebral palsy.

⁴⁷ 2012 Nurses Report, *supra* note 32 at 3; 15.4% of nurses worked in community, and 9.6% in long term care.

⁴⁸ *Ibid.* at 3.

⁴⁹ *Ibid.*

entire Canadian hospital sector, with few exceptions, was just as dense with unions as the rest of the Canadian public sector. Therefore, the collective bargaining structures between nurses' unions and provincial governments are the result of several decades of experience, debate and refinement. As such, they provide the best example of the operation of a traditional labour law model in the contemporary health policy context.

The six provinces that I have chosen to study are representative of the labour law models for nurses found in all thirteen provinces and territories. As Chapter 3 explains in more depth, they all fundamentally share Wagnerist origins, but they are also a balanced sample of different contexts and legal approaches for analysis. They are regionally balanced: all four western provinces, one of the two large central provinces, and one of the four Atlantic provinces. They are also balanced between size and economic scale from small and fiscally challenged (Nova Scotia, Manitoba) to large and fiscally strong (Ontario, Alberta).⁵⁰ And the six provinces display the full range of labour law models for nurses found across Canada. They encompass the most centralized bargaining structures (British Columbia, Alberta) to structures with a mix of central and local bargaining (Ontario, Manitoba). And most importantly they capture the full diversity of dispute resolution methods found across all provinces: from the “no strike” model of interest arbitration used in Ontario to the “limited strike” models in force in the other five provinces studied here.

⁵⁰ Of the ten provinces, Ontario had the highest Gross Domestic Product (GDP) in 2014 (\$722 billion) followed by Alberta (\$376 billion). British Columbia had the fourth-highest GDP (\$237 billion). By contrast, the 2014 GDP of Saskatchewan (\$82 billion), Manitoba (\$64 billion) and Nova Scotia (\$39 billion). See Statistics Canada, “Gross domestic product, expenditure-based, by province and territory”, online at <http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/econ15-eng.htm>.

I use a 15-year (1999-2014) time frame that spans the decade since the watershed 2004 Baker-Norton study on adverse events in Canadian hospitals,⁵¹ a time when patient safety rapidly increased as policy priority. This time frame also spans the years since 2000, when the federal government began increasing its transfers to the provinces for health care, and during which provincial governments began aggressively seeking efficiencies in how the new funding was to be spent. During this time frame, nurses' unions have been equally aggressive in demanding more nursing hires, higher wages, better hours of work and lower workloads, citing a chronic shortage of nurses and the risks to patient safety of nurse understaffing and overwork. Thus, the policy climate in this period has fostered the emergence of the patient safety – efficiency tension in a range of nurse bargaining disputes across a fifteen-year span.

Chapter Outline

Chapter 1

In Chapter 1 I describe the constancy of the “efficiency imperative” in health policy, and argue that efficiency poses a formidable obstacle even to pursuit of policies that are universally supported by all stakeholders and actors in the system. This is the case with patient safety: efficiency acts as a constant counterweight to the pursuit of patient safety, even as patient safety is a formidable goal. It is important to understand this efficiency-patient safety tension to properly understand my critiques in Chapters 4 and 5 of how nurse collective bargaining has resolved patient safety issues.

⁵¹ R. Baker, & P. Norton, “The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada” (2004) 170:11 *Canadian Medical Association Journal* 1678 – 1686.

Thus, my first chapter will explain and situate these goals more concretely within the broader context of the current challenges facing Canadian health care. Beginning with patient safety, I show that prevention of medical errors during patient care in hospitals and other settings has been the subject of much study and policy debate. Adverse events include medication errors, poor hygiene or infection control, and other harms to patients arising from errors in the care process. The landmark 2004 Baker/Norton study of adverse events in Canadian hospitals found that 7.5 per cent of the patients – or about 185,000 patients a year – suffered at least one adverse event.⁵² It found that almost 40 per cent of those errors were preventable. Between 9,000 and 23,000 people die annually from preventable error, they concluded. Also in 2004, the Canadian Institute for Health Information (CIHI) reported that 24% of Canadians surveyed said that they or a family member had experienced a preventable adverse event in the previous two years, and more than half said the most recent event had “serious consequences”.⁵³ In 2005, CIHI’s survey of Canadian nurses reported that 18% of nurses said that “occasionally or frequently” patients received the wrong medication or dosage in the previous year, and that 35% of patients acquired a nosocomial infection.⁵⁴ In 2007 CIHI reported that one in 10 patients surveyed reported medication errors in the previous two years; three in 20 reported an adverse event, and almost half of those resulted in a “serious health problem”.⁵⁵ CIHI has also reported on the “mortality ratio” of Canadian hospitals, which

⁵² *Ibid.*

⁵³ CIHI, *Healthcare in Canada, 2004 (Part A: Focus on Safe Care)* at x, online at

<https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC375&lang=fr&media=0c>.

⁵⁴ CIHI, *Findings from the 2005 Study of the Work and Health of Nurses* (CIHI, 2005) at 34, online at <http://www.hc-sc.gc.ca/hcs-sss/pubs/nurs-infirm/2005-nurse-infirm/index-eng.php>.

⁵⁵ CIHI, “Analysis in Brief - Patient Safety in Canada: An Update” (2007) at 18, online at

https://secure.cihi.ca/free_products/Patient_Safety_AIB_EN_070814.pdf. Hospital-acquired infections were among the most common types of adverse events reported. The report also reported that more than 1,700 birth

“compares the actual number of deaths in a region or a hospital to the number that would have been expected based on the types of patients a region or hospital treats.”⁵⁶

I then turn my attention to efficiency, which I describe as a principle of health policy that is often invoked in response to calls for more investments to improve patient safety. I will not embark on a wide-ranging discussion of efficiency as a general principle, nor on a critique of the weight accorded to efficiency in public sector administration and health care, as both subjects have been well addressed elsewhere. Rather, I will focus on how efficiency is manifested and expressed across many settings in health care today.

Efficiency and patient safety are in constant tension. Governments may question whether limitless amounts of resources should be devoted to reducing patient risk, given that applying resources to that use is a trade-off in the form of fewer resources for other important services in the system. The question, they might argue, is determining which specific investments in patient safety have the most effectiveness, and shifting resources away from investments with only a marginal impact on safety. However, I argue, governments are also very susceptible to short-sighted and politically safe decision-making in health policy and nurse collective bargaining which can compromise patient safety. The impact of “efficiency” as an imperative will be seen in Chapters 4 and 5 as it operates to motivate governments to resist nurses’ union proposals on patient safety issues.

traumas occurred each year, leading to longer hospital stays for mothers and infants. It also reported that more than 200 foreign objects were left inside patients in the previous two years.

⁵⁶ CIHI, *HSMR: A New Approach for Measuring Hospital Mortality Trends in Canada* (2007) at 6, online at https://secure.cihi.ca/free_products/HSMR_hospital_mortality_trends_in_canada.pdf.

Chapter 2

Chapter 2 is crucial because it seeks to establish the evidentiary basis for my starting premise: that nursing workload and time worked are issues the resolution of which has a significant and demonstrable connection to the rates of adverse patient events. Because of these connections, I argue that nursing workload and hours worked are properly called “patient safety issues”, with a strong element of public interest to accompany the fundamentally private nature of employment issues. That is, these issues are normally thought of as matters of contract between two private actors, with no wider importance. I argue, however, that they do have a wider importance based on the existing evidence linking them to the risk of adverse events.

There is a large body of published research that explores the link between nurse working conditions and the risk of medical error. CIHI's 2005 survey of Canadian nurses, for example, found that nurses working overtime were more likely to report a medication error, and other relationships between working conditions and medical errors.⁵⁷ Similarly, research by the Canadian Nurses' Association found that long working hours and on-the-job fatigue for nurses increase the risk of adverse events.⁵⁸ Other academics have published research linking nurse staffing models (proportion of RN to non-RNs in a team) to patient safety outcomes.⁵⁹ Other studies have focused on the patient safety effects of

⁵⁷ CIHI, *Findings from the 2005 Study of the Work and Health of Nurses* (CIHI, 2005), *supra* note 54 at 34, online at <http://www.hc-sc.gc.ca/hcs-sss/pubs/nurs-infirm/2005-nurse-infirm/index-eng.php>.

⁵⁸ Canadian Nurses' Association *et. al.*, *Nurse Fatigue and Patient Safety: Research Report* (2010), online at https://www.cna-aicc.ca/~media/cna/page-content/pdf-fr/fatigue_safety_2010_report_e.pdf?la=en; CNA, “Long Working Hours of Hospital RNs Associated With Increased Errors” (2010), online at https://www.cna-aicc.ca/~media/cna/page-content/pdf-en/rs_long_working_hours_e.pdf?la=en.

⁵⁹ *E.g.* L. Hall *et. al.*, “Nurse staffing models, nursing hours, and patient safety outcomes” (2004) 34:1 *Journal of Nursing Administration* 41-45, online at http://journals.lww.com/jonajournal/Abstract/2004/01000/Nurse_Staffing_Models,_Nursing_Hours,_and_Patient.9.aspx; C. Duffield *et. al.*, “Nursing staffing, nursing workload, the work environment and patient outcomes” (2011)

nursing work schedules, workflow interruptions and sleep disorders.⁶⁰ However I will give first priority and the most weight to systematic reviews of research. Systematic reviews have the most weight as scientific evidence because they provide the results of a rigorous review of hundreds and sometimes thousands of individual studies. In doing systematic reviews, scholars devise a comprehensive method of searching for studies and a rigorous set of criteria for determining whether to include them. The reviewers then synthesize and report the results of the studies that they have included. In the nursing realm, my findings are that there is by 2015 a critical mass of knowledge, catalogued by numerous systematic reviews, that connects nursing workload and time-worked issues to patient outcomes and specifically the rates of adverse events.

Chapter 3

In my critiques in Chapters 4 and 5, I tie the trends observed in nurse-government bargaining back to the deeper norms underlying the legal structures which constitute these bargaining structures. Thus, it will be important to explain these norms, and I will strive to do so in Chapter 3. The negotiation structures in which nurses' unions and governments bargain are formal legislative mechanisms within which bargaining relationships have evolved between nurses' unions, hospitals and other health care

24:4 *Applied Nursing Research* 244-255, online at

<http://www.sciencedirect.com/science/article/pii/S0897189709001311>.

⁶⁰ See e.g. A. Elfering *et. al.*, "Workflow interruptions, cognitive failure and near-accidents in health care" (2015) 20:2 *Psychology, Health & Medicine* 139-147; F. Gartner *et. al.*, "Impaired work functioning due to common mental disorders in nurses and allied health professionals: the Nurses Work Functioning Questionnaire" (2012) 85:2 *International Archives of Occupational and Environment Health* 125-138; and J. Geiger-Brown *et. al.*, "The Impact of Work Schedules, Home, and Work Demands on Self-Reported Sleep in Registered Nurses" (2011) 53:3 *Journal of Occupational and Environmental Medicine* 303-307.

employers, and provincial governments. These legislative structures are fundamentally based on the “Wagnerist” theory of labour law discussed above.

I trace the evolution of the Wagner model from its origins in the U.S. to its introduction to the Canadian government and public sectors, including the spread of collective bargaining to Canadian public hospitals, and finally to the formation in each province of nurses’ unions. I also explain some of the unique ethical challenges for nurses engaged in collective bargaining, foremost among them the ethics of engaging in strike action to support bargaining demands. Nurses’ unions, I show, have been a strong defender of nurses as well as the professional values they bring to the workplace. They see themselves as having a dual role as advocates for both nurses and their patients, and have used the tools available to them under the Wagner model of collective bargaining to advance these interests.

Chapter 4

In Chapter 4 I turn to analyzing the outcomes of the nurse collective bargaining structures on patient safety issues. I begin this analysis by first looking at the most immediate and obvious outcomes: existing nurse collective agreement terms governing nurse workload or time worked. To demonstrate this claim, I examine and explain the relevant parts of the collective agreements between the nurses’ unions and hospitals or health regions (depending on the province) in each of the six provinces under review. Each of these agreements is central in nature, meaning that it covers all nurses in a province who are employed by health regions or hospitals. From each of these agreements I have extracted the provisions dealing with workload, hours of work and scheduling, and analysed them from the standpoint of their potential to reduce adverse

events. I argue that within these collective bargaining structures, nurses' unions have been able to achieve some important contract terms that regulate time worked. However, protections against excessive nurse workload remain elusive. On a whole, I conclude, more could be done in nurse collective agreements to advance patient safety interests.

Chapter 5

In Chapter 5, I turn to critique how patient safety issues have been raised and debated in nurse-government collective bargaining in the past two decades. I ask if and to what extent it has been an issue in these negotiations and, if so, how the outcomes of these negotiations incorporated patient safety norms, if at all. I will explore how patient safety claims and bargaining demands are contested between nurses' unions and governments in a selection of key negotiating "rounds" in various provinces in the past twenty years. This selection consists of nursing labour disputes in which patient safety was invoked as a value or justification for one or more bargaining demands. It thus encompasses all the nursing labour disputes in which patient safety was set in opposition to the goal of efficiency, and provides an objective account of the decisions, actions and patient safety claims that have taken place in these kinds of disputes.

In many of these disputes, bargaining impasses arose in which nurses' unions indicated a willingness to go on strike – lawfully or not – to press for their demands, and in which governments just as frequently suggested and in some cases enacted special legislation to end disputes and impose a contract over the union's objections. In provinces where strikes are forbidden by law, interest arbitrators have been tasked with deciding between the parties' demands, often with limited information and under great time constraints.

Based on my review of this experience, I argue that nurses' unions have had some success in advancing patient safety issues through collective bargaining, but that the legal model in which they negotiate makes them vulnerable to government action to end negotiations and impose terms on patient safety issues. The experience in Ontario, however, has been different, as nurses' unions have been able to more effectively advance patient safety issues through collective bargaining under an interest arbitration model of dispute resolution. My tentative conclusion is that these trends in bargaining suggest that the current bargaining structures in which patient safety-related bargaining issues are resolved do not foster due and adequate attention to the central goal of patient safety, but rather place important constraints on the ability of nurses' unions to advance patient safety-related bargaining demands.

Chapter 6

In my concluding Chapter 6, I suggest reforms to the nurse collective bargaining structures that would ensure patient safety values and interests, and not those of providers, are given first-order priority and attention. I argue that nursing workload and time-worked issues should be removed from the current labour law models altogether and placed within a separate, locally-based "patient safety committee" model. This framework, I argue, holds the promise of providing a better forum than the current labour law model for raising, debating and deciding workload and time-worked issues. In this model, I argue, patient safety issues will be decided in a more open, evidence-based and polycentric way than they presently are under the Wagnerist labour law model. Objections to this programme of reform might be heard, however, from Wagnerist labour law theory,

and I attempt to defend my reforms against such objections, relying on an alternative, context-specific conceptualizing of Wagnerist values.

As discussed above, the Wagnerist literature on public sector collective bargaining has tended to posit a tension between the interests of public employee unions and citizens on the other, with the unions representing employee interests and government representing the citizen. My analysis rejects this Wagnerist premise as it applies in the context of nursing and the citizen interest in patient safety. The evidence from Chapter 2 shows that the interests of nurses in lower workloads, reasonable hours of work and predictable scheduling align with patient interests in safe care. As such, the limitations of the Wagner model at promoting workplaces with these features work against the improvement of patient safety. Therefore, the reforms I propose are intended to remedy those shortcomings and better situate nurses' unions to advance patient safety interests when engaging with governments in negotiations on issues of workload, hours of work and scheduling.

CHAPTER ONE:

THE PATIENT SAFETY - EFFICIENCY TENSION IN CANADIAN HEALTH POLICY

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Introduction

This opening chapter is a necessary prelude to Chapters 4 and 5. It is intended to explain the goals of patient safety and efficiency within health policy more broadly, and thus provide needed context for the analysis in Chapters 4 to 6. I argue that both patient safety and efficiency have become dominant values in Canadian health policy, and that while they are often invoked in support of policy decisions or other actions, they are also susceptible to being used sheerly as rhetorical devices. This is especially true, I argue, of efficiency, which combines a strong rhetorical force with an inherent subjectivity, and thus

is susceptible to misuse by governments as a pretext for simple government cost-cutting in the health care system.

Patient Safety as an Explicit Canadian Health Policy Goal

The Increasing Interest in Patient Safety, 2004-Present

Medical errors and other mishaps which harm patients have drawn increased scrutiny from Canadians in the past ten years.⁶¹ Adverse events include medication errors, poor hygiene or infection control, and other harms to patients arising from errors in the care process. The landmark 2004 Baker-Norton study of adverse events in Canadian hospitals found that 7.5 per cent of the patients – or about 185,000 patients a year – suffered at least one adverse event. It found that almost 40 per cent of those errors were preventable. Their estimates were that anywhere from 9,000 to as many as 23,000 people die annually from preventable error in hospitals.⁶²

In the decade since the Baker-Norton study, Canadian governments, researchers and patient safety advocacy bodies have gradually increased reporting and awareness of medical errors and other adverse events during patient care. Comprehensive nationwide databases of adverse events are still in the evolutionary stage, but efforts by federal

⁶¹ See, e.g., T. Boyle, “Nurses say hospital ‘dangerous,’ but CEO denies charge” *Toronto Star*, February 28, 2014, online at http://www.thestar.com/life/health_wellness/2014/02/28/humber_river_hospital_dangerous_says_nurse_association_ceo_denies_the_charge.htm; V. Kubinec, “Medication mix-up leaves cancer patient, wife shocked - Man given different patient’s medications by mistake at Health Sciences Centre”, *CBC News*, April 3, 2014, online at <http://www.cbc.ca/news/canada/manitoba/medication-mix-up-leaves-cancer-patient-wife-shocked-1.2596397>; T. Blackwell, “Inside Canada’s secret world of medical error”, *National Post*, January 16, 2015, online at <http://news.nationalpost.com/2015/01/16/inside-canadas-secret-world-of-medical-errors-there-is-a-lot-of-lying-theres-a-lot-of-cover-up/>; G. Mason, “Wildrose Leader Jean spurred by son’s tragic medical experience”, *Globe and Mail*, April 22, 2015, online at <http://www.theglobeandmail.com/news/alberta/alberta-wildrose-leader-brian-jean-enters-critical-stretch-of-campaign/article24070378/>.

⁶² Baker & Norton, “The Canadian Adverse Events Study”, *supra* note 51.

government and other national patient safety bodies have already generated important knowledge of the true extent of errors and the harms they cause. For example, in 2004, the CIHI focused on patient safety in its annual report⁶³ and established a Patient Safety Division⁶⁴ overseeing various projects which gather adverse event data from Canadian hospitals and other institutions. These projects include the Canadian Hospital Reporting Project the Hospital Standardized Mortality Ratio project⁶⁵, and the National System for Incident Reporting.⁶⁶ With data from these projects, CIHI publishes some adverse event data on its website.⁶⁷ Health Canada has also established a Medication Incident Reporting and Prevention System.⁶⁸

Provinces have also begun collecting patient safety data and making it publicly accessible. In Ontario, for example, hospitals are now required to report the occurrence of a series of eight patient safety indicators including the following:

- Clostridium difficile (*C. difficile*)
- Methicillin-resistant Staphylococcus aureus (MRSA)
- Vancomycin-resistant Enterococci (VRE)
- Hospital Standardized Mortality Ratio (HSMR)
- Rates of ventilator-associated pneumonia
- Rates of central line infections
- Surgical site infection prevention percentage
- Hand hygiene compliance among health care

⁶³ CIHI, *Healthcare in Canada, 2004 (Part A: Focus on Safe Care)* online at <https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC375&lang=fr&media=0c>.

⁶⁴ CIHI, Patient Safety Division, online at <http://www.cihi.ca/cihi-ext-portal/internet/en/tabbedcontent/health+system+performance/quality+of+care+and+outcomes/patient+safety/cihi010649>.

⁶⁵ L. Vogel, "Landmark tool assesses Canadian hospitals (2012) 184:8 *Canadian Medical Association Journal* 86, online at <http://www.cmaj.ca/content/184/8/866.full>.

⁶⁶ CIHI, *The National System for Incident Reporting: Program Overview* (2011) online at http://www.cihi.ca/CIHI-ext-portal/pdf/internet/NSIR_PROGRAM_OVERVIEW_EN.

⁶⁷ CIHI, "Your Health System", online at <http://yourhealthsystem.cihi.ca/#!/indicators/005/hospital-deaths-hsmr>.

⁶⁸ The Canadian Medication Incident Reporting and Prevention System (CMIRPS) is "a collaborative pan-Canadian program of Health Canada, the CIHI, the Institute for Safe Medication Practices Canada (ISMP Canada) and the Canadian Patient Safety Institute (CPSI). The goal of CMIRPS is to reduce and prevent harmful medication incidents in Canada.", online at <http://www.cmirps-scdpim.ca/?p=14>.

- Surgical Safety Checklist Compliance.⁶⁹

As well, in 2011 the Ontario Ministry of Health and Long-Term Care issued a directive that hospitals must report “critical incidents”⁷⁰ involving medications and intravenous fluids to CIHI’s National System for Incident Reporting.⁷¹ Results are published through the website of HealthQualityOntario.⁷² As well, since 2004 the Ontario Medication Incident Database (OMID), supported by the Ontario Ministry of Health and Long-Term Care, has been collecting data on medication incidents.⁷³ Quebec has similar legislative requirements: hospitals are required to disclose adverse event data to the provincial ministry of health⁷⁴, and both the ministry⁷⁵ and some individual hospitals publish such

⁶⁹ Effective December 2012, patient safety indicator results, as reported by Ontario hospitals, as well as other patient safety information, are available on Health Quality Ontario’s (HQO) website. Publicly reporting patient safety indicators aligns with HQO’s mandate to monitor and report on Ontario’s health care system to the public, online at <http://www.hqontario.ca/public-reporting/patient-safety>.

⁷⁰ *Excellent Care for All Act, 2010*, S.O. 2010, c. 14, amending the *Public Hospitals Act*, R.S.O. 1990, c. P.40; *Hospital Management Regulation*, R.R.O. 1990, Reg. 965, section 1(1) defines a “critical incident” as

Any unintended event that occurs when a patient receives treatment in the hospital,
 (a) that results in death, or serious disability, injury or harm to the patient, and
 (b) does not result primarily from the patients' underlying medical condition or from a known risk inherent in providing the treatment

Section 2 of the *Regulation* requires disclosure and reporting of critical incidents.

⁷¹ Ontario MOHLTC, “Guidelines for Critical Incident Reporting” (2010) online at http://www.health.gov.on.ca/en/pro/programs/ecfa/docs/guidelines_cir.pdf.

⁷² Online at <http://www.hqontario.ca/public-reporting/patient-safety>.

⁷³ The OMID is a component of the Ontario Medication Safety Support Service (MSSS) and ISMP Canada's Medication Incident and Near Miss Reporting Program. Data on medication errors are available online at https://www.ismp-canada.org/download/ocil/ON_Critical_Incidents_Analysis_Report_3JUL2014.pdf.

⁷⁴ *An Act Respecting Health Services and Social Services*, R.S.Q., c. S-4.2, ss. 8, 183.1, 183.2, 233.1, 235.1; “Quebec makes medical errors public”, *CBC News*, December 6, 2011, online at <http://www.cbc.ca/news/canada/montreal/quebec-makes-medical-errors-public-1.1124587>.

⁷⁵ Data since 2011 are found at Quebec, ministère de la Santé et des Services sociaux, *Rapport semestriel des incidents et accidents survenus lors de la prestation des soins et services de santé au Québec (Période du 1er octobre 2013 au 31 mars 2014)*, online at <http://msssa4.msss.gouv.qc.ca/fr/document/publication.nsf/961885cb24e4e9fd85256b1e00641a29/c98781ce6012799785257d8100527734?OpenDocument>.

data on their own websites.⁷⁶ Nova Scotia⁷⁷ and Saskatchewan⁷⁸ also have legislation requires health authorities to compile and report data on adverse events. Non-governmental patient safety groups such as the Canadian Patient Safety Institute⁷⁹ (CPSI) and the Institute for Safe Medication Practices Canada (ISMP-Canada)⁸⁰ have also gathered data on adverse events and published their findings.⁸¹ The CPSI has also formulated adverse event disclosure guidelines for Canadian health care facilities.⁸²

What Do the Data Say About Patient Safety in Canada?

These federal and provincial data-gathering efforts have shed important light on the frequency of a wide range of adverse events. In 2004, the Canadian Institute for Health Information (CIHI) reported that 24% of Canadians surveyed said that they or a family member had experienced a preventable adverse event in the previous two years,

⁷⁶ See, e.g., Jewish General Hospital (Montreal), "Total Reported Incidents and Accidents", online at http://www.igh.ca/en/qi/IncidentsAccidents?mid=ctl00_LeftMenu_ctl00_TheMenu-menulitem010; and Centre hospitalier universitaire de Sherbrooke, "Incidents and accidents", online at <http://www.chus.qc.ca/en/care-services/incidents-accidents/>.

⁷⁷ *Patient Safety Act*, S.N.S. 2012, c. 13, s. 4, online at <http://canlii.ca/t/8qml>; *Patient Safety Reporting Regulations*, N.S. Reg. 55/2013, s. 4, online at <http://canlii.ca/t/8rhj>; Nova Scotia Department of Health, "Public Reporting of Patient Safety Indicators" (2012), online at http://novascotia.ca/dhw/qps/public_reporting.asp.

⁷⁸ *The Regional Health Services Act*, S. S. 2002, c. R-8.2, ss. 58(1) and (2); *The Critical Incident Regulations*, R.R.S. 2000, c. R-8.2, Reg. 3.

⁷⁹ Canadian Patient Safety Institute, online at <http://www.patientsafetyinstitute.ca/English/Pages/default.aspx>; P. Hassen et. al., "The Canadian Patient Safety Institute: Building a safer system and stronger culture of safety" (2006) 48:7 *B.C. Medical Journal* 334-338, online at <http://www.bcmj.org/article/canadian-patient-safety-institute-building-safer-system-and-stronger-culture-safety>.

⁸⁰ Medication Safety Support Service (MSSS), online at <https://www.ismp-canada.org/msss.htm>, and ISMP Canada's Medication Incident and Near Miss Reporting Program, online at https://www.ismp-canada.org/err_report.htm.

⁸¹ The CPSI has also funded studies of adverse events, including a 2012 study of paediatric care: CPSI, *Canadian Paediatric Adverse Events Study* (2013) online at http://www.patientsafetyinstitute.ca/English/research/commissionedResearch/PaediatricAdverseEvents/Documents/CPSI_Canadian_Paediatric_Adverse_Events_doc_March%205_2013_English_Final.pdf; see also A. Matlow et. al., "Adverse Events among Children in Canadian Hospitals: The Canadian Paediatric Adverse Events Study" (2012) 184:13 *Canadian Medical Association Journal* 709-718.

⁸² CPSI, *Canadian Disclosure Guidelines: Being open with patients and families* (2011) online at <http://www.patientsafetyinstitute.ca/English/toolsResources/disclosure/Documents/CPSI%20Canadian%20Disclosure%20Guidelines.pdf>.

and more than half said the most recent event had “serious consequences”.⁸³ In 2005, CIHI’s survey of Canadian nurses reported that 18% of nurses said that “occasionally or frequently” patients received the wrong medication or dosage in the previous year, and that 35% of patients acquired a nosocomial (in-hospital acquired) infection.⁸⁴ In 2007 CIHI reported that one in 10 patients surveyed reported medication errors in the previous two years; three in 20 reported an adverse event, and almost half of those resulted in a “serious health problem”.⁸⁵ CIHI has also reported on the “mortality ratio” of Canadian hospitals, which “compares the actual number of deaths in a region or a hospital to the number that would have been expected based on the types of patients a region or hospital treats.”⁸⁶ The CIHI data suggest that the rate of hospital mortality has dropped since 2009, from 100 deaths per 100 expected deaths to 85 per 100.⁸⁷ CIHI also studied how often patients had to return to hospital after their first visit, reporting that one in 12 patients were readmitted to hospital within a month. The rate of return was higher in rural and lower-income provinces, and was estimated to cost the system an additional \$1.8 billion.⁸⁸

⁸³ CIHI, *Healthcare in Canada, 2004 (Part A: Focus on Safe Care)* at x, online at

<https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC375&lang=fr&media=0c>.

⁸⁴ CIHI, *Findings from the 2005 Study of the Work and Health of Nurses* (2008), *supra* note 54 at 34, online at

<http://www.hc-sc.gc.ca/hcs-sss/pubs/nurs-infirm/2005-nurse-infirm/index-eng.php>.

⁸⁵ CIHI, “Analysis in Brief - Patient Safety in Canada: An Update” (2007) at 18, online at

https://secure.cihi.ca/free_products/Patient_Safety_AIB_EN_070814.pdf. Hospital-acquired infections were among the most common types of adverse events reported. The report also reported that more than 1,700 birth traumas occurred each year, leading to longer hospital stays for mothers and infants. It also reported that more than 200 foreign objects were left inside patients in the previous two years.

⁸⁶ CIHI, *HSMR: A New Approach for Measuring Hospital Mortality Trends in Canada* (2007), *supra* note 56 at 6.

⁸⁷ CIHI, *Your Health System*, “Hospital Deaths (HSMR)”, online at

<http://yourhealthsystem.cihi.ca/hsp/inbrief?lang=en#!/indicators/005/hospital-deaths-hsmr;/mapC1;mapLevel2;/>; N. Hamilton, “Results Show Canadian Hospitals Improving Patient Safety”, Healthcare Insurance Reciprocal of Canada, April 12, 2012, online at <https://www.hiroc.com/News-Media/News/Results-show-Canadian-hospitals-improving-patient.aspx>.

⁸⁸ CIHI, *All-Cause Readmission to Acute Care and Return to the Emergency Department* (2012) “One in 12 patients readmitted to Canadian hospitals within 30 days”, online at http://www.cihi.ca/cihi-ext-portal/internet/en/document/health+system+performance/release_14june12.

More data on adverse events is coming from the provinces as well. In Ontario, the Ministry of Health and Long Term Care publishes the “critical incident” statistics it collects from hospitals and other institutions. These figures show improvement on some indicators but none on others. For example, while the rate of “hand hygiene compliance” rose from 53 per cent in 2008 to 86 per cent in 2014, the rate of contraction of MRSA during hospital stays remained constant.⁸⁹ The ISMP-Canada’s data on medication errors in Ontario hospitals also reported that in 2013, 29 “critical medication incidents” happened in Ontario hospitals, with 21% of those contributing to a patient’s death.⁹⁰ In 2012, there were 36 such incidents reported, 10 causing patient deaths.⁹¹ In Quebec, health ministry figures showed that more than 211,000 adverse events occurred in Quebec hospitals in 2013-14.⁹² And in Nova Scotia, the government reported that “hand hygiene compliance” by health care workers had increased slightly from 2013 to 2014⁹³, and that the percentage of hospital patients contracting *C. difficile* had dropped during that period as well.⁹⁴

⁸⁹ All figures derived from the Ontario government online at <http://www.hqontario.ca/public-reporting/patient-safety>.

⁹⁰ Institute for Safe Medication Practices Canada, “Ontario Hospital Critical Incidents Related to Medications or IV Fluids: Analysis Report, January to December 2013”, online at https://www.ismp-canada.org/download/ocil/ON_Critical_Incidents_Analysis_Report_3JUL2014.pdf.

⁹¹ Institute for Safe Medication Practices Canada, “Ontario Hospital Critical Incidents Related to Medications or IV Fluids: Analysis Report, October 2011 to December 2012”, online at http://www.ismp-canada.org/download/ocil/ON_Critical_Incidents_Analysis_Report_31May2013.pdf.

⁹² Quebec, ministère de la Santé et des Services sociaux, *Rapport semestriel des incidents et accidents survenus lors de la prestation des soins et services de santé au Québec (Période du 1er octobre 2013 au 31 mars 2014)* at 18, online at <http://msssa4.msss.gouv.qc.ca/fr/document/publication.nsf/961885cb24e4e9fd85256b1e00641a29/c98781ce6012799785257d8100527734?OpenDocument>.

⁹³ Nova Scotia Department of Health and Wellness, “How Often Are Healthcare Workers Cleaning Their Hands?”, online at http://novascotia.ca/dhw/qps/public_reporting.asp; in 2014, 71% of healthcare workers washed their hands before treating a patient, and 86% did so afterward, up from 64 and 81% in 2013.

⁹⁴ Nova Scotia Department of Health and Wellness, “How Often Do Patients Get *Clostridium difficile* Infection While In Hospital?”, online at http://novascotia.ca/dhw/qps/c-diff_psi.asp; in 2014, 2.36 patients per 10,000 contracted *C. difficile*, down slightly from 2013.

From non-governmental patient safety studies, more data has emerged. In 2012, the Canadian Patient Safety Institute published an important national report on the prevalence of adverse events in the treatment of children.⁹⁵ The investigators found that 9.2 percent of children admitted to hospital had an adverse event. Adverse events related to surgery were the most frequent, and those in the emergency department were significantly more common among children aged 1–5 years than among other age groups. In similar studies by different researchers, it was concluded that Canadians have a one in 10 chance of contracting a “nosocomial” infection – one acquired from a hospital visit – and that in 2002 one in 12 children contracted a nosocomial infection while in hospital.⁹⁶ In addition to CIHI and the CPSI, the McGill University-based *Health Care in Canada Survey*, begun in 1998, has in some reports surveyed patients and health providers on patient safety issues. In its 2006 report, it asked “Are you likely to be subject to a serious medical error?” while in a Canadian hospital. Sixty percent of patients and the public answered yes, as did forty percent of doctors and 74 percent of nurses.⁹⁷

From all the above data, it appears Canada does not compare well internationally on measures of patient safety. A 2014 survey by CIHI, based on data from the Organization for Economic Co-operation and Development (OECD), rated Canada “poor” on patient safety measures relative to other OECD countries. The report concluded that “Canada falls behind most other OECD countries on measures of patient safety in the

⁹⁵ CPSI, *Canadian Paediatric Adverse Events Study* (2013), *supra* note 81; Matlow *et. al.*, “Adverse Events among Children in Canadian Hospitals”, *supra* note 81.

⁹⁶ A. Gravel *et. al.*, “Point Prevalence Survey of Health Care—Associated Infections Within Canadian Adult Acute-Care Hospitals” (2007) 66:3 *Journal of Hospital Infection* 243–248.

⁹⁷ Health Care in Canada Survey, *Health Care in Canada Survey 2006: A national survey of health care providers, managers, and the public* (2006), online at http://www.who.int/patientsafety/news/2006_hcic.pdf.

acute care setting.”⁹⁸ Among its findings was that Canada reported some of the highest rates of accidental puncture or laceration, as well as of foreign bodies left in during surgical procedures. It also had among the highest rates of obstetrical trauma.⁹⁹ In a similar vein, the U.S.-based Commonwealth Fund reported that on patient safety Canada ranked 10th of 11 major industrialized countries; only the U.S. was worse.¹⁰⁰ Among its patient safety indicators were (with Canada’s rank):

- Patients believing a medical mistake was made in treatment or care in the past two years (6th of 11)
- Patient given wrong medication or wrong dose at a pharmacy or while hospitalized in the past two years (4th of 11)
- Patient given incorrect results for a diagnostic or lab test in the past 2 years (8th of 11)
- Hospitalized patients reporting infection in hospital or shortly after discharge (8th of 11)¹⁰¹

Patient Safety as Health Policy

Based on the foregoing, it seems clear that patient safety has become a pressing policy issue. Patients have the most immediate and obvious interest in lessening medical errors, but so too do governments, in the form of political accountability for medical errors with widespread impact, and in the form of financial liability to victims of adverse events. For example, in a five-year period, the Quebec government paid out more than \$62 million in damages to patients because negligence and medical errors.¹⁰² The safety of patients

⁹⁸ CIHI, “International Comparisons: A Focus on Quality of Care” (2014), online at https://secure.cihi.ca/free_products/OECD_AFocusOnQualityOfCareAiB_EN.pdf; Figure A: “How Provinces Compare With OECD Countries on Quality of Care Indicators”, online at http://www.cihi.ca/CIHI-ext-portal/internet/en/documentfull/health+system+performance/indicators/international/oecd_etool_results.

⁹⁹ CIHI, *Learning From the Best: Benchmarking Canada’s Health System* (2011), online at <https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC1676>.

¹⁰⁰ K. Davis et. al., *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2014 Update*, online at http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf.

¹⁰¹ *Ibid.* at 15.

¹⁰² ____, “Medical errors and negligence cost Quebec \$62M: report”, CTV News Montreal, July 14, 2014, online at <http://montreal.ctvnews.ca/medical-errors-and-negligence-cost-quebec-62m-report-1.1912699>.

is also an obvious mandate of the managers and administrators of health regions, hospitals and other health care facilities.¹⁰³

For all health professionals and their governing regulatory Colleges, patient safety is a fundamental value. Indeed, patient safety is at the core of why health professionals are subject to licensure and regulation by codes of conduct. Health economists have noted the “information asymmetry” between providers and patients that place patients in a vulnerable market position, and that protection of the consumers of health services - patients - from incompetent and/or unsafe care cannot be left to the free market.¹⁰⁴ Patient safety is thus a fundamental tenet of all health professions’ obligations and a core feature of their identity as professionals. “Safe, compassionate, competent and ethical care” are the core ethical duties in nursing.¹⁰⁵ According to the Canadian Nurses’ Association (CNA) Code of Ethics, nurses also have specific patient safety-related ethical duties. Among these duties are that nurses should:

- “advocate for practice settings that maximize the quality of health outcomes for persons receiving care”
- “question and intervene to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care.”
- “admit mistakes and take all necessary actions to prevent or minimize harm arising from an adverse event . . . [and] work with others to reduce the potential for future risks and preventable harms.”

¹⁰³ See, e.g., Ontario Hospital Association (OHA), “Quality and Patient Safety”, online at <http://www.oha.com/currentissues/keyinitiatives/patientsafety/pages/default.aspx>; OHA, *2010-2013 Quality and Patient Safety Plan (QPSP)*, online at <http://www.oha.com/CurrentIssues/keyinitiatives/PatientSafety/QPSP/Pages/Default.aspx>; OHA, *A Guidebook to Patient Safety Leading Practices* (2010) online at <https://www.oha.com/KnowledgeCentre/Library/Documents/Final%20-%20Patient%20Safety%20Guidebook.pdf>.

¹⁰⁴ T. Epps, “Regulation of Health Care Professionals”, Ch. 2 in J. Downie, C. Flood & T. Caulfield eds., *Canadian Health Law and Policy*, 4th ed. (Toronto: LexisNexis Canada, 2011) at 76.

¹⁰⁵ Canadian Nurses Association, *Code of Ethics for Registered Nurses (2008 Centennial Edition)* (2008) *supra* note 40 at 8.

Codes of ethics issued by provincial Colleges of Nurses often have similar provisions, and where evidence suggests that an adverse event is tied to negligent, incompetent or otherwise substandard care provided by a regulated professional, the nursing Colleges have a mandate to investigate and, where appropriate, discipline nurses.¹⁰⁶ These Colleges have also promulgated standards¹⁰⁷ and position statements¹⁰⁸ on patient safety-related nursing issues. The CNA and some provincial nurses' associations have also issued position statements and research studies linking patient safety to nurse fatigue and other workplace factors.¹⁰⁹ As Chapters 4 and 5 will show, nurses' unions have positioned themselves as patient safety advocates in collective bargaining; however, they have also advanced patient safety values outside the negotiation arena.¹¹⁰ Many provincial nurses' unions as well as the Canadian Federation of Nurses' Unions (CFNU) have sponsored research on a wide range of patient safety issues that are tied

¹⁰⁶ See e.g. *Nursing Act, 1991*, supra note 39; *Professional Misconduct Regulations (Nursing Act, 1991)*, supra note 41.

¹⁰⁷ See e.g. College of Nurses of Ontario, *Practice Standard, Professional Standards*, online at http://www.cno.org/Global/docs/prac/41006_ProfStds.pdf; College of Nurses of Ontario, *Practice Standard, Medication* (Revised 2015), online at <http://www.cno.org/Global/docs/prac/41007%20Medication-Rev%202015%20watermark%20v3.pdf>; College of Registered Nurses of British Columbia, *Professional Standards for Registered Nurses and Nurse Practitioners* (2012), online at <https://www.crnbc.ca/Standards/Lists/StandardResources/128ProfessionalStandards.pdf>; College & Association of Registered Nurses of Alberta, *Working Extra Hours: Guidelines for Regulated Members on Fitness to Practise and the Provision of Safe, Competent, Ethical Nursing Care* (2011), online at http://www.nurses.ab.ca/content/dam/carna/pdfs/DocumentList/Guidelines/RN_ExtraHours_Sept2011.pdf.

¹⁰⁸ See e.g. College of Registered Nurses of Nova Scotia (and five other N.S. health profession Colleges) *Joint Position Statement on Patient Safety* (2015), online at <http://crnns.ca/wp-content/uploads/2015/02/Patient-Safety-2007.pdf>.

¹⁰⁹ Canadian Nurses' Association et. al., *Nurse Fatigue and Patient Safety: Research Report* (2010), supra note 58; Canadian Nurses Association & University of Toronto Faculty of Nursing, *Nurses and Patient Safety: A Discussion Paper* (2004), online at https://www.cna-aicc.ca/~media/cna/page-content/pdf-fr/patient_safety_discussion_paper_e.pdf?la=en; Registered Nurses' Association of Ontario (RNAO), "Position Statement: Patient Safety" (2004), online at <http://rnao.ca/policy/position-statements/patient-safety>.

¹¹⁰ British Columbia Nurses' Union, *Position Statement on Nursing Workload and Patient Safety* (2015), online at <https://www.bcnu.org/AboutBcnu/Documents/position-statement-patient-safety.pdf>; Saskatchewan Union of Nurses, *Registered Nurses Committed to Patient Safety* (2015), online at <http://sun-nurses.sk.ca/government-relations/patient-safety>; Saskatchewan Union of Nurses, "SUN takes to social media with patient safety message" (2014), online at http://www.makingthedifference.ca/sun_takes_to_social_media_with_patient_safety_message.

to nursing workload, hours worked, nursing fatigue, the shift of tasks from nurses to non-nurses, and other aspects of the nursing workplace.¹¹¹ In many instances the unions call for mandated minimum nurse-to-patient ratios to ensure sufficient nursing staff for the provision of safe care.¹¹² For example, the British Columbia Nurses' Union's proposed nurse-to-patient ratios included (expressed as # of nurses: # of patients):

Emergency Room 1:3
ICU Patients in ER 1:1
Triage 1:1
Intensive/Critical Care 1:2
Labour and Delivery 1:1
Medical/Surgical 1:4
Neo-natal Intensive Care 1:1
Operating Room 2:1
Pediatrics–General Medical Ward 1:4
Pediatric Oncology 1:2
Pediatric Surgery 1:3
Post-Anesthesia Recovery (conscious) 1:2
Post-Anesthesia Recovery (unconscious) 1:1
Postpartum 1:4¹¹³

Some nurses' unions, such as in Saskatchewan, have set up patient safety reporting mechanisms in which front-line nurses can report patient safety concerns to their union.¹¹⁴ Similarly, nurses' unions have encouraged use of "professional responsibility" complaint procedures in the collective agreement to report on unsafe

¹¹¹ L. Berry & P. Curry, *Nursing Workload and Patient Care: Understanding the Value of Nurses, the Effects of Excessive Workload, and How Nurse-Patient Ratios Can Help* (Ottawa: Canadian Federation of Nurses Unions, 2012), online at http://nursesunions.ca/sites/default/files/cfnu_workload_paper_pdf.pdf; MacPhee, M. (CFNU), *Valuing Patient Safety: Responsible Workforce Design* (2014), online at <https://nursesunions.ca/news/valuing-patient-safety-responsible-workforce-design>.

¹¹² See, e.g., Nova Scotia Government and General Employees' Union, "Our Proposed Ratios" (2015), online at <http://nsgeu.ca/nsgeu-nurses-put-patient-safety-first/>.

¹¹³ British Columbia Nurses' Union, *Position Statement on Mandated Nurse-Patient Ratios, March 2015* (2015), online at https://www.bcnu.org/AboutBcnu/Documents/PS_Mandated_Nurse_Patient_Ratios_2015-1.pdf.

¹¹⁴ The Saskatchewan Union of Nurses has established a patient safety reporting form on its website, online at <http://sun-nurses.sk.ca/professional-practice/share-your-story>.

working conditions or other circumstances posing a risk to patient safety.¹¹⁵ As well, nurses' unions that are still exclusively Registered Nurses have tended to oppose the shifting of their traditional nursing tasks to Licensed Practical Nurses and other non-nurse providers on the grounds that taking such tasks from Registered Nurses increases the risks of medical error. For example, the SUN stridently opposed the Saskatchewan government's 2014 expansion of LPN duties to permit them to perform more nursing tasks. The SUN stated:

Allowing employers to utilize providers as they see fit based on financial considerations without evidence and evaluation of medical appropriateness, formal education, and patient outcomes, threatens professional nursing standards and puts patients at risk of harm. If allowed to continue, this ad hoc and budget -driven tinkering with scopes of practice and models of care threatens to drag professional nursing back to the apprenticeship model that was abandoned in the 1970s precisely due to concerns about the quality and safety of patient care.¹¹⁶

As Chapter 4 will show, nurses' unions have used the collective bargaining processes outlined in Chapter 2 to advance patient safety-related issues such as nurse-patient ratios and restrictions on the transfer of nursing work to non-nurses.

Nursing Trends Commonly Tied to Patient Safety

What are the specific nursing workplace trends most often tied to patient safety by the nursing profession? The CIHI regularly collects and publishes data on nursing workforce trends (numbers of nurses, where they work, age), and there have been

¹¹⁵ See *e.g.* British Columbia Nurses' Union, "Safe Patient Care. It's in our contract. Use it!", online at <https://www.bcnu.org/news-and-events/campaigns-and-initiatives/current-campaigns/safe-patient-care> .

¹¹⁶ Saskatchewan Union of Nurses, "Proposed Changes to SALPN Bylaws: Background Information" (2014), online at http://sun-nurses.sk.ca/+pub/document/SRNA/Backgrounder_sept%2029.pdf at 1; CBC News Regina, "Registered nurses say proposed changes could hurt patients: LPNs accuse RNs of fear-mongering and hysteria", September 17, 2014, online at <http://www.cbc.ca/news/canada/saskatchewan/registered-nurses-say-proposed-changes-could-hurt-patients-1.2769608> .

several key studies of the working experiences of nurses, most notably CIHI's 2005 *Survey of the Work and Health of Nurses*.¹¹⁷ From these and other sources, some basic patient safety-related trends in nursing have been reported. These include:

Nursing Shortage: A chronic undersupply of nurses has been attributed to increased risk of adverse events because of the additional workload and hours worked for the nurses in the system. CIHI's 2005 survey of nurses reported that more than one-third of nurses (38%) reported inadequate staffing.¹¹⁸ Recruitment and retention of nurses has thus become a commonly-stated priority for provincial governments. For example, Ontario's "Nursing Strategy" is a standing component within the Ministry of Health and Long-Term Care, with a mandate to recruit and retain nurses in Ontario to reduce wait times and reduce workloads for nurses.¹¹⁹ How have these efforts fared? The number of nurses in Canada increased 8 per cent from 2009 to 2013, to 408,093 total.¹²⁰ While this increase outpaced the rate of growth in the Canadian population, most of the increase was in the supply of Licensed Practical Nurses rather than of Registered Nurses.¹²¹ As well, 2014 data from CIHI show that the total supply of nurses (meaning licensed to practice, whether or not working) in Canada has declined for the first time in almost twenty

¹¹⁷ CIHI, *Findings from the 2005 Study of the Work and Health of Nurses* (2008), *supra* note 54.

¹¹⁸ *Ibid.* at 30.

¹¹⁹ See Ontario Nursing Strategy, online at

http://www.healthforceontario.ca/en/Home/Nurses/Training_%7C_Practising_In_Ontario/Nursing_Strategy.

According to the Ministry, "The Nursing Strategy is a comprehensive strategy that is intended to address the core reasons for instability in the nursing workforce. It also aims to increase recruitment and retention of health care professionals, thus improving access to care, reducing wait times and improving patient and resident outcomes.

¹²⁰ CIHI, *Regulated Nurses, 2013: Report* (July 2014), online at https://secure.cihi.ca/free_products/Nursing-Workforce-2013_EN.pdf; CIHI, *Regulated Nurses, 2012 – Summary Report* (2013), online at https://secure.cihi.ca/free_products/RegulatedNurses2012Summary_EN.pdf; for trends prior to 2012 see also CIHI, *Regulated Nurses: Canadian Trends, 2007 to 2011* (2012), online at https://secure.cihi.ca/free_products/Regulated_Nurses_EN.pdf.

¹²¹ CIHI, *Regulated Nurses, 2012 – Summary Report* (2013) at vi, online at https://secure.cihi.ca/free_products/RegulatedNurses2012Summary_EN.pdf.

years, although the number of employed nurses continued to increase.¹²² Despite these increases, Canada still has a shortage of nurses. As of 2013, Canada had the 14th highest ratio of nurses to population (9.52 nurses for every 1,000 population) in the 38 countries included in a study by the Organisation for Economic Co-operation and Development (OECD).¹²³

Nurse Wages: Wages and other elements of nurse compensation have been characterized as patient safety-relevant issues because they are linked to efforts to recruit and retain nurses, to the extent that they are sufficient to remedy the shortage of nurses.¹²⁴ Throughout most of the 1990s, nurse wages remained mostly frozen as provincial governments underwent fiscal austerity¹²⁵ and cost cutting measures. From 1999 to approximately 2002, however, increases in federal government transfers to the provinces for health care translated into significant wage hikes for nurses in the largest and economically dominant provinces of Ontario, Alberta, British Columbia, and modest increases for nurses in other provinces. Since approximately 2002, wage rates have crept upward gradually but consistently in each province. Based on 2012 figures, the highest

¹²² CIHI, *Regulated Nurses, 2014*, online at https://secure.cihi.ca/free_products/RegulatedNurses2014_Report_EN.pdf; K. Grant, "Supply of nurses falls in Canada for first time in almost 20 years: report", *Globe and Mail*, June 23, 2015, online at <http://www.theglobeandmail.com/life/health-and-fitness/health/supply-of-nurses-falls-in-canada-for-first-time-in-almost-20-years-report/article25069547/>.

¹²³ Organisation for Economic Co-operation and Development (2016) Nurses (indicator). doi: 10.1787/283e64de-en (Accessed on 04 September 2016), online at <https://data.oecd.org/healthres/nurses.htm>.

¹²⁴ J. Spetz, & R. Given, "The Future of the Nurse Shortage: Will Wage Increases Close the Gap?" (2003) 22:6 *Health Affairs* 199-206; J. Spetz, "Hospital nurse wages and staffing, 1977 to 2002: cycles of shortage and surplus" (2004) 34:9 *Journal of Nursing Administration* 415-422; M. McHugh & C. Ma, "Wage, Work Environment, and Staffing: Effects on Nurse Outcomes" (2014) 15:3-4 *Policy, Politics, & Nursing Practice* 72-80.

¹²⁵ CIHI, *National Health Expenditure Trends, 1975 to 2015*, online at <https://www.cihi.ca/en/spending-and-health-workforce/spending/national-health-expenditure-trends> at 7, "Figure 1: Total health expenditure as a percentage of GDP, Canada, 1975 to 2015". The report stated "As governments focused on fiscal restraint, total health expenditures grew more slowly than GDP between 1993 and 1997. Consequently, the health-to-GDP ratio fell each year in that period, reaching 8.7% in 1997."

starting salary for registered nurses was \$66,746 in Saskatchewan, while the lowest was in Quebec, at \$42,724.¹²⁶ For Licensed Practical Nurses, the top starting salary was \$51,350 in Saskatchewan and the lowest was Quebec at \$36,644.¹²⁷

Nursing Workload: A consistent theme of nurses' unions is that the patient care responsibilities for individual nurses have become excessive. While hours of work and scheduling refer to the length of shifts and their timing, workload refers to the actual number of patients (or clients). The 2005 CIHI survey of nurses reported that two-thirds of nurses "often felt that they had too much work for one person", 45 per cent said they did not have enough time to fulfill all their job duties, and "nearly 6 in 10 reported that because they had so much to do, they could not do everything well."¹²⁸

Hours of Work: The length of time nurses work in each week or month is related to both the shortage of nurses and the workload nurses carry on the job: reliance on longer shifts and on overtime by hospitals and other health care employers is due in large part to simple staffing shortfalls. CIHI's 2005 figures showed that, not including overtime, Canadian nurses (including those who worked only part time) worked an average of 32.2 hours per week at their main job.¹²⁹ About three in 10 nurses, it reported, "usually" worked an average of 5.4 hours of paid overtime per week, but the rate that nurses worked unpaid overtime was higher. Nearly half the nurses surveyed said they "usually" worked an

¹²⁶ Canadian Federation of Nurses' Unions, "Overview of Key Nursing Contract Provisions" (October 2012), online at https://nursesunions.ca/sites/default/files/contract_comparison_english.pdf.

¹²⁷ *Ibid.*

¹²⁸ CIHI, *Findings from the 2005 Study of the Work and Health of Nurses* (2008), *supra* note 54 at 41.

¹²⁹ *Ibid.* at 15.

average of four hours a week of unpaid overtime. Most nurses reported that they often arrived early, stayed late or worked through breaks to get work done.¹³⁰

Work Schedules: In addition to workload and hours of work, nurses' unions have raised patient safety concerns about the consistency and predictability of nursing work schedules. CIHI's 2005 survey reported that less than half of nurses "always" knew what hours they would be working in advance¹³¹, and more than one-third reported that their shift had changed at least once in the previous two weeks.¹³²

As Chapter 4 will show in more detail, nurses' unions have tied all the foregoing workplace trends to the risk of adverse events, and have often made them important subjects of collective bargaining. In positing themselves as advocates for patient safety, nurses' unions see themselves as agents of patient interests. In demanding more hires, better workloads, less overtime and more regular scheduling, the unions invoke the goals of patient safety.

However, as with any agency relationship, it is important to recognize the existence of potentially competing private interests of the agent. In the case of the self-regulating health professions – physicians, nurses and many others – it is important to acknowledge that each of them have some distinct interests and each has tended to promote their own interests, both economic and professional. Economically, the professions tend to support more investments in compensation for their services. Professionally, they tend to advocate for increasing roles in the health care system and to resist the transfer of

¹³⁰ *Ibid.* at 41.

¹³¹ *Ibid.* at 22.

¹³² *Ibid.* at 25.

services or functions away from their profession. And at a general level, health professions remain entrusted by governments with the task of regulating the competence, ethics and conduct of the professionals working in the system.¹³³

Through unions and collective bargaining as well as other modes of advocacy, nurses have strengthened their political voice in the system and have used it to advance the interests of working nurses as well as those of patients. However, like all professions, nursing also must be seen at least partly as a self-interested group in the system, and that as such it is to be expected that they will take positions that have at least a tangential benefit to the incomes or working conditions of nurses. They can also be expected to be resistant to change in the system broadly and in the modes of health care delivery. As Tuohy observed, professions:

...are likely to yield a relatively slow pace of incremental change. The slow pace is in part a function of the need to achieve a substantial degree of consensus among peers before changes are made. It also reflects an important implication of peer-group identification: a change threatening any given segment of the group is likely to be perceived, and accordingly resisted, as a threat to all.¹³⁴

However, none of the foregoing invalidates the positions taken by the nursing profession on the links between certain aspects of their working lives and patient safety. To acknowledge that patient safety is susceptible to use as a rhetorical device is not to delegitimize the voice of the nursing profession on patient safety or other health policy issues that intersect with the personal and professional interests of nurses. To the contrary, as I show in Chapter 2, there is a strong causal connection in the scientific literature between nurse working conditions and patient safety.

¹³³ T. Epps, "Regulation of Health Care Professionals", *supra* note 104.

¹³⁴ Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*, *infra* note 149 at 133.

The Pursuit of Efficiency in Canadian Health Care

Efficiency: About Means, Not Ends

Efficiency is a pervasive value in health care systems around the world. Efficiency can be called a policy goal but it is fundamentally about means rather than ends. Efficiency does not dictate substantive policy or program goals; it dictates that such goals be pursued in the least costly way. Economists have distinguished technical from allocative efficiency; as one describes these concepts:

Based on the seminal definitions of efficiency by Farrell (1957), technical efficiency is producing the maximum amount of output from a given amount of input or alternatively, producing a given output with minimum input quantities, such that when a firm is technically efficient, it operates on its production frontier. Allocative efficiency occurs when the input mix is that which minimises cost, given input prices or alternatively, when the output mix is that which maximises revenue, given output prices. Technical and allocative efficiency comprise 'overall efficiency'. When a firm is efficient overall, it operates on its cost or revenue frontier¹³⁵

In health care systems, economists conceive of “output” in terms of health outcomes, although there is an ongoing debate about how to measure “production” in the health services context. In large part, this debate stems from the deeper difficulties in defining “quality” in health care.¹³⁶ Under any definition of quality, though, patient safety is always a key indicator. “Inputs”, or costs, are measured more easily, as the price of the labour, capital and goods required to provide health services. The pursuit of efficiency, then, is in essence the application of classic economic theory to the design and funding of health care systems.

¹³⁵ B. Hollingsworth, “The measurement of efficiency and productivity of health care delivery” (2008) 17:10 *Health Economics* 1107-1128 at 1108.

¹³⁶ A. Donabedian, “Evaluating the Quality of Medical Care” (2005) 83:4 *The Milbank Quarterly* 691-729.

Economic, Political and Legal Pressures Toward Efficiency

Population growth and economic uncertainty continue to place a heavy demand on a wide range of social programs funded by governments. Health care remains the largest expenditure for provincial governments, but resources are also needed in public schools, universities, social service agencies and municipalities. And in the wake of increased concerns about domestic security, governments have faced an upsurge in calls for more funding for police services. As in health care, each of these sectors is also highly unionized and features their own recurring labour relations conflicts over resources and spending, most frequently between public school teachers' unions and provincial governments. Within the health care system, economic pressures toward greater efficiency come from the many competing user/patient groups needing services, from an aging population which will demand more resources, and from the ongoing demands of physicians, nurses and other health professionals for compensation increases.¹³⁷ Greater efficiency in the delivery of any public service, it is thought, will allow more of these competing priorities to be met. However, in a theme I will return to again, frequently it seems that the goal is not in fact efficiency but mere cost containment. Indeed, controlling public spending has become a constant theme of federal and provincial politics since the 1990s; fears of deficit spending persist, as does a reluctance to increase the tax burden on businesses and individuals. Thus, whilst government speak the language of efficiency

¹³⁷ Foremost among these groups are doctors, who frequently press provincial governments for fee increases. Relations between Ontario doctors and the government deteriorated in 2016 to the point that members of the Ontario Medical Association voted down a tentative agreement in August 2016: E. Gee, "Ontario physicians decisively dismiss province's new fee agreement", *Globe and Mail*, Aug. 15, 2016, online at <http://www.theglobeandmail.com/news/national/ontario-doctors-reject-controversial-fee-deal-with-province/article31420236/>.

in truth the objective is more usually mere cost containment. This is perhaps not surprising given that the longer-term effects of cost-containment initiatives – e.g. the cost of medical errors – may not be something that any present government will experience within its mandate.

Under the current Canadian single-payer Medicare model, a parallel private sector is virtually nonexistent for hospital and physician services.¹³⁸ Private sectors do exist in home care, long term care, prescription drugs and other parts of Medicare besides hospitals and physicians, but as it stands today Canada remains a single-payer health care system in relation to hospital and doctor services. Therefore, all citizens – except for the very affluent who may retain their own “opted-out” physicians and hospitals – are fully subscribed to the fate of the Canadian system. Citizens are mostly dependent on the state and health policy decision makers to fund and deliver care that ensure basic levels of accessibility (i.e. waiting times for required procedures) and quality (objective health outcomes from treatment).

Thus, it is not surprising to find that polls tend to show that Canadians see improving efficiency in health care delivery as a top priority.¹³⁹ A 2014 study by CIHI reported that Canada’s system could be much more efficient, finding that regions in Canada varied from 0.65 to 0.82 on a scale of efficiency (with 1.0 being perfect efficiency).

¹³⁸ For a good historical review of the evolution of the Canadian Medicare model, see Affidavit of Gregory Marchildon filed in *Cambie Surgeries Corporation v. British Columbia (Medical Services Commission)* Vancouver Registry No. S090663.

¹³⁹ L. Priest & R. D’Aliesio, “Health-care efficiency seen as more critical than funds, survey finds”, *Globe and Mail*, December 20, 2011, online at <http://www.theglobeandmail.com/news/national/health-care-efficiency-seen-as-more-critical-than-funds-survey-finds/article4181627/>; and Environics Research Group, “Canadians Feel Improving the Health Care System Lies With Addressing Inefficient Management Over Expanding Funding”, last updated December 21, 2011, cited January 6, 2012, online at http://www.environics.ca/news-andinsights?news_id=110.

It concluded that “if all regions were perfectly efficient, between 12,600 and 24,500 premature deaths could possibly be prevented in Canada.”¹⁴⁰ That is, efficiency would free up more resources to devote to treating more patients, thus leading to fewer premature deaths.

Political pressures will persist as more is learned about where the efficiency of the Canadian health care system ranks internationally. A 2014 study by the U.S.-based Commonwealth Fund compared the efficiency of the U.S. health care system to that of ten other countries including Canada.¹⁴¹ It ranked the countries on a series of indicators. Canada’s rank on some of these indicators was:

- Total expenditures on health as a percent of Gross Domestic Product: 7th of 11
- Percentage of national health expenditures spent on health administration and insurance: 4th of 11
- Visited Emergency Department for a condition that could have been treated by a regular doctor, had he/she been available: 11th of 11
- Medical records/test results did not reach doctor’s office in time for appointment, in past 2 years: 10th of 11
- Sent for duplicate tests in past 2 years: 7th of 11
- Hospitalized patients went to ER or were rehospitalized for complication after discharge: 10th of 11¹⁴²

Overall, the report ranked Canada next to last (10th) in efficiency, better only than the U.S.¹⁴³

Legal pressures have also lent greater importance to efficiency in the delivery of health care. In 2005, the Supreme Court of Canada ruled in the *Chaoulli* decision that

¹⁴⁰ CIHI, *Measuring the Level and Determinants of Health System Efficiency in Canada* (2014), online at https://secure.cihi.ca/free_products/HSE_TechnicalReport_EN_web.pdf at v; see also CIHI, *Health System Efficiency in Canada: Why Does Efficiency Vary Among Regions?* (2014), online at http://www.cihi.ca/cihi-ext-portal/pdf/internet/hse_short_aib_10apr14_en.

¹⁴¹ Commonwealth Fund, *International Profiles of Health Care Systems, 2014* (2015), online at http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/jan/1802_mossialos_intl_profiles_2014_v7.pdf.

¹⁴² *Ibid.* at 23.

¹⁴³ *Ibid.*

Section 7 of the *Canadian Charter of Rights and Freedoms* protects a citizen's right to pay privately for faster care than they would receive in the public system.¹⁴⁴ The *Chaoulli* decision gave greater immediacy to this political demand by giving citizens a new tool – the *Charter* – to escape from a dissatisfactory public system. Indeed, it is now being deployed by a private clinic in British Columbia in a *Charter* challenge that, if successful, would permit physicians (at least in B.C.) to receive private payment for services that are covered by the provincial Medicare plan and to extra-bill.¹⁴⁵

The combination of these pressures – economic, political and legal – has driven governments to pursue what might be called an efficiency-driven “performance imperative” in health care, in which governments are committed to re-investments in health care, but do not want to spend new money in inefficient modes of delivery. Technological advances have created opportunities to shift care to a wider range of settings than physicians' offices and hospitals - those contemplated in the *Canada Health Act*. Innovations to improve the cost-effectiveness of care have taken many forms such as primary care reform, hospital restructuring, tele-health, e-health and a shift of acute care into the home and community sectors.

It would be wrong to say that “performance” is an entirely novel concept in Canadian health policy. Rather, what is new is its meaning. Performance was once measured by inputs, so that the more investments by the state in the system, the better it would perform. That is, the more resources, technical, financial and human, devoted to

¹⁴⁴ *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 S.C.R. 791; C. Flood, “*Chaoulli's* Legacy for the Future of Canadian Health Care Policy” (2006) 44:2 *O.H.L.J.* 273-310.

¹⁴⁵ *Cambie Surgeries Corporation v. British Columbia (Medical Services Commission)* Vancouver Registry No. S090663; most court documents have been made available unofficially online by the B.C. Health Coalition, online at <http://www.bchealthcoalition.ca/what-you-can-do/save-medicare/court-documents>.

the system, the better it would perform in terms of quality and accessibility. Health economist Robert Evans described this understanding of performance as a “Medico-Technical model” of health care economics, in which “...’supply, that is, the amount providers wish to provide at current costs of production and rates of reimbursement, is ... equated with the technical concept of ‘need’.”¹⁴⁶ Evans noted:

On the important issues of how to ensure technical efficiency in health care production, or how the earnings of providers will or should be determined, the model is silent.¹⁴⁷

Evans concluded that this model of health economics policy “dominated health care planning and policy making in Canada to the end of the 1960s, and still underlies much thinking on this subject.”¹⁴⁸ In line with this view, governments generally avoided difficult issues of efficiency – and the potential conflicts with health professionals this might spawn – with more spending. Performance values prior to the ones at work today were risk-averse, preferring not to tamper with established funding, rationing and delivery practices. In part, this risk aversion took the form of accommodation of physicians and other professional groups.¹⁴⁹ Thus, before the restraint and restructuring of the 1990s, public spending on health care had steadily increased, as did the incomes of many provider groups in the system.¹⁵⁰

¹⁴⁶ R. Evans, *Strained Mercy: The Economics of Canadian Health Care* (Toronto: Butterworths, 1984) at 22.

¹⁴⁷ *Ibid.*

¹⁴⁸ *Ibid.* at 23.

¹⁴⁹ C. Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (Oxford, U.K.: Oxford University Press, 1999) at 204.

¹⁵⁰ Evans, *Strained Mercy*, *supra* note 146 at 15: from 1947 to 1971, the income of the average doctor rose from 3.26 times the average taxpayer to 5.57 times.

Rhetorical and Real Manifestations of Efficiency in Canadian Health Policy

Governments at all levels in Canada have embarked on a wide range of policies that they call efficiency-driven but that are just cost-cutting exercises. Beginning at the highest level of governance, in 2014 the federal government has invoked efficiency in changing how it calculates the amount of funding provinces receive based on their compliance with the Canada Health Act's five funding criteria.¹⁵¹ In 2014 the Harper government implemented per capita-based funding in place of the equalization-based models of funding under the former Canada Health Transfer program that provided subsidies to assist smaller and less wealthy provinces.¹⁵²

The cost-reduction theme continued in policy pronouncements from federal research entities. To promote efficiency, the CIHI in 2012 issued a "performance measurement framework" for provinces and health regions to use.¹⁵³ In this framework, CIHI posited three health system goals: (1) promoting population health, (2) providing services that meet the needs and expectations of the population, and (3) "value for money", which CIHI described as:

"...related to the other two since it measures the level of achievement of these goals compared with the resources used. Therefore, value as defined here is concerned with the ability of the health system to balance the allocation of resources to obtain the best outcomes (health status, health system responsiveness and equity) for the resources used."¹⁵⁴

¹⁵¹ *Canada Health Act*, R.S.C. 1985, c. C-6, s. 7. The five funding criteria are (not in order of priority) "public administration", "comprehensiveness", "universality", "portability", and "accessibility".

¹⁵² G. Marchildon & H. Mou, "A Needs-Based Allocation Formula for Canada Health Transfer" (2014) 40:3 *Canadian Public Policy* 209-223.

¹⁵³ CIHI, "A Performance Measurement Framework for the Canadian Health System" (2012), online at https://secure.cihi.ca/free_products/HSP-Framework-ENweb.pdf.

¹⁵⁴ *Ibid.* at 4.

Here, the concern again is with preserving the “resources used” and using efficiency as the rhetorical tool to support this concern.

In turn, efficiency has dominated provincial health policy. Everywhere, governments at provincial and regional levels have pursued efficiency with a businesslike fervour. In Ontario, the 2012 Drummond Report on public service reform said, in the health care context, that “quality and efficiency go hand in hand.”¹⁵⁵ Provincial ministries of health now prepare and publish multi-year “business plans” or “service plans” that define performance indicators and set efficiency and performance targets; Alberta¹⁵⁶ and British Columbia¹⁵⁷ are typical in this regard. Provinces are also starting to change how they fund their public hospitals. In 2012, for example, Ontario unveiled a new health care plan that included a shift in hospital funding from global budgets to a mixture of capitation and activity-based funding. In line with hospital funding reform have been efforts to shift more services once provided in hospitals out to the home care and community care sectors. Ostensibly the purpose of this shift to community based care is that the same services can be provided at less cost by a mix of public and private providers. This shift, however, masks the increasing reliance on private finance in these sectors.

¹⁵⁵ Ontario, Ministry of Finance Commission on the Reform of Ontario's Public Services, *Public Services for Ontarians: A Path to Sustainability and Excellence* (Toronto, ON: Queen's Printer for Ontario, 2012), Ch. 5, online at <http://www.fin.gov.on.ca/en/reformcommission/>.

¹⁵⁶ Alberta Health, *Health System Outcomes and Measurement Framework 2013*, online at <http://www.health.alberta.ca/documents/PMIS-Outcomes-Measurement-Framework-2014.pdf>; Alberta Health, “Performance Measures: Better Quality, Better Outcomes, Better Value”, online at <http://www.albertahealthservices.ca/performance.asp>; Alberta Health Services, *2013-2014 Annual Performance Report*, online at <http://www.albertahealthservices.ca/assets/about/publications/ahs-pub-pr-2013-14-dashboard.pdf>.

¹⁵⁷ British Columbia Ministry of Health, “Setting Priorities for the B.C. Health System” (2014), online at <http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf>; British Columbia Ministry of Health, *2015/16 – 2017/18 Service Plan* (February 2015), online at <http://www.bcbudget.gov.bc.ca/2015/sp/pdf/ministry/hlth.pdf>.

A prominent instance of efficiency-driven hospital reform has been the adoption of “Lean” work organization models. “Lean” is a model for organizing factory production which originated with Toyota. At Lean’s core is the constant search for wasted movements, actions and tasks in the production process, and the careful elimination of those wasted elements from the chain of work. Saskatchewan’s Ministry of Health wholeheartedly embraced the Lean model in 2008, and describes it as follows:

Lean is a patient-focused approach to managing and delivering care that continuously improves how we work. There are many processes involved in health care. Lean is about finding and eliminating waste in these processes. Waste is defined as anything that does not add value from the patient’s perspective.¹⁵⁸

In Saskatchewan, the Lean model applied to nursing care was called “Releasing Time to Care” or RTC.¹⁵⁹ The goal of RTC is to change how nursing work is organized to free up, or “release” time that can be used for direct patient care. Lean has come under criticism, however. In 2014, six years into the Lean program, the Saskatchewan Union of Nurses said that the program was unduly focused on short-term cost -cutting and paid insufficient attention to its impact on patient safety. “We are finding that Lean does not fit with the registered nursing process, safe nursing practice, registered nurse decision-making or the formulation of nursing diagnoses,” said the union president.¹⁶⁰

Efficiency’s Influence on Canadian “Health Human Resource” Policy

¹⁵⁸ Saskatchewan Health Quality Council, “Continuous Improvement: Lean”, online at <http://hqc.sk.ca/improve-health-care-quality/lean/>.

¹⁵⁹ Online at <http://hqc.sk.ca/improve-health-care-quality/releasing-time-to-care/>.

¹⁶⁰ “Saskatchewan nurses say Lean program has little impact on patient care”, *Globe and Mail*, March 19, 2014, online at <http://www.theglobeandmail.com/news/national/saskatchewan-nurses-say-lean-program-has-little-impact-on-patient-care/article17561357/>.

The impact of efficiency is perhaps felt most in the rise of “productivity” in policy discourse about the supply and allocation of “health human resources”, the cold moniker for the nurses and other health providers working in the system. Governments and health employers agree with the need for some level of increased investment in HHR, but are at the same time seeking more efficiency in the form of greater “output” from physicians, nurses and other HHR in (and those coming in) to the system.

This “productivity” focus is somewhat novel in HHR policy. As Birch et al (2007) observed, HHR policy was traditionally derived from past utilization patterns, demographics and population studies which determined need for particular provider groups, then estimating whether and how much of a deficit or surplus there is for that group, then calculating changes in training programs needed to reach the optimal outcome.¹⁶¹ Today, however, the authors observed that HHR policy:

... is aimed at having the right number of people with the right skills in the right place at the right time to provide the right services to the right people...It involves comparing estimates of future requirements for and supplies of human resources as well as considering policy options for addressing any differences between requirements and supplies...¹⁶²

The authors argued that health care provider productivity should be a factor in determining how many new positions are needed of a given provider group. In the case of nurses, the authors stated, “[h]igher increases in productivity” would reduce the number of new nursing positions needed to meet population needs.¹⁶³

¹⁶¹ S. Birch *et. al.*, “Human Resources Planning and the Production of Health: A Needs-Based Analytical Framework” (2007) 33:s1 *Canadian Public Policy* S1-S16 at S2.

¹⁶² *Ibid.*

¹⁶³ *Ibid.* at S12.

Productivity – efficiency in other terms – continued to be important in national-level analyses of the Canadian health care system. In 2002, the foundational Romanow¹⁶⁴ and Kirby¹⁶⁵ reports called for adding more nurses and doctors to the system, but also began to call for greater efficiencies in delivery and more productivity by health professionals. The Kirby Report also called for measures to promote recruitment of health professionals, but gave greater emphasis to the need for more productivity by those professionals working in the system. Kirby focused his comments on physicians' productivity, but extended this view to nurses as well. He concluded:

Still, not enough is known about the productivity of nurses and what could be done to improve it. ... The Committee believes that the same type of productivity research that is proposed with respect to physicians is also needed in order to understand better how nurses spend their time at work, and what institutional barriers stand in the way of improved productivity. This is why the recommendation made above includes all health care professionals.¹⁶⁶

Federal government HHR initiatives since the Romanow and Kirby reports have echoed the recruitment and productivity themes. These included the Federal/Provincial/Territorial (F/P/T) Advisory Committee on Health Delivery and Human Resources (ACHDHR), which in 2007 issued a report, *Framework for Collaborative Pan Canadian Health Human Resource Planning*, which also emphasized productivity.¹⁶⁷

¹⁶⁴ Commission on the Future of Health Care in Canada (Roy J. Romanow, Chair), *Building on Values: The Future of Health Care in Canada – Final Report*. (Ottawa: Commission on the Future of Health Care in Canada, November 2002) ("Romanow Report"), online at <http://www.publications.gc.ca/site/eng/237274/publication.html>.

¹⁶⁵ Standing Senate Committee on Social Affairs, Science and Technology (Hon. Michael J.L. Kirby, Chair), *The Health of Canadians – The Federal Role: Final Report. Volume Six: Recommendations for Reform* (Ottawa: Senate of Canada, October 2002) ("Kirby Report"), online at <http://www.parl.gc.ca/Content/SEN/Committee/372/soci/rep/repoct02vol6-e.pdf>.

¹⁶⁶ Kirby Report, *ibid.* at 187.

¹⁶⁷ Federal/Provincial/Territorial (F/P/T) Advisory Committee on Health Delivery and Human Resources (ACHDHR), *Framework for Collaborative Pan Canadian Health Human Resource Planning*, online at http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/hhr/2007-frame-cadre/2007-frame-cadre-eng.pdf.

Efficiency Demands Evidence

The pursuit of efficiency in Canadian health policy has made evidence-based decision-making a fundamental policy method. Evidence-based decision-making reflects a desire to replace politics and subjectivity in decision making with evidence and objectivity. Ideally, evidence is used to create the indicators for measuring performance trends such as accessibility and quality of care. Such indicators are then used, in conjunction with further evidence of health outcomes, to measure and evaluate the relative merits of different funding, organizational, or other options in response to policy problems. The goal of this approach to decision making is to connect health care policy decisions to predicted outcomes with reference to established norms and indicators of performance.

To fuel the search for efficiency and greater performance, there is more evidence than ever before. Certainly, provinces are the front-line gatherers of patient care and spending information, but provinces also receive valuable evidence and analysis on nursing HHR trends from federal agencies, most notably the Canadian Institute for Health Information. In 2012, CIHI developed a model for measuring efficiency in Canadian health care that included a list of performance indicators and “health system inputs” as variables in the efficiency equation. These performance indicators, in turn, have shaped CIHI’s data gathering efforts.¹⁶⁸ In addition to its vast expenditure and primary health care information collections, the CIHI also gathers immense amounts of HHR data.

¹⁶⁸ CIHI, *Developing a Model for Measuring the Efficiency of the Health System in Canada* (2012), online at https://secure.cihi.ca/free_products/HS_Efficiency_Tech_Report_EN-web.pdf

Patient Safety and Efficiency: Points of Conflict, Potentials for Misuse

In the foregoing, I argued that patient safety and efficiency are both high priorities for Canadian health policy. However, they are not harmonious goals in practice. The tension between them – between the urge to invest in patient safety and the urge to show value for money - emerges most clearly in the labour relations negotiations, agreements and arbitrations reviewed in Chapter 4. In these episodes, nurses' unions typically press for contract terms on staffing, scheduling and workload that they tie to patient safety, but which involve added cost for hospitals. In response, governments and hospitals have insisted that this additional cost be more clearly justified by tangible improvements in patient safety, or that the cost – even if justified – is simply not affordable because of the wide array of health professions making similar claims and the broader multiplicity of patient and user groups demanding more resources. Thus, in the realm of negotiations over patient safety-related issues, which will be canvassed in greater depth in Chapter 4, efficiency acts as a countervailing pressure just as it does in health policy and HHR policy more generally.

The tension between patient safety and efficiency is less at a fundamental level than at an operational level. At an abstract level, patient safety and efficiency can in some respects be harmonious. Efficiency, in theory, can be seen to promote patient safety by freeing up resources that can in turn be used to hire more nurses and provide better working conditions for them, or for other patient safety measures. Conversely, improvements to patient safety would, if measured, result in an improvement in efficiency because it represents a good health outcome in the performance equation. Each concept

could also claim to envelop the other within its meaning. Patient safety advocates would argue that efficiency is not about goals, only means, that efficiency is implied in every public sector endeavour, and therefore that efficiency need not be given additional weight in determining whether a particular patient safety proposal should be adopted. Conversely, efficiency proponents might claim that patient safety is already accounted for within the performance analysis, subsumed under the broader rubric of “quality”. Thus, there is no pure dichotomy between patient safety and efficiency.

Rather, the points of conflict between these two concepts arise during negotiations, debates and adjudications on concrete proposals that are claimed to advance one or the other objective. Hence, efficiency is typically invoked as a response to a concrete change to a rule or policy that is claimed to advance patient safety, and conversely patient safety is typically invoked as a response to a concrete proposal that is claimed to advance efficiency. The two concepts are not fundamentally antagonistic but rather collide at the level of negotiations, disputes, agreements and adjudications over specific issues such as nurse workload, hours of work and scheduling, and Chapter 4 will explore these outcomes in episodes in greater depth.

Patient safety and efficiency are politically charged concepts. Thus, caution and a certain measure of skepticism is warranted when approaching claims that invoke them in support. As Chapter 4 will show, these claims can arise in many labour law forums, including bargaining demands by nurses’ unions, responses to those demands by governments, settlements of disputes or arbitration decisions. The nursing profession, through its various provincial unions, has sought a variety of workplace improvements to workload, hours of work and scheduling, all of which have ties to and are often founded

on patient safety. At the same time, however, the labour law structures governing nurses' unions require them to advance the personal and professional employment interests of nurses. After all, it is the core function of a trade union to seek tangible economic or other improvements to the terms of employment for those it claims to represent.

In this sense, it becomes vital to acknowledge the dual public/private functions that nurses' unions claim to perform: while frequently espousing the public interest in their negotiation and other advocacy, nurses' unions are at the same time self-interested organizations accountable solely – by law and custom – to its member nurses. This does not render their claims meritless in any way; rather, it requires a closer examination, on an issue-by-issue basis, of whether the available evidence supports a link between sought-after improvements to nurses' working conditions and improvements in patient safety outcomes. Where the evidence does support such links, then the public and private roles of the nurses' unions are in harmony. In Chapter 2, I will explore this question in greater detail.

Of greater concern, in my view, is the high potential for self-interested political or economic behaviour to be rhetorically grounded in efficiency. There is a distinction between efficiency claims that promote reducing the cost of providing a constant range and accessibility of services and efficiency claims that simply promote cost cutting via reducing the range and accessibility of services. The former is a technical claim to seek greater cost-effectiveness, while the latter is a political claim to simply reduce the role of government in the health care system. Efficiency, then, can be used as a rhetorical device to cloak a deeper policy agenda to shrink the public role in health service provision. As Janice Gross Stein explained, this is precisely what happened during much of the 1990s

in Canada, as governments invoked efficiency when raw spending reductions were the goal. She wrote:

From 1992 through 1997, per capita public expenditures for health care not only held stable, but dropped. Expenditure did not keep pace with population growth, much less allow for the added costs associated with the aging of the population and new technologies. Controlling – or cutting – costs can be inefficient if it reduces the effectiveness of health care by an even larger margin. Much of the language of the past decade misconstrues efficiency to mean cost-containment. When this happens, as I argued in the previous chapter, efficiency becomes a cult.¹⁶⁹

Obviously, a free and open political debate about the single-payer model of Canadian health care has unfolded with great vigour since the enactment of the Canada Health Act in 1984, and pressures to allow greater private access to medical and hospital services will be part of that debate. In navigating this debate, governments are aware of the political sensitivity of the perception that they might be somehow eroding the Canadian Medicare model. As such, to the extent that governments at either level wish to promote a departure from the current single-payer model without risking the political cost this might entail, they will be tempted to cloak this agenda in the rhetoric of efficiency. In this context, it becomes especially important to consider that governments, and particularly governments with a stated political opposition to the current single-payer model, will be tempted to deploy “efficiency” in this way.

Conclusion

As stated at the beginning, this Chapter is a necessary prelude to the rest of my project. In Chapters 4 and 5 I show how efficiency has operated in nurse collective

¹⁶⁹ J. Stein, *The Cult of Efficiency* (Toronto: Anansi Press, 2001) at 97.

bargaining as a force of resistance to nurses' union bargaining proposals on workload, hours of work and scheduling. As I will argue there, the protections found in nurse collective agreements on these issues are often diluted by exceptions or limited in application, which can be ascribed to government resistance to more fulsome protections, resistance that in turn flows from the efficiency imperative. Governments often invoke cost, efficiency or productivity as rhetorical devices to oppose nurses' union demands for greater protections. In this Chapter, I explain the roots of this imperative. Efficiency is and will continue to be a dominant force throughout Canadian social policy, especially health policy. As the philosopher and political scientist Stein ably demonstrated in her work cited above, efficiency has become so pervasive that it operates at a near-subliminal level. The danger of ignoring the infusion of efficiency-based rhetoric in health policy is that it becomes more difficult to separate good faith applications of the efficiency principle from bad faith uses.

In the HHR realm, as I argued here, efficiency can be used in bad faith to resist enlarging the pool of health providers and argue instead for asking the existing pool of nurses, doctors and others to simply "produce" more for patients. The call for productivity is simply the importation of efficiency into HHR policy at the ground level – where it falls to the individual nurse to do more work within the same time and resource constraints. It absolves higher-level decision-makers in health policy from making the tough but important choices to invest in expanding the pool of health providers rather than adopting "Lean" production models or other schemes to give the appearance of efficiency while attaining the short-term political goal of cost containment.

Efficiency, thus understood, stands in tension with the goal of patient safety, and this tension is the policy context in which the labour relations outcomes on patient safety-related issues reviewed in Chapter 4 arise. As will be seen, bargaining, agreements and arbitrations on issues such as staffing, workload, scheduling all take shape in labour relations processes in which nurses' unions invoke patient safety and governments invoke efficiency. All the labour disputes dealing with these issues featured this bipolarity of views, and this tension also explains the myriad exceptions and other modifiers to collective agreement terms that dilute their effectiveness at improving patient safety.

**CHAPTER TWO:
ESTABLISHING NURSE WORKLOAD AND TIME WORKED
AS “PATIENT SAFETY ISSUES”**

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Introduction and Chapter Overview

In this Chapter I argue that the issues of nursing workload and hours worked are “patient safety issues” that should be treated as public policy matters. This argument is a necessary preface to my analysis in chapters 4 to 6, in which I examine how these patient safety issues were raised, negotiated and resolved in nurse collective bargaining from 1999 to 2014. Chapter 1 set the context in which patient safety has emerged as a strong priority in Canadian health policy, showing how the efficiency imperative in health policy operates in resistance to it. The balance of influence between patient safety and efficiency is shaped in part by our knowledge of the risk factors for adverse events, a science that I show in this Chapter is constantly expanding. Relying on systematic reviews and selected individual studies, I make the argument that the research evidence has reached a critical

mass in support of the patient safety-relatedness of the nursing workload and time worked. After clarifying some frequently-used key concepts and terms and explaining my research method, I set out my research findings. In my view, these findings suggest that the social science on the connection between nursing workload, hours of work and preventable medical errors has matured to a point where it is now plausible to treat these notionally private issues as matters of public interest to patients and their families.

Concepts and Terms

To make my argument in this Chapter, I rely on published studies and reviews on the effect of nursing workload and hours worked on patient safety. Patient safety has been measured in different ways. The most common measure has been to track the occurrence of one or more “adverse events” during the nursing care process. A non-exhaustive list of these events includes medication errors, falls, pressure ulcers, failure to rescue, infections of many different kinds, mortality rates, unplanned extubation and sepsis.

In this study, I define “patient safety issue” liberally to mean any nursing-related topic or subject that has a scientifically demonstrable probabilistic connection, relationship or association with any adverse patient outcome that results from error or oversight during the care process. Studies measuring broad types of phenomena such “30-day mortality”, “failure to rescue”, “adverse events” and “patient health outcomes” capture the adverse events attributable to error or omission, but may also include the occurrence of adverse events that are not preventable in some way. Still, such measures will by their nature reflect at least a trend in patient safety even if in some studies their scope goes beyond negligence-caused illnesses.

At the same time, many other studies define patient safety by reference to one or more specific events presumed to be most likely due to error or oversight. Medication errors, for example, are indicators of patient safety because they presumably arise due to mistakes by staff. Infections or other hospital-acquired conditions reflect poor patient safety practices in relation to germ control and hygiene. Patient falls are sometimes studied as measures of patient safety, as are urinary tract infections, which are presumably preventable with proper patient monitoring. Unplanned extubations and bed pressure ulcers, similarly, can happen because of inattention. The common feature of these indicators is that they arise due to mistake, oversight, cutting corners during the work process, poor communication or misunderstandings, a failure to document or a failure to follow germ control policy. In turn, it seems *prima facie* arguable that these events happen because of nurse workload or hours of work – and the science has come to prove it.

As I use the term, nursing “workload” is a measure of the ratio of patients per nurse on a unit, adjusted for the complexity or criticality of the patients’ conditions. Certainly, a small number of highly critical patients can require more work than a larger number of more stable patients. Still, all things being equal, nursing workload is a measure of the overall patient burden expressed as a numerical ratio. Staffing levels – meaning the number of nurses assigned to a unit on a particular shift - are a frequent measure of workload in the literature, as they directly affect this ratio. Similarly, I use “time worked” to mean the amount of time worked by a given nurse in a single shift or series of shifts. In some studies, time worked is measured in shift length; in other studies, in overtime worked, and in still others it is measured in total hours worked in a week or month.

Approach to Scientific Evidence

In this thesis, I use scientific evidence to critique the outcomes of nurse collective bargaining. In other words, I aspire to evidence-based decision-making (or “EBDM” for brevity). As Chapter 1 explained, EBDM is the way health policy decisions are supposed to be made. Without evidence to support efficiency-based claims, the danger arises – discussed in Chapter 1 – of efficiency being used only as a rhetorical device to cloak an aggressive cost-cutting agenda by a neo-liberal government. Thus, the ideals of efficiency and effectiveness – as those concepts are truly intended to be used - cannot be realized without reliable evidence on the issues in question. In nurse collective bargaining, I believe that patient safety issues of nursing workload and time worked as precisely these kinds of issues, and critique the decisions made in collective bargaining with what I believe to be the best available evidence.

Legal academics without formal scientific training should be careful in how they use published research studies from the social sciences. Scientific findings have great rhetorical force because of the rigour and objectivity that are expected in the social sciences. Such findings become evidence that educates policy makers and steers them toward the most rational policy choices. As Fafard (2008) explained:

[A] health sciences perspective adopts and adapts a linear, problem-solving approach to public policy. Having observed illness and disease in the population, the challenge is to better understand the causes of illness and disease, however complex, and having done so, move to addressing those causes by bringing to bear the best possible evidence. The original impetus for policy change may in fact be normative, for example when public health officials seek to mitigate the negative aspects of homelessness or drug addiction in order to improve the health of vulnerable populations. However, having decided that action

is necessary, the goal is one of acting based on the best available evidence and/or acting in a way that is least likely to cause harm.¹⁷⁰

Applying Fafard's paradigm here, the problem needing attention is the prevalence of medical error in Canadian health care. In the context of health service delivery, this approach seeks out problems in the quality or efficiency of health care, searches for explanations or causes, and attempts solutions. Lessening adverse events is a policy goal that fits neatly within this model. The more we learn about the root causes of medical error, the more likely we are to lessen it. My approach to the problem asks if some of the systemic causes¹⁷¹ of medical error include nursing workload or hours worked.

Systematic reviews and meta-analyses are the best evidence for health policy decision-making. They play a kind of mediating role linking the opaque and specialized realm of science and the lay and generalized world of public policy. Systematic reviews are crucial to evidence-based decision making because they strive to filter out studies that fall below a scientific standard of reliability. This is not to say that studies reviewed but discarded by systematic reviewers are invalid as science altogether. Rather, they are saying that those studies do not meet the test for use as a basis for making health policy decisions on the specific issue the systematic review is designed to address.

Systematic reviews are essentially distillations of existing scientific findings as disseminated in published articles. They use carefully chosen search terms on well-known databases. They begin with gathering a large initial set of articles that result from

¹⁷⁰ P. Fafard, "Evidence and Healthy Public Policy: Insights from Health and Political Sciences" (Ottawa: National Collaborating Centre for Healthy Public Policy, May 2008) at 4, online at http://www.cprn.org/documents/50036_EN.pdf.

¹⁷¹ L. Hardcastle, *The Role of Tort Liability in Improving Governmental Accountability in the Health Sector* (Doctor of Juridical Science (S.J.D.) Dissertation, Faculty of Law, University of Toronto, 2013) Chapter 2, "The Role of Systems in Patient Injuries", at 47-80, PDF, online at https://tspace.library.utoronto.ca/bitstream/1807/35178/21/Hardcastle_Lorian_E_201303_PhD_thesis.pdf.

the searches. They use teams of scientists and reviewers to sift through this initial set according to a carefully formulated set of inclusion criteria. These criteria set the standards for determining which studies should be used in trying to determine the best available scientific knowledge, and which can be ignored and discarded. These criteria typically include the quality of the methods used in a study, the type of study used, the size of the observed pool of patients or data, and other factors bearing on the scientific quality of a study's findings.¹⁷²

As early as 2001, health policy decision makers began shifting from primary studies to systematic reviews as the focus of evidence-based decision-making.¹⁷³ This Chapter is itself not offered as anything approaching a systematic review, nor does it purport to be a formal scientific critique of the many such reviews that have been done. Notwithstanding this limitation, the rigorous nature of the reviews I have chosen here lends great weight to their findings. Science can still inform my analysis so long as it is received with deference to the expertise of those in the field and with an understanding of the reasons why the context and methods used in systematic reviews are important.

Research Sources and Process

My general approach to researching the literature on nurse workload, time worked and patient safety was to use broad searches that erred on the side of overinclusion, followed by a careful review of titles and abstracts to determine inclusion. I used the

¹⁷² A. Holopainen *et. al.*, "Systematic review – a method for nursing research" (2008) 16:1 *Nurse Researcher* 72-83; A. Garg *et. al.*, "Systematic Review and Meta-analysis: When One Study Is Just Not Enough" (2008) 3:1 *Clinical Journal of the American Society of Nephrology* 253-260.

¹⁷³ D. Evans, "Systematic reviews of nursing research" (2001) 17:1 *Intensive and Critical Care Nursing* 51-57; D. Evans & A. Pearson, "Systematic reviews: gatekeepers of nursing knowledge" (2001) 10:5 *Journal of Clinical Nursing* 593-599.

MedLine, PubMed, Ovid and Google Scholar databases. On each of these, I performed several searches using different combinations of key words. Specifically, I undertook:

- a) Searches of “nurse” and “staffing”, “nurse” and “hours”, “nurse” and “scheduling”, broadly framed to be sure to capture all studies that looked at nursing workload or hours worked. From these I selected articles that appeared from their title or abstract to have a connection with patient safety or adverse events; and
- b) Searches of “nurse” and “patient safety”, “nurse” and “adverse events”, “nurse” and “error”, broadly framed to capture all studies that looked at any nursing-related factors in the prevalence of adverse events.

By framing these searches broadly, I believe I captured all possibly relevant articles published on the connections between nursing workload or hours of work and one or more indicia of adverse events or patient safety.¹⁷⁴ I conducted a first round of these searches in August 2014, and updated this research in March 2016. I then reviewed the pool of possibly relevant articles to select out and separate all the systematic reviews or meta-analyses from the single-study articles. From these I selected articles that seemed from their title or abstract to connect nursing workload or hours worked to adverse events.

Among the single-study articles, I included all studies that involved looking at associations between nurse workload or hours worked and patient safety. These included studies on patient safety trends generally, adverse events, medical errors, and one or more of the specific events mentioned above as being associated with medical error. Some studies correlated nurse workload and time worked to “health outcomes” or “patient outcomes” generally; of these, I excluded any that measured simple bottom line health

¹⁷⁴ J. Belisario *et al.*, “Search strategies to identify observational studies in MEDLINE and EMBASE” (2013) Cochrane Library, online at <http://onlinelibrary.wiley.com/enhanced/doi/10.1002/14651858.MR000041>.

outcomes in hospital patients and included those that used medical errors as indicia of poor health outcomes.

Nursing Workload and Patient Safety

Systematic Reviews

The strongest evidence that nursing workload is a patient safety issue comes from systematic reviews. Staffing levels directly affect nurse workload, as more nurses means fewer patients per nurse, and vice-versa. Systematic reviews of studies connecting nurse staffing and patient safety outcomes are among the most numerous. By now thousands of such studies have been conducted across the world, and many systematic reviews have emerged attempting to distil knowledge from them.

In 2004, a team of researchers based in California did an early systematic review of studies connecting nurse staffing to a range of health outcome indicators, which included adverse events (Lang *et al*, 2004).¹⁷⁵ They looked at nearly 3,000 studies connecting patient, nurse and hospital outcomes published between 1980 and 2003. The outcomes studied were in-hospital adverse events, which included infections, pneumonia, failure to rescue, inpatient mortality and urinary tract infections. The purpose was to determine whether these studies justified implementation of legislated nurse-patient ratios in California. In 1999 California enacted Assembly Bill 394, which set minimum nurse-to-patient ratios for hospitals in that state.¹⁷⁶ The starting ratio in 1999 of 6 patients per nurse was lowered to 5 patients per nurse in 2005.¹⁷⁷ The researchers found, based

¹⁷⁵ T. Lang *et. al.*, “Nurse–Patient Ratios: A Systematic Review on the Effects of Nurse Staffing on Patient, Nurse Employee, and Hospital Outcomes” (2004) 34:7-8 *Journal of Nursing Administration* 326-337.

¹⁷⁶ Nurse-patient ratios were introduced into California law by Assembly Bill 394 (AB 394), 1999, online at ftp://www.leginfo.ca.gov/pub/99-00/bill/asm/ab_0351-0400/ab_394_bill_19991010_chaptered.html.

¹⁷⁷ T. Lang *et. al.*, “Nurse-Patient Ratios”, *supra* note 175 .

on the data extracted from these studies, lower rates of failure to rescue and inpatient mortality correlated with higher nurse staffing levels. They concluded, “If the baseline adverse event rate is already low, changes in nurse staffing may show no effect. Alternatively, where baseline rates are high, identical staffing changes may produce substantial benefit.”¹⁷⁸

A 2005 systematic review by U.K. researchers focused on the effects of nurse staffing on the prevalence of adverse events that negatively affect patient outcomes (Lankshear *et al*, 2005).¹⁷⁹ Commissioned by the Chief Nursing Officer of England and funded by the Department of Health and NHS, the team did a systematic review of all the scientific literature published since 1990 on nurse staffing and patient health outcomes. From a starting set of 8,644 search results, the team filtered out most of the studies because they did not meet their inclusion criteria. They noted a “consistent pattern of results”: nine large studies found a “significant inverse relationship between RN staffing levels and mortality rates”; four studies found such a relationship for failure to rescue, and seven of eight studies showed positive associations between nurse-patient ratios and rates of pneumonia, UTI, ulcers, falls, and wound infections.

The Canadian Health Services Research Foundation funded a 2005 systematic review on nurse staffing and patient safety.¹⁸⁰ The reviewers used 27 searches of

¹⁷⁸ *Ibid.* at 332.

¹⁷⁹ A. Lankshear *et. al.*, “Nurse Staffing and Healthcare Outcomes: A Systematic Review of the International Research Evidence” (2005) 28:2 *Advances in Nursing Science* 163-174.

¹⁸⁰ A. Sanchez-McCutcheon *et. al.*, “Evaluation of Patient Safety and Nurse Staffing” (Ottawa: Canadian Health Services Research Foundation, November 2005); this research was used in J. Ellis *et. al.*, “Staffing for Safety: A Synthesis of the Evidence on Safe Staffing and Patient Safety” (Ottawa: Canadian Health Services Research Foundation, 2006), online at <http://www.cfhi-fcass.ca/SearchResultsNews/06-09-01/e1b9468c-dafe-4ccf-b4f3-3f29ee0cb7e6.aspx>.

academic databases and retrieved 5,693 studies published between 1990 and 2005 which studied the relationship between reported adverse events and nurse staffing levels. They selected 73 studies for the final review from which they drew a series of conclusions. From these studies, the researchers found that staffing levels “directly correlated” to the risk of in-hospital mortality and adverse events. They recommended a four-to-one ratio of patients to nurses in hospitals, and a two-to-one ratio for critical and intensive care.¹⁸¹ If these ratios were to be met in Canada, enormous new investments in hiring additional nurses would be required. As noted earlier, the OECD ranked Canada 14th of 38 countries in nurse-patient ratio, at 9.52 nurses per 1,000 population.¹⁸² That figure would have to double or even quadruple to meet a ratio of four or two patients per nurse.

A 2007 systematic review by Minnesota-based researchers focused on adverse events in intensive care and surgical units.¹⁸³ It looked at the association between nurse staff levels and patients’ chances of survival. The reviewers began with 2,858 search results and filtered them down to 96 using the recommendations for the Meta-Analysis of Observational Studies in Epidemiology (MOOSE).¹⁸⁴ Using these studies, the reviewers extracted data indicating that higher nurse staff levels reduced the risk of death in hospital. Since staffing levels directly affect workload, this review supports a link between workload and adverse outcomes which include adverse events. They estimated that an increase by one nurse per patient day would save five lives per 1,000 hospitalized patients in ICUs and six per 1,000 surgical patients. One additional nurse per patient day would also lead,

¹⁸¹ *Ibid.* at 14.

¹⁸² OECD (2016), Nurses (indicator), *supra* note 123.

¹⁸³ R. Kane *et. al.*, “The association of registered nurse staffing levels and patient outcomes: Systematic review and meta-analysis”, (2007) 45:12 *Medical Care* 1195–1204.

¹⁸⁴ Meta-analysis of Observational Studies in Epidemiology (MOOSE), online at <https://www.editorialmanager.com/jognn/account/MOOSE.pdf>.

they concluded, to a 60% lower chance of respiratory failure in ICUs and a 51% lower chance of unplanned extubation.¹⁸⁵

Further support for the patient safety impact of nursing workload in the intensive care context comes from a 2009 systematic review by U.K. researchers.¹⁸⁶ Intensive care units have been the focus of research in part because they are uniquely sensitive to staffing levels. The patients require constant monitoring and their conditions are wildly unpredictable. This review asked whether and to what extent characteristics of the nursing workforce, such as the number of nurses per patient and the skill mix of the nursing staff, affected rates of mortality and adverse events including post-operative complications and hospital-acquired infections. After a rigorous search and review covering studies from 1990 to 2006, 15 articles were targeted for inclusion. Ten of these 15 reported a statistical relationship between nurse staffing and the prevalence of adverse patient events.

Since 2010, the number and diversity of studies on nurse workload and patient safety has mushroomed. Two systematic reviews published in 2010 and 2012 focused on nurses in critical care.¹⁸⁷ In the 2010 review, by a team of Orlando-based researchers, 26 studies were ultimately selected for inclusion on the issue of whether there was an association between nurse staffing and certain critical care adverse events such as infections, unplanned extubations and other post-operative complications. The

¹⁸⁵ R. Kane *et al.*, “The association of registered nurse staffing levels and patient outcomes”, *supra* note 183 at 1197-1198.

¹⁸⁶ E. West *et al.*, “Nursing resources and patient outcomes in intensive care: a systematic review of the literature” (2009) 46:7 *International Journal of Nursing Studies* 993-1011.

¹⁸⁷ D. Aragon-Penoyer, “Nurse staffing and patient outcomes in critical care: A concise review” (2010) 38:7 *Critical Care Medicine* 1521-528.

consensus of these studies was that there was a strong association between lowering nurse-patient ratios and an increase in adverse outcomes in intensive care unit patients.¹⁸⁸ The 2012 review, based in Australia, selected 19 studies from a decade of published research, and concluded that there was a consensus that “a trend exists between increased nurse staffing levels and decreased adverse events.”¹⁸⁹

The nursing workload-adverse event connection was also found to exist in children’s hospitals in a 2011 systematic review.¹⁹⁰ In that review, based in Australia, studies on nurse staffing and adverse events in patients under age 19 published between 1993 and 2010 were retrieved and filtered by two expert reviewers according to a critical appraisal instrument from the Joanna Briggs Institute.¹⁹¹ The adverse events covered by the researchers included mortality, infections, failure to rescue, medication administration errors, postoperative complications and pressure ulcers. From 316 initial search results, eight studies remained after the review process. The reviewers concluded that increased nursing hours per patient day was associated with decreases in those adverse events.¹⁹²

The U.S. experience with legislated nurse-to-patient ratios has spawned a plethora of studies on the nurse workload-patient safety link, followed by systematic reviews of this literature. A 2013 review by Shekelle, for example, suggested a patient safety benefit from

¹⁸⁸ *Ibid.* at 1525.

¹⁸⁹ M. McGahan *et. al.*, “Nurse staffing levels and the incidence of mortality and morbidity in the adult intensive care unit: A literature review” (2012) 25:2 *Australian Critical Care* 64–77 at 74.

¹⁹⁰ S. Wilson *et. al.*, “The effect of nurse staffing on clinical outcomes of children in hospital: a systematic review” (2011) 9:2 *International Journal of Evidence Based Healthcare* 97-121.

¹⁹¹ Joanna Briggs Institute, “Critical appraisal tool for Systematic reviews”, in *Joanna Briggs Institute Reviewers’ Manual*, 2011 Edition (Adelaide, Australia: JBI, 2011), Appendix II at 145, online at <http://joannabriggs.org/assets/docs/sumari/reviewersmanual-2011.pdf>.

¹⁹² S. Wilson *et. al.*, “The effect of nurse staffing on clinical outcomes of children in hospital”, *supra* note 190 at 108.

nurse-to-patient ratios.¹⁹³ There, the reviewers selected 28 studies from an initial search pool of 546 titles. They found a “consistent relationship” between lower patient-to-nurse ratios and safer care.¹⁹⁴ The reviewer concluded by illustrating as follows:

An increase of 1 RN fulltime equivalent (FTE) per patient day was related to a 9% reduction in the odds of death in the ICU, a 16% reduction in the surgical setting, and a 6% reduction in the medical setting. With respect to other outcomes, lower rates of hospital-acquired pneumonia, pulmonary failure, unplanned extubation, failure to rescue, and nosocomial bloodstream infections were related to higher RN staffing in pooled analyses of several studies.¹⁹⁵

Taken as a whole, all of the foregoing systematic reviews tend to support a strong relationship between nurse workload and the risk of adverse events. These provide a strong evidentiary basis to see nursing workload as a patient safety influence, and thus as an important public policy issue.

Single Studies

Bearing in mind the scientific limitations of any individual study, it is still important to acknowledge some important and illuminating studies, which connect workload and patient safety. In the wide diversity of studies on nursing workload, different measures of workload have been used. The most common measure is that of staffing levels, expressed typically as the number of nurses, or the total nursing hours worked, per unit per shift. More nurses, of course, means less workload per nurse. A related measure is nurse-to-patient ratios. There are some studies that refer more broadly to staffing

¹⁹³ P. Shekelle, “Nurse-Patient Ratios as a Patient Safety Strategy: A Systematic Review” (2013) 158:5 *Annals of Internal Medicine* 404-409.

¹⁹⁴ *Ibid.* at 405.

¹⁹⁵ *Ibid.*

“models”, but the “models” compared in them are simply staffing policies featuring differing levels of nurse staffing.

The scope of some studies is broad. A 2007 California study, focused on hospitalized children, found that nurse-staffing levels affected the chances of a wide range of adverse events including postoperative pulmonary complications, pneumonia, and urinary tract infections.¹⁹⁶ Other studies have looked at the nursing workload effects on “patient safety outcomes” as a broadly defined category.¹⁹⁷ For example, a 2013 Quebec-based study compared how different “models” of nursing care affected the prevalence of a range of “patient safety outcomes” that included medication administration errors, falls, pneumonia, urinary tract infection, unjustified restraints and pressure ulcers.¹⁹⁸ It found that “professional” models that had higher nurse staffing levels experienced between 25% and 50% fewer such events than “functional” models that used fewer nurses.

In a similar vein, many studies study the effects of workload and staffing on an often-broad set of “adverse events”. A 2011 study of thirteen U.S. military hospitals found

¹⁹⁶ B. Mark *et. al.*, “Nurse Staffing and Adverse Events in Hospitalized Children” (2007) 8:2 *Policy, Politics & Nursing Practice* 83-92. The researchers used five years of data (1996-2001) on more than three million paediatric patients across 286 state hospitals.

¹⁹⁷ L. Liu *et. al.*, “Exploring the association between nurse workload and nurse-sensitive patient safety outcome indicators” (2012) 20:4 *Journal of Nursing Research* 300-309.

¹⁹⁸ C. Dubois *et. al.*, “Associations of patient safety outcomes with models of nursing care organization at unit level in hospitals” (2013) 25:2 *International Journal for Quality in Health Care* 110-117. According to the authors at 111: “Professional” staffing models “reflect managerial decisions that recognize nursing as a professional discipline. These models employ more nursing workers with higher formal education and have professional governance structures supporting the efforts of these knowledge workers.” By contrast, the “functional models reflect a view of nursing as a broad set of tasks that can be carried out by a variety of workers, presumably in response to factors such as economic and labour-market constraints. As such, these models draw more on less educated staff, including licensed practical nurses (LPNs) and unregulated assistive staff, to deliver nursing services than do the professional models.”

that total nursing care hours were associated with the likelihood of adverse events.¹⁹⁹ Similarly, a 2013 study of intensive care units in Austria concluded that higher workload, increased the risk of medical errors.²⁰⁰ They defined medical errors as any event “that harmed or could have harmed a patient, whether by omission or commission”.²⁰¹ They found that workload had a “considerable effect” on the rate of medical error in the ICU.²⁰²

Here it is worthwhile to pause amidst these studies with percentages and models to recall that even minor changes in the chances of adverse events represent major damages and losses for those patients involved. When dealing in the cold mathematical terms of probabilities and risk assessments, the nature of the risks at stake here – real patient lives and the well-being of their families – makes even minor improvements in risk a highly worthwhile pursuit. In other words, it is no answer to these studies to point out that some models of nurse work organization only correlate with seemingly minor improvements in the risk of error.

Some workload-patient safety studies are yet more general in scope by subsuming the prevalence of adverse events within the broader concept of “patient outcomes”. For example, a 2004 study of 19 teaching hospitals in Ontario compared the effect of different nurse “staffing models” on the patient “outcomes” of patient falls, medication errors, wound infections, and urinary tract infections. Staffing models that used more nurses per

¹⁹⁹ P. Patrician *et. al.*, “The association of shift-level nurse staffing with adverse patient events” (2011) 41:2 *Journal of Nursing Administration* 64-70.

²⁰⁰ J. Steyrer *et. al.*, “Attitude is everything? The impact of workload, safety climate, and safety tools on medical errors: a study of intensive care units” (2013) 38:4 *Health Care Management Review* 306-316. The researchers conducted a prospective, cross-sectional study in 57 ICUs treating 378 total patients over a two-day period.

²⁰¹ *Ibid.* at 310.

²⁰² *Ibid.* at 313.

shift had fewer such outcomes.²⁰³ Again, it is important to note that even minor reductions in the statistical rate of adverse events means real human lives saved. Some studies centered on the link between nursing “work conditions” or “practice environments” as measured by nurse workload among other indicators. In a 2007 U.S.-based study, researchers examined records for 15,846 patients in 51 adult intensive care units in 31 hospitals, and surveyed 1,095 nurses on a range of working conditions including workload and time worked.²⁰⁴ They concluded that lower nurse workloads correlated to “significantly lower”²⁰⁵ chances of catheter-associated infections and ventilator-associated pneumonia. A 2008 Pennsylvania study found that nurse staffing levels and workload correlated with increased odds of the outcomes of death or failure to rescue among oncology patients.²⁰⁶ In 2011, an Australian study had similar findings.²⁰⁷ In that project, researchers collected five years of patient and nurse data from New South Wales hospitals. They concluded that fewer patient falls and medication errors happened on units with heavier nurse workloads. Specifically, for every two fewer nurses per patient on a ward, one less medication error was expected.²⁰⁸

²⁰³ L. McGillis Hall *et. al.*, “Nurse Staffing Models, Nursing Hours, and Patient Safety Outcomes”, *supra* note 59. This was a descriptive correlational study of adult medical, surgical, and obstetric inpatients within 19 Ontario teaching hospitals. They concluded (at 44), “On units that employed a lower proportion of professional nursing staff (RNs/RPNs), there were a higher number of medication errors and wound infections.”

²⁰⁴ P. Stone *et. al.*, “Nurse working conditions and patient safety outcomes” (2007) 45:6 *Medical Care* 571–578.

²⁰⁵ This study did not express findings in terms of actual patient lives lost, but rather in terms of increased risk of one or more of the adverse events listed.

²⁰⁶ C. Friese *et. al.*, “Hospital Nurse Practice Environments and Outcomes for Surgical Oncology Patients” (2008) 43:4 *HSR: Health Services Research* 1145-1163. This study also expressed its findings in terms of observed patterns in nursing workplaces with lower staffing levels, rather than in concrete patient numbers.

²⁰⁷ C. Duffield *et. al.*, “Nursing staffing, nursing workload, the work environment and patient outcomes”, *supra* note 59.

²⁰⁸ *Ibid.* at 251, Table 3, showed that for every medication error measured, there was a 1.99 coefficient in relation to the proportion of nurses to patients on that ward.

The California experience with legislated nurse-to-patient ratios has, as noted above, begotten a long line of research studies²⁰⁹ and an accompanying set of systematic reviews. A 2013 study provides a recent example.²¹⁰ It looked at whether the state-staffing mandate enacted in 1999 had led to any positive impact on patient health outcomes including adverse events. They concluded that, while there was a negligible impact on some indicators, some patient safety indicators such as failure to rescue and infections had dropped significantly in line with the reduced nursing workload.²¹¹ Specifically, they found that, compared with out-of-state hospitals without mandated nurse-patient ratios, the California hospitals studied reported 37% less incidences of failure to rescue, approximately 15% fewer instances of both respiratory failure and postoperative sepsis.²¹²

In a 2014, nationwide United States study of more than 400,000 open-heart surgeries performed at more than 5,000 hospitals in the U.S. between 1998 and 2010, the researchers found that lower patient-to-nurse ratios corresponded to lower chances of post-operation infections and other adverse events.²¹³ They concluded that the “[r]isk of preventable complications from [aortic valve replacement] surgery was associated with

²⁰⁹ S. Cho & S. Yun, “Bed-to-nurse ratios, provision of basic nursing care, and in-hospital and 30-day mortality among acute stroke patients admitted to an intensive care unit: Cross-sectional analysis of survey and administrative data” (2009) 46:8 *International Journal of Nursing Studies* 1092–1101.

²¹⁰ B. Mark *et. al.*, “California’s minimum nurse staffing legislation: Results from a natural experiment” (2013) 48:2-1 *Health Services Research* 435-454. The researchers used California hospital data from 2000 to 2006.

²¹¹ *Ibid.*, at 450.

²¹² *Ibid.* at 448, Table 3, “Difference-in-Difference Fixed Effects Poisson Model Estimates of Percentage Change in Incidence of PSIs in California Relative to Comparison State Hospitals in the Same Preregulation Staffing Quartile in the Initial and Final Regulatory Periods”.

²¹³ N. Arkin *et. al.*, “The association of nurse-to-patient ratio with mortality and preventable complications following aortic valve replacement” (2014) 29:2 *Journal of Cardiac Surgery* 141-148 at 146.

higher nurse-to-patient ratios and larger hospital size. Nurse-to-patient ratio showed a 6% decreased risk of complications.”²¹⁴

Along with the foregoing studies looking at a wide range of patient safety indicators have been many important examinations of the workload effects on specific patient outcomes indicative of patient safety levels. Mortality rate is among the most common indicator measured, and many studies have shown it to be directly influenced by nursing workload. An early example of this kind was a study, published in 2002, of mortality rates in Pennsylvania hospitals over a 19-month period in 1998-1999.²¹⁵ More than 232,000 patients across 168 state hospitals were included. The investigators asked whether nurse-patient ratios had a statistical relationship with rates of 30-day mortality and failure to rescue. They found that for each additional patient per nurse there was a 7% greater chance of death within 30 days of admission and a 7% increase in the odds of a failure to rescue. Similar findings emerged in a 2002 Ontario-based study²¹⁶ and in 2003 in a study involving 232 California hospitals.²¹⁷ Almost a decade later these findings were repeated in a 2011 study in the *New England Journal of Medicine*.²¹⁸ That project

²¹⁴ *Ibid.*

²¹⁵ L. Aiken *et. al.*, “Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction” (2002) 288:16 *Journal of the American Medical Association* 1987-1993

²¹⁶ A. Tourangeau *et. al.*, “Nursing-related determinants of 30-day mortality for hospitalized patients” (2002) 33:4 *Canadian Journal of Nursing Research* 71-88. This study reviewed records for 46,941 patients discharged from 75 Ontario hospitals who had a diagnosis of acute myocardial infarction, stroke, pneumonia or septicemia. It concluded that a 10 per cent increase in nurses on staff was associated with five fewer patient deaths per 1,000 discharges.

²¹⁷ S. Cho *et. al.*, “The effects of nurse staffing on adverse events, morbidity, mortality and medical costs” (2003) 52:2 *Nursing Research* 71-79. The researchers concluded that an additional hour of nursing care per patient day reduced the chances of pneumonia by 8.9%.

²¹⁸ J. Needleman *et. al.*, “Nurse Staffing and Inpatient Hospital Mortality” (2011) 364:11 *New England Journal of Medicine* 1037-1045. The investigators concluded that there was a “significant association” between higher nurse staffing levels and lower 30-day mortality rates.

reviewed staff and patient data from more than 197,000 patients over more than 176,000 nursing shifts in 43 hospitals.

Aside from bottom-line mortality rates, other studies have focused on specific adverse events such as hospital-acquired infections. One U.S.-based study in 2010 drew links between nurse staffing and workload and the rate of hospital-acquired conditions.²¹⁹ In that study, data on nearly 35,000 patients treated in 11 medical-surgical units from four hospitals in three states were included, and showed that higher levels of nurse staffing lessened the chances of in-hospital-acquired diseases. The researchers reported that "... an increase of 1% in RN percentage in staffing reduced the number of adverse events by 3.4%, and a 5% increase in the RN percentage would decrease the number of adverse events by 15.8%."²²⁰ Similarly, a Brazil-based study in 2012 concluded that excessive nursing workload was the "main risk factor" for hospital-acquired infections (HAI).²²¹ There, the researchers concluded that "... excessive nursing work load was significantly associated with the risk of acquiring HAI with an odds ratio of more than 11."²²² In the same vein, studies have shown that lower nursing workloads lead to fewer patient falls²²³ and fewer unplanned extubations in intensive care units.²²⁴

²¹⁹ K. Frith *et al.*, "Effects of Nurse Staffing on Hospital-Acquired Conditions and Length of Stay in Community Hospitals" (2010) 19:2 *Quality Management in Health Care* 147-155.

²²⁰ *Ibid.* at 151.

²²¹ R. Daud-Gallotti *et al.*, "Nursing workload as a risk factor for healthcare associated infections in ICU: a prospective study" (2012) 7:12 *PLoS One* E52342, online at <http://journals.plos.org/plosone/article/asset?id=10.1371%2Fjournal.pone.0052342.PDF>.

²²² *Ibid.* at 3 (pdf).

²²³ E. Lake *et al.*, "Patient falls: association with hospital Magnet status and nursing unit staffing" (2010) 33:5 *Research in Nursing and Health* 413-425.

²²⁴ J. Marcin *et al.*, "Nurse staffing and unplanned extubation in the pediatric intensive care unit" (2005) 6:3 *Pediatric Critical Care Medicine* 254-257.

Nursing Time Worked and Patient Safety

Systematic Reviews

I now turn from the research connecting patient safety with nurse workload to that connecting patient safety to nursing hours worked. Several systematic reviews have emerged that synthesize findings from the many thousands of studies on nurse working hours and adverse events.²²⁵ A 2014 review by a McMaster University team of nursing researchers examined studies published between 1980 and 2012 that investigated the relationship between nurse overtime and patient outcomes including rates of medical error.²²⁶ Nine articles were selected from an initial search set of 653, from which the reviewers found that increased nurse overtime were related to poorer patient outcomes.²²⁷ Medication errors, for example, “were found to be significantly increased alongside increasing overtime”.²²⁸ Specifically, for example, the reviewers endorsed studies showing a 30% increase in medication errors reported by nurses working four or more hours of overtime in a shift, and a tripling in the chances of error by nurses working 12.5 or more hours in a shift.²²⁹

²²⁵ C. Estabrooks *et. al.*, “Effects of shift length on quality of patient care and health provider outcomes: systematic review” (2009) 18:3 *Quality and Safety in Health Care* 181-188; V. Lobo *et. al.*, “Integrative review: an evaluation of the methods used to explore the relationship between overtime and patient outcomes” (2014) 71:5 *Journal of Advanced Nursing* 961-974; S. Bae. & D. Fabry, “Assessing the relationships between nurse work hours/overtime and nurse and patient outcomes: systematic literature review” *infra* note 230; J. Clendon & V. Gibbons, “12 h shifts and rates of error among nurses: A systematic review” (2015) 52:7 *International Journal of Nursing Studies* 1231-1242; R. Harris *et. al.*, “Impact of 12 h shift patterns in nursing: A scoping review” (2015) 52:2 *International Journal of Nursing Studies* 605-634.

²²⁶ V. Lobo *et. al.*, “Integrative review: an evaluation of the methods used to explore the relationship between overtime and patient outcomes”, *supra* note 225.

²²⁷ *Ibid.* at 970.

²²⁸ *Ibid.*

²²⁹ *Ibid.*

Similar findings emerged in another 2014 review by nursing researchers from the University of Texas.²³⁰ The reviewers retrieved 2,836 initial studies published from 2000 to 2013 on the link between nurse overtime and patient health outcomes, and reduced that set down to 24 which met their inclusion criteria. From this final set, they concluded that nurses working more than 8 hours per shift or more than 40 hours per week, who take less than 10 hours off between shifts, and those working voluntary overtime were “significantly related to the incidence of adverse patient outcomes.”²³¹

Some reviews have focused on the patient safety impact of nurses working 12 hour shifts. A 2015 review based in New Zealand examined 5,429 studies published before 2014 on the connection between 12-hour shifts and rates of medical error, and selected 26 for final analysis.²³² There, the reviewers found that the consensus of the studies they selected showed higher rates of error and adverse events when nurses worked longer shifts. Similarly, a 2015 U.K. study reviewed 158 possible studies on the relationship between 12-hour shifts and patient outcomes.²³³ After narrowing this pool to 95 studies, the reviewers noted that lengthier shifts tended to be associated with poorer overall health outcomes, including more adverse events:

Shift length remained a significant predictor of nurse-reported quality and safety even after adjusting for nursing demographics, hospital structural characteristics and nursing organisational features. Two studies concluded that nurses’ perceived risks of making an error significantly increase when work shifts last 12 and half hours or more and another, that nurses who work shifts of more than 13 h are more likely to report frequent central

²³⁰ S. Bae & D. Fabry, “Assessing the relationships between nurse work hours/overtime and nurse and patient outcomes: systematic literature review” (2014) 62:2 *Nursing Outlook* 138–156.

²³¹ *Ibid.* at 139, 153. “Adverse patient outcomes” meant “medication errors, falls, decubitus ulcers, failure to rescue, nurse perceptions of quality, hypoglycemic events, perceived adverse events, errors or near misses, pneumonia deaths, patient dissatisfaction, nosocomial infection, abdominal aortic aneurysm post-operative deaths, mortalities, central line associated blood- stream infection, urinary tract infection, ventilator associated pneumonia, gastrointestinal bleeding, shock cardiac arrest, and sepsis.”

²³² J. Clendon & V. Gibbons, “12 h shifts and rates of error among nurses: A systematic review”, *supra* note 225.

²³³ R. Harris *et. al.*, “Impact of 12 h shift patterns in nursing: A scoping review”, *supra* note 225.

line associated bloodstream infections and patient/family complaints. Others have found that 12 h night nurses believe their alertness decreases significantly as the night shift progresses, suggesting a risk of compromised patient care. Trinkoff et al. (2011) compared nurse work schedules with mortality measures and found that pneumonia deaths are significantly more likely in hospitals where nurses report schedules of 13 h or more. McClelland (2007) used a policy-capturing design and found that the fatigue experienced by nurses during 12 h shifts significantly contributes to inconsistent policy judgements.²³⁴

(references omitted)

Conclusions from systematic reviews such as the foregoing lend support to the patient safety relevance of nurse employment issues affecting hours of work and overtime.

Single Studies

Without purporting to be a systematic review, a brief sample of some of the individual studies connecting patient safety to nurse shift length and time worked will further illustrate the public importance of issues affecting nursing time worked. A line of studies from the U.S. and elsewhere have tied working hours to patient safety, inspired in part by concerns about nursing overtime and excessive hours in publicly-funded hospitals in many U.S. states. A 2004 study, for example, used nurse surveys and patient data to investigate if any relationship existed between nursing hours worked and the frequency of medical errors.²³⁵ They concluded that nurses were three times as likely to make an error if they worked shifts lasting 12 hours or more.²³⁶ Similarly, a 2010 study by the Canadian Nurses' Association found that long working hours and on-the-job fatigue for nurses increase the risk of adverse events.²³⁷

²³⁴ *Ibid.* at 621.

²³⁵ A. Rogers et al., "The Working Hours of Hospital Staff Nurses and Patient Safety" (2004) 23:4 *Health Affairs* 202-212.

²³⁶ *Ibid.* at 206.

²³⁷ Canadian Nurses' Association et al., *Nurse Fatigue and Patient Safety: Research Report* (2010), *supra* note 58; CNA, "Long Working Hours of Hospital RNs Associated With Increased Errors" (2010), *supra* note 58.

Multi-jurisdictional studies of nursing shift length and overtime have had similar findings.²³⁸ A 2013 study of 577 hospitals in four densely populated states concluded that “nurses working shifts of 10 hours or longer were associated with worse reports of patient care quality and overall safety grade compared with nurses working 8 to 9 hours.”²³⁹ They urged “a reevaluation of widespread extended nurse shift length.”²⁴⁰ Researchers in a 2014 study covering 12 European countries echoed these finding: nurses working for 12 hours were more likely to report poor or failing patient safety and more care activities left undone.²⁴¹ Other studies have focused on the patient safety effects of nursing work schedules, workflow interruptions and sleep disorders.²⁴²

Medication errors have been a particular focus of studies linking nursing hours to adverse events. The Canadian Institute for Health Information’s 2005 study found that nurses working overtime were more likely to report a medication error.²⁴³ A 2008 Statistics Canada report using the same data as CIHI found that 22 per cent of nurses working overtime reported medication errors, while only 14 per cent of those who do not work

²³⁸ See, e.g., A. Trinkoff *et. al.*, “Nurses’ Work Schedule Characteristics, Nurse Staffing, and Patient Mortality” (2011) 60:1 *Nursing Research* 1-8 at 6. In that study, researchers conducted a 2004 survey of 633 nurses in 71 hospitals in North Carolina and Illinois. They found that nurse hours worked had an “independent effect” on patient mortality rates, when staffing levels and hospital characteristics were controlled. Pneumonia deaths were more likely when nurses worked longer shifts.

²³⁹ A. Stimpfel & L. Aiken, “Hospital staff nurses’ shift length associated with safety and quality of care” (2013) 28:2 *Journal of Nursing Care Quality* 122-129 at 128. The researchers surveyed 22 275 hospital staff RNs from 577 hospitals in California, New Jersey, Pennsylvania, and Florida.

²⁴⁰ *Ibid.* at 128.

²⁴¹ P. Griffiths *et. al.*, “Nurses’ shift length and overtime working in 12 European countries: the association with perceived quality of care and patient safety”, (2014) 52:11 *Medical Care* 975-981. This study surveyed 31,627 registered nurses in 488 hospitals across 12 countries.

²⁴² See e.g. A. Elfering *et. al.*, “Workflow interruptions, cognitive failure and near-accidents in health care”, *supra* note 60; Gartner *et. al.*, “Impaired work functioning due to common mental disorders in nurses and allied health professionals: the Nurses Work Functioning Questionnaire”, *supra* note 60; and J. Geiger-Brown *et. al.*, “The Impact of Work Schedules, Home, and Work Demands on Self-Reported Sleep in Registered Nurses”, *supra* note 60.

²⁴³ CIHI, *Findings from the 2005 Study of the Work and Health of Nurses*, *supra* note 54 at 34, online at <http://www.hc-sc.gc.ca/hcs-sss/pubs/nurs-infirm/2005-nurse-infirm/index-eng.php>.

overtime reported such errors.²⁴⁴ In that study, the investigators found that nurses working 12-hour shifts are less likely (18%) to make medication errors than nurses working 8-hour shifts (22%).

Implications and Limitations

Taken as a whole, the studies reviewed above demonstrate strong evidentiary links between nurse workload and time worked and patient safety. Consequently, the *fact* of independent high-quality evidence shifts these issues from the notionally private realm of contract between nurses and their employers – with each jockeying to maximize their own self-interest -- to the very public and political realm of preventing medical errors and protecting patients. Where it is proven by scientific consensus that such work patterns cause medical errors and harm patients needlessly, the *real* economic benefits of utilizing nurses in lengthy shift patterns or high workload contexts rapidly disappear: true, governments may save money in the short-run by reducing expenditures on nursing but the long-term costs are born by patients, their families and society.

My conclusions above do not mean that unlimited investments in hiring more nurses or instituting nurse-patient ratios must be undertaken without regard to real efficiency. To the contrary, the ever-present efficiency imperative in health policy will present a formidable policy challenge.²⁴⁵ Efficiency is not diametrically opposed to patient safety, but does question how effective any particular measure, including hiring more

²⁴⁴ K. Wilkins & M. Shields, “Correlates of medication error in hospitals” (2008) 19:2 *Health reports / Statistics Canada, Canadian Centre for Health Information* at 7-18, online at <https://www.scopus.com/record/display.uri?eid=2-s2.0-54549116891&origin=inward&txGid=0#>.

²⁴⁵ B. Mark *et. al.*, “An Examination of Technical Efficiency, Quality, and Patient Safety in Acute Care Nursing Units” (2009) 10:3 *Policy, Politics & Nursing Practice* 180-186.

nurses or adopting nurse-patient ratios, is at actually reducing the risk of error. Money spent on making patients safer is unavailable for other priorities. As Warburton (2009) explained:

This notion that every action comes at the cost of other, forgone actions also applies to patient safety improvements, and to research on these improvements. The financial and human costs of poor patient safety are by now well understood ... But while they are useful as a spur to action, these global cost estimates can lead us to forget that – at least initially – every action comes at the expense of not doing something else. Putting more effort into safety will likely force hospitals to put less effort into something else, at least in the short run.²⁴⁶

Granted, efficiency has a role to play in the deployment of strategies to improve patient safety – but how the actors in a debate frame the relative costs and risks about such strategies is vital to how those debates resolve. Where the evidence is of such a range, depth and clarity as it is on the risk reduction effects of lower nurse workload and time worked, a fuller appreciation of those benefits can reveal the true effectiveness of various staffing strategies such as nurse-patient ratios.

Still, caution must also be exercised in how far to attempt to apply the evidence in practice. To agree that there is a relationship between lower nurse workload and lower adverse events does not amount to endorsement of this practice across all health care settings in all geographic locales. Diversity is the hallmark feature of Canadian health care. Where findings in one context such as critical care suggest a real patient safety gain from an investment in more nurses on staff, this may not hold true, or with the same force, in the context of children's care, or in the context of entirely different diseases or

²⁴⁶ R. Warburton, "Improving patient safety: an economic perspective on the role of nurses" (2009) 17:2 *Journal of Nursing Management* 223-229 at 224.

conditions. Causation is another limitation I must confront. As has been stated many times elsewhere, adverse events and medical errors never arise from a single cause.

One must also be alive to the political realities within the health care system. As Tuohy and others have noted²⁴⁷, physicians sit atop a kind of political hierarchy among the health professions with the amount of influence they wield as a group. Indeed, every health profession, from physicians to nurses to midwives, regularly invokes patient interests in advocating for more positions and better working conditions. In doing so each profession, nursing included, is necessarily motivated by a certain level of territoriality and associational self-interest. Dobrow *et al* (2004) argued that context greatly affects what constitutes evidence and how evidence is used.²⁴⁸ Among the factors comprising the decision-making context are political forces. They explained how these forces drive the creation and use of evidence, using evidence about cancer screening to illustrate:

For example, in developing policy recommendations for colorectal screening many political interests can be considered, including those of patients with colorectal cancer and their families, different health providers and funders of health services. Health providers can have very different views on modalities for screening. Family physicians will speak to the difficulty of getting patients to comply with faecal occult blood testing. Not surprisingly, radiologists will usually favour screening with double contrast barium enemas, or now, virtual colonoscopy (a form of diagnostic imaging), while gastroenterologists and surgeons will tend to favour sigmoidoscopy or colonoscopy as the modality for initial screening. Each of these stakeholders will put forward their own forms of evidence, as well as criteria for what should be considered to be good evidence, thus influencing the decision-making context.²⁴⁹

²⁴⁷ C. Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*, *supra* note 149; C. Tuohy, "The Costs of Constraint and Prospects for Health Care Reform in Canada" (2002) 21:3 *Health Affairs* 32-46.

²⁴⁸ M. Dobrow *et. al.*, "Evidence-based health policy: context and utilisation" (2004) 58:1 *Social Science & Medicine* 207–217 at 209. The authors "developed a conceptual framework for evidence-based decision-making, focusing on how context impacts on what constitutes evidence and how that evidence is utilised", and "broadly define[d] the decision-making context to include all factors within an environment where a decision is made."

²⁴⁹ *Ibid.* at 210.

One could apply this analysis to how nurses use evidence on workload and hours worked. Clearly, the implications of all this research are more jobs for nurses and for a better bargain for them as employees. Yet in the patient safety context I believe that the foregoing review of evidence overcomes any assumption that nurses in arguing for better working conditions in pursuit of patient safety are using this only as a bargaining tool to maximize their own interests. The impact of nursing workload and hours worked is real and has been demonstrated to the satisfaction of independent expert academic reviewers. The nursing profession has produced its own body of research on patient safety, and many of the findings of that work call for more investment in nurses and better working conditions.²⁵⁰ As forceful as these studies may be on their merits, I have deliberately avoided using them because of the risk that associational self interest would colour their conclusions. I have preferred peer-reviewed scientific work done by researchers outside nurses' unions and nurse associations.

Conclusion

No science is infallible, and no scientific claim is beyond skepticism. In this Chapter I have tried to stand on the shoulders of the by now many teams of scholars who have systematically reviewed nearly two decades of studies. I rely upon the

²⁵⁰ Canadian Nurses Association & University of Toronto Faculty of Nursing, *Nurses and Patient Safety: A Discussion Paper* (2004), *supra* note 109; Canadian Nurses Association, "Nurse Fatigue & Patient Safety: Research Report" (2010), *supra* note 58; L. Berry & P. Curry, *Nursing Workload and Patient Care: Understanding the Value of Nurses, the Effects of Excessive Workload, and How Nurse-Patient Ratios Can Help*, *supra* note 111; Canadian Federation of Nurses' Unions, Submission to the House of Commons Standing Committee on Health, "Safe Staffing Saves Lives: Innovations in Health Human Resources" (2013), online at http://nursesunions.ca/sites/default/files/cfnu_submission_standing_committee_health_on_tech_innovation_-_final.pdf; Canadian Federation of Nurses' Unions, "Valuing Patient Safety: Responsible Workforce Design" (2014), *supra* note 111.

methods deployed in these systematic reviews, and in many key single studies, in making my claim that nursing workload and time worked are properly called “patient safety issues”.

Patient safety issues are public policy issues. Thus, I will examine how patient safety issues are approached by the parties in nurse collective bargaining through the lens of evidence-based policy making. How the parties to bargaining decide these issues is a matter of public importance, and how the legal model for collective bargaining shapes these decisions becomes equally important in turn.

**CHAPTER THREE:
THE “WAGNERIST” LEGAL FRAMEWORKS FOR NURSE COLLECTIVE
BARGAINING IN CANADA**

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Introduction

The heart of this thesis is a critique of how the “patient safety issues” defined in the last Chapter are debated and resolved within the labour law models governing nurse collective bargaining. To properly set up this critique, it is necessary to understand these labour law models, which this Chapter undertakes to do. As well, an understanding of the doctrinal underpinnings of the labour law frameworks governing nurse collective bargaining is essential to understanding my argument in Chapter 6 about labour law reforms to improve patient safety.

In this spirit, this Chapter provides important background on the legal frameworks in which nurses’ unions and governments bargain over patient safety issues. As we shall

see, these frameworks derive from a distinct and well-established theory and tradition in labour law called “Wagnerism”. As I explain, Wagnerism is a historically specific legal tradition anchored in the tumultuous history of labour relations in North America. After outlining labour law as a field and defining my scope of study, I explain Wagnerist labour law theory, and then show how Wagnerism is reflected in the existing labour law models for nurses.

Labour Law: A Brief Overview

Labour law is a subset of employment law, which is the body of statutory and common law rules regulating employment relationships. Employment law, as a matter of “property and civil rights”, falls under provincial jurisdiction under Canada’s constitutional division of powers.²⁵¹ Thus, employment law consists of a body of common law rules and provincial statutes. Provincial statutes regulating employment include minimum standards legislation, workplace health and safety legislation, and legislation providing compensation for work-related injuries or illnesses. Provincial human rights codes also prohibit discrimination in employment.

Accompanying the foregoing collection of provincial statutes, labour relations legislation exists in every province to provide employees in the private sector a procedure for establishing collective bargaining relationships with their employer.²⁵² This legislation

²⁵¹ Labour and employment law are not explicitly mentioned in the constitutional division of powers between the federal and provincial levels of government in Canada. Rather, it has been held by a series of Supreme Court of Canada decisions that employment and labour relations fall primarily under the property and civil rights jurisdiction under section 92(13) of the *Constitution Act, 1867* (U.K.), 30 & 31 Victoria, c. 3. The federal government may only legislate in the labour relations field in relation to employers that are tied to another head of federal power such that they are a federal business, work or undertaking. For an extensive discussion of the federal-provincial division of powers in labour law, see G. Adams, *Canadian Labour Law*, *supra* note 1, Part 2, Chapter III, at paras. 3.50 – 3.130.

²⁵² B. Langille, “Labour Law is a Subset of Employment Law” (1981) 31:2 *U.T.L.J.* 200-230.

sets up a scheme of procedures and protections under which employees may choose, by majority vote, to have a trade union negotiate their terms and conditions of employment on their behalf with their employer. If a union is “certified”, that means it has the exclusive legal right to negotiate on behalf of the group of workers affected. Labour legislation provides numerous other protections and duties, all designed to protect employees’ right to collectively choose to bargain through a trade union with their employer. Importantly, labour statutes also all establish specialized, quasi-judicial labour relations boards and give those boards wide enforcement and supervision powers over all the rights and duties set out in the statutes. It is within this larger regulatory framework that the nurse collective bargaining frameworks in focus here are established. General labour legislation, together with additional statutory schemes to create central bargaining and to regulate nursing labour disputes, constitute their statutory underpinning.

Scope of Study: Six Provinces in Focus

As explained in the Introduction, I am restricting the scope of my study to six provinces, and within those provinces my focus is further narrowed to that of registered nurses working in acute care hospitals or, in provinces with regionalized health care, for regional health authorities. As discussed earlier, this focus is necessary as there are too many unions in too many different sectors and employers of health care to cover everyone adequately. I have chosen to focus on registered nurses because of the central role they have in health services delivery, and because they are the largest group of regulated health professionals that work in employment relationships. I also restrict my scope to those nurse employers covered by the central collective bargaining structures in each province. In Ontario, these are hospital nurses, and outside Ontario these include nurses

working at any service provided by a regional health authority. Thus, I do not include in my present analysis collective bargaining relationships between nurses' unions and various single employers or groups of employers, such as nursing homes or long term care centres. The six provinces I focus on also feature the full spectrum of dispute resolution methods for collective bargaining, from strike-based methods outside Ontario to interest arbitration, which has been in place in Ontario since 1965.

“Wagnerism: The Foundation of Canadian Labour Law

I turn now to the theory underlying the labour law models for nurses in Canada – Wagnerism.²⁵³ Wagnerism derives its name from the American politician who in 1935 introduced the first national collective bargaining law in the U.S., the *National Labor Relations Act*.²⁵⁴ Since then, it has become a short form symbol for a deep and rich legal tradition in both the U.S. and Canada. The “Wagner Act” was part of the larger package of social policy reforms introduced by President Franklin Roosevelt during the 1930s called the “New Deal”. The Wagner Act’s basic model of rules and procedures to establish and protect collective bargaining by workers laid down the foundational principles of labour law for every North American jurisdiction that later enacted similar legislation. In Canada, Wagnerism was imported first during a wartime executive order, the 1944 P.C. 1003, and was adopted as the labour law model in every province by the 1950s.²⁵⁵

²⁵³ R. Adams, “A Pernicious Euphoria: 50 Years of Wagnerism in Canada” (1995) 3 *Can.Lab. & Emp.L.J.* 321.

²⁵⁴ The formal title of the so-called “Wagner Act” was *National Labor Relations Act* (1935) 49 Stat. 449, 29 U.S.C. § 151–169.

²⁵⁵ *Wartime Labour Relations Regulation* (Order in Council P.C. 1003); for an in-depth historical review of the spread of the “Wagner Act” model to the provinces after World War 2, see G. Adams, *Canadian Labour Law*, *supra* note 1, Part I, Chapter I “Historical Introduction”, “4-World War II Onwards”, at paras. 1.180 – 1.250. See also *Health Services and Support - Facilities Subsector Bargaining Assn v. British Columbia*, *supra* note 2, paras 55-63, where McLachlan and Lebel JJ., for the majority, reviewed the evolution of collective bargaining law in Canada in the 20th century in the course of their reasons for holding that section 2(d) of the *Charter* guarantees the right to a meaningful process of collective bargaining with their employers.

Before delving into the granularity of the Wagnerist labour law models that have evolved for Canadian nurses, in which the patient safety issues established in Chapter 2 are negotiated, it is important to understand some of the basic precepts of Wagnerism. Wagnerism offers no single unifying theme for labour law. Rather, it is better seen as a bundle of several different but complementary beliefs about what labour law is intended to do and why. Here, I focus on three such beliefs: (i) increasing bargaining power of employees; (ii) voluntarism; and (iii) industrial peace.²⁵⁶

The **first** Wagnerist belief is that collective bargaining is necessary to allow employees to increase their bargaining strength vis a vis their employer by having a single entity – a trade union – negotiate one collective agreement for all employees of an employer. In Wagnerist theory, employment is posited as a relationship of subservience. Employees are seen as vulnerable to exploitation or opportunistic behaviour by employers because of the vast difference in negotiating strength between the parties, which results in turn from employees having to compete for jobs. Weiler (1980) explained the importance of remedying this imbalance of power. Collective bargaining, he wrote:

...addresses the inherent inequality in negotiating effectiveness between large firms and individual employees, in which the employee either takes the wages set by the firm or loses his job. Now workers speak with a collective voice. The trade union representative can match the knowledge, the skill, and the time of the company's personnel manager in judging what is the appropriate level of wages, and he wields effective bargaining leverage in making that judgment stick.²⁵⁷

²⁵⁶ In formulating these four strands, I draw from the Supreme Court of Canada's 2007 *Health Services* decision, *supra* note 2 at para. 57, citing Professor Karl Klare's formulation of Wagnerism's purposes, from his 1978 article on Wagnerism. See K. Klare, "Judicial Deradicalization of the *Wagner Act* and the Origins of Modern Legal Consciousness, 1937-1941" (1978) 62:3 *Minn. L. Rev.* 265 at 281-84.

²⁵⁷ Weiler, *Reconcilable Differences*, *supra* note 7 at 27.

Collective bargaining, on this view, has been a social and moral good and as a means to further redistribution and lessen the income inequalities that modern capitalism fosters.²⁵⁸

The pursuit of “industrial democracy” is a variant on the goal of improving employee bargaining.²⁵⁹ Since employees devote so much of their lives to their jobs and depend so greatly on their incomes and job security, fairness demands that they have a say in setting the terms and conditions under which they work. Just as citizens deserve a voice in their politics, goes this theory, so too do workers deserve a democratic voice in the workplace. Unions, in this scenario, provide workers the “loyal opposition” to the employer’s “government” role in the workplace. By democratizing how employers make workplace rules and conditions, collective bargaining is intended to bring the rule of law to the workplace.²⁶⁰

A **second** organizing belief of Wagnerism is voluntarism, by which I mean the belief that free will and voluntary choices of individuals are to govern decision-making.²⁶¹ In Wagnerism, voluntarism means that workers’ free and voluntary choices are to determine whether or not unionization occurs, with whom else they will join in bargaining, what the union asks for on behalf of the workers, and whether any particular settlement

²⁵⁸ “They should have the right because individual employees have little bargaining power compared to the forces of the huge modern organization.”: R. Adams, *Industrial Relations Under Liberal Democracy* (Columbia, S.C.: University of South Carolina Press, 1995) at 65. Redressing inequality of bargaining power was also cited as a key labour law goal in B. Langille, “Labour Law’s Theory of Justice”, Ch. 7 in B. Langille & G. Davidov eds., *The Idea of Labour Law* (Oxford, U.K.: Oxford University Press, 2011).

²⁵⁹ Adams, *Industrial Relations Under Liberal Democracy*, *supra* note 258 at 64.

²⁶⁰ Weiler, *Reconcilable Differences*, *supra* note 7 at 31: “Many theorists of industrial relations believe that this function of protecting the employee from the abuse of managerial power, thereby enhancing the dignity of the worker as a person, is the primary value of collective bargaining, one which entitles the institution to positive encouragement from the law.”

²⁶¹ Klare, “Judicial Deradicalization of the *Wagner Act* and the Origins of Modern Legal Consciousness”, *supra* note 256 at 282. Klare emphasized that “The *Wagner Act* was intended to protect the free choice of workers to associate amongst themselves and to select representatives of their own choosing for collective bargaining.”

in collective bargaining or before arbitration or labour board proceedings ought to be binding.²⁶² Voluntarism also requires that, in bargaining, voluntary settlements are the ideal and, where achieved, not to be evaluated or assessed by outsiders on fairness grounds or any other measure of distributive or other form of justice.

Voluntarism undergirds both the adherence to the strike mechanism as the method of dispute resolution, and the shortcomings of interest arbitration I discuss in Chapter 5. Paul Weiler, a leading Canadian labour law scholar, succinctly explained the function of the strike mechanism as one of exerting pressure on the parties to settle. He wrote:

[The parties] experience viscerally the pain of disagreement with their opposite numbers at the bargaining table. Soon they realize that it is much less painful to agree, even if they do have to move considerably closer to the terms proposed by the other side. In that way strike action plays an indispensable role in resolving deadlocks in a collective bargaining relationship.

...

It is a common experience in industrial relations to achieve a midnight settlement on the eve of the strike deadline in difficult negotiations. The ability to compromise simply would not be there unless the parties were striving mightily to avoid the harmful consequences of a failure to settle. In the larger system it is the credible threat of the strike to both sides, even more than its actual occurrence, which plays the major role in our system of collective bargaining...²⁶³

That is, aside from all the other rationales for the right to strike, its greatest value lies in this tendency to make conflict painful, thus leading to settlements. Since voluntary settlements are the ideal way collective agreements are to be established, the strike mechanism strives to ensure that they are. As I will argue later in Chapter 5, the “midnight

²⁶² R. Adams, *Industrial Relations Under Liberal Democracy*, *supra* note 258 at 65; S. Tucker & A. Mucalov, “Industrial Voluntarism in Canada” (2010) 65:2 *Relations industrielles* 215-235.

²⁶³ Weiler, *Reconcilable Differences*, *supra* note 7 at 66.

settlement” is a common occurrence in nurse collective bargaining, more so because of the essentiality of nursing work.

In a similar vein, voluntarism underlies Wagnerism’s opposition to the use of a third-party interest arbitrator to settle bargaining disputes. This opposition holds that interest arbitration removes what the strike mechanism provided: the negative consequences for the parties if they fail to reach a voluntary settlement. Specifically, goes this argument, without the looming prospect of a strike, the union and employer will have little reason to make compromises and be more content to leave the dispute in the hands of a third party.²⁶⁴ In addition, any arbitrator-made settlement is itself suspect for not being the true product of consensus between the parties.²⁶⁵ Thus, voluntarism is felt throughout Wagnerism’s preferences for the mode of dispute resolution.

Along with bargaining power and voluntarism, the **third** broad belief within Wagnerism is the promotion of industrial peace – or, expressed conversely, the prevention or management of labour-management conflict.²⁶⁶ Wagnerism starts from the

²⁶⁴ D. Johnston & I. McKenna, “Public Interest Disputes and Compulsory Arbitration: A Case Study of Hospitals in Ontario”, *supra* note 13 ; T. Schulz, “The Pros and Cons of Interest Arbitration: An Employer’s Perspective” [1994-95] *Labour Arbitration Yearbook* 429; J. Solberg, “The Pros and Cons of Interest Arbitration: A Union Perspective” [1994-95] *Labour Arbitration Yearbook* 409.

²⁶⁵ Weiler, *Reconcilable Differences*, *supra* note 7 at 223. Professor Weiler wrote about interest arbitration:

... The problem with that solution should be apparent. Although it does preserve the collective ability of employees to challenge the unilateral prerogative of their employer, it does so at the expense of *free* collective bargaining. The analogy with grievance arbitration does not really hold. The latter applies standards, which the parties have already freely negotiated in their contract, in order to resolve concrete and largely marginal disputes about their application. By contrast the job of the interest arbitrator is to create those contract standards, not to apply them. By and large the interest arbitrator creates them out of whole cloth, out of his own sense of fairness and economic reasonability, or, conceivably and occasionally, by applying general standards for collective agreements laid down in a statute. But in either case we sacrifice the right of the parties to agree on the terms of a contract which is satisfactory to their particular needs. We replace that with the power of government or one of its legal agents to impose a contract which, ideally, will avoid a work stoppage.

²⁶⁶ Purpose clauses in many collective bargaining statutes typically express this objective. See, *e.g.* *Labour Relations Act, 1995*, S.O. 1995, c. 1, Sch. A, s. 2, which lists the following purposes:

1. To facilitate collective bargaining between employers and trade unions that are the freely-designated representatives of the employees.

premise that there exists a fundamental conflict of interest between employer and employee, with each trying to maximize their gains from the other. This working-class unrest historically manifested in labour conflicts which harmed employers and in some cases the public at large. Industrial conflict is thus considered a social problem that collective bargaining can solve²⁶⁷, or at least manage, by channeling it into a legalized dispute resolution process refereed by a labour relations board. In this spirit, provincial labour legislation contains extensive mediation and conciliation mechanisms that must be exhausted before any lawful strike action can occur.²⁶⁸ Other prerequisites to a lawful strike can include the taking of a labour relations board-supervised strike vote, and the provision of adequate notice of a strike by the union.²⁶⁹ Only when these legislative hurdles have been cleared is a strike lawful. The purpose of these restrictions is to ensure that the strike weapon is only used as a pressure tactic to attempt to secure gains in negotiation, and for no other purposes. For the same reason, provincial labour statutes also prohibit strike action throughout the life of a collective agreement, and require any disputes about alleged breaches of the agreement to be determined through a system of grievance arbitration.²⁷⁰ Thus, modern labour legislation at once relies on the strike

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2. To recognize the importance of workplace parties adapting to change.
 3. To promote flexibility, productivity and employee involvement in the workplace.
 4. To encourage communication between employers and employees in the workplace.
 5. To recognize the importance of economic growth as the foundation for mutually beneficial relations amongst employers, employees and trade unions.
 6. To encourage co-operative participation of employers and trade unions in resolving workplace issues.
 7. To promote the expeditious resolution of workplace disputes.

²⁶⁷ In *Saskatchewan Federation of Labour*, *supra* note 2, Abella J. explained that controlling strikes and industrial conflict was part of the rationale for the Wagnerist labour law framework: paras. 43-44.

²⁶⁸ See *e.g.* *Labour Relations Act, 1995*, *supra* note 266, s. 79.

²⁶⁹ See, *e.g.*, (B.C.) *Labour Relations Code*, R.S.B.C. 1996, c. 244, s. 59; *Ontario Labour Relations Act, 1995*, *supra* note 266, s. 79(3).

²⁷⁰ *Ibid.*, s. 79(1) (no strikes during life of collective agreement) and s. 48 (mandatory arbitration clause in all collective agreements). See also (B.C.) *Labour Relations Code*, *supra* note 269, s. 57. Professor Weiler also discussed the use of grievance arbitration: see Weiler, *Reconcilable Differences*, *supra* note 7 at 89-91.

mechanism to resolve disputes, yet at the same time strictly curtails the right to strike, confining it to narrowly defined times, places and purposes.

Wagnerism's stability function is "sociological", in that labour law is an instrument of order and co-operation between two opposing social groups – capital and labour. Work has always been a common focus of sociological study, and the emergence of industrial relations and human resource management as discrete vocations owes much to the sociological tradition.²⁷¹ Wagnerism is a sociological enterprise, in that it proceeds from the existence of certain baseline assumptions about work.²⁷² These include:

- employment is the predominant mode of work organization;
- subordination and hierarchy are the basic features of employment;
- social problems (class conflict, if one is a Marxist) arise from subordination and vulnerability at work; and
- employees will want to form unions and bargain collectively as a way of redressing subordination.

Sociological theories of labour law derive much from the work of English scholar Otto Kahn-Freund's classic elucidations of industrial relations and the sociological phenomenon that emerged in England called "collective *laissez-faire*".²⁷³ Collective *laissez-faire* was Kahn-Freund's term for the labour relations system in the U.K., which emerged organically rather than from legislation. As described by one English scholar of labour law:

Rather than intervening directly in employment relations, successive British governments left it to trade unions and employers to negotiate the rules that would govern working lives

²⁷¹ H. Collins, "Labour Law as a Vocation" (1989) 105 *L.Q. Rev.* 468-484; more generally, see R. Gordon, "Law as a Vocation: Holmes and the Lawyer's Path" in S. Burton ed., *The Path of the Law and Its Influence* (Cambridge, U.K.: Cambridge University Press, 2000) 7-32.

²⁷² R. Solow, *The Labor Market as a Social Institution* (Cambridge, U.K.: Basil Blackwell, 1990).

²⁷³ P. Davies, & M. Freedland, *Kahn-Freund's Labour and the Law* (London: Stevens and Sons, 1983).

and production. According to Kahn-Freund's principle of collective *laissez-faire*, it was critical that this negotiation should proceed collectively and autonomously of the state. Such was the imbalance of power between individual employees and employers that the very idea of freedom of contract in this context was a sham: the vast majority of employers were in a position to dictate terms and conditions. If workers banded together to create trade unions, however, they could increase their bargaining power and become the equal of the employer or employers' association. While governments could rightfully act to promote the creation of trade unions and the institution of collective bargaining machinery they ought not, as a general rule, to intervene directly in the regulation of either individual or collective employment relations. Collective *laissez-faire* involved, as Kahn-Freund pithily put it, 'the retreat of the law from industrial relations and of industrial relations from the law'.²⁷⁴

All three of these Wagnerist beliefs have given shape to the current model of collective bargaining now found in every province. That model is derived from the basic template of the Wagner Act scheme of collective bargaining. The "pure" Wagnerist theory of labour law mandates that an effective collective bargaining system be comprised of a series of distinct but related features, which include:

- Collective bargaining on a single-employer basis, not on a multi-employer or "sectoral" basis.
- The right of employees to unionize and to choose their union free from employer interference;
- The freedom for unions to define the groups of employees they seek to represent, subject to a "community of interest" standard;
- Employer duties to recognize a certified union as the exclusive bargaining agent for its employees, and to not bargain in "bad faith" with the union; and
- Resolution of bargaining disputes by strike or lock-out, after statutory preconditions to a lawful strike are met. Interest arbitration is only to be used for disputes involving "essential" public services or employees.

²⁷⁴ R. Dukes, "Otto Kahn-Freund and Collective Laissez-Faire: An Edifice without a Keystone?" (2009) 72:2 *Mod. L. Rev.* 220-246 at 221.

The legal frameworks for nurse collective bargaining discussed next all share these Wagnerist features in common, with variations to structure and dispute resolution that have arisen in the health care sector.

The Wagner model of labour law discussed here now also has constitutional protection. Early Charter decisions from the 1980s initially held that the Charter did not apply at all to labour law or collective bargaining, and that governments had a free hand to change labour law – including the right to strike – as they saw fit.²⁷⁵ All this changed dramatically in 2007, when the Supreme Court of Canada in *B.C. Health Services* held that section 2(d) of the *Charter* guarantees employees a “meaningful process of collective bargaining”²⁷⁶. In 2011, the Supreme Court in *Fraser*²⁷⁷ declined to give constitutional

²⁷⁵ *Reference Re Public Service Employee Relations Act (Alta.)* [1987] 1 S.C.R. 313 (the “*Alberta Reference*”), paras. 94-98; the *Alberta Reference* was one of three decisions comprising what came to be known as the “Labour Trilogy” of cases, in which the Court refused to assign constitutional protection to collective bargaining. See also *P.S.A.C. v. Canada*, [1987] 1 S.C.R. 424; and *R.W.D.S.U. v. Saskatchewan*, [1987] 1 S.C.R. 460.

²⁷⁶ *Health Services and Support - Facilities Subsector Bargaining Assn. v. British Columbia*, *supra* note 2. At issue in *Health Services* was the *Health and Social Services Delivery Improvement Act*, S.B.C. 2002, c. 2, and the *Health Sector Labour Adjustment Regulation (Health and Social Services Delivery Improvement Act)*, B.C. Reg. 39/2002. This statute and regulation removed a range of issues from health sector collective bargaining in B.C. They came into force only three days after first reading as Bill 29 in 2001 (*Health Services*, para. 6), with no consultation with the affected unions beforehand. The majority held that section 2(d) of the *Charter*, *supra* note 2, requires governments which enact laws that substantially infringe on a matter important to collective bargaining to “consult and negotiate in good faith” with the affected unions. Failure to afford such meaningful consultation leading up to legislative reforms will result in a breach of section 2(d). This failure to consult was a key reason why the majority in *Health Services* found that the B.C. government breached section 2(d) by enacting the Bill 29. In 2016, the Supreme Court relied on the same grounds – a lack of meaningful pre-legislative consultation with affected unions – to strike down legislation enacted by the same B.C. government in 2002 (“Bill 28”), *infra* note 521. Bill 28, discussed in more detail in Chapter 6, removed the issue of class size from teacher collective bargaining on the basis that class size is an education policy issue rather than a collective bargaining matter. By a 7-2 majority, the Supreme Court of Canada reversed the B.C. Court of Appeal’s ruling that there had been sufficient consultation with the teachers’ unions before Bill 28, and adopted the dissenting opinion of Donald J.A. as the majority opinion of the Supreme Court. See *British Columbia Teachers’ Federation v. British Columbia*, 2016 SCC 49, [2016] 2 S.C.R. 407, rev’g 2015 BCCA 184, rev’g 2011 BCSC 469.

²⁷⁷ *Ontario (Attorney General) v. Fraser*, 2011 SCC 20, [2011] 2 S.C.R. 3.

protection to any elements of the Wagnerist labour law model, a decision that attracted a lot of debate from legal scholars both opposed to ²⁷⁸ and in favour of it. ²⁷⁹

In 2015, the Supreme Court of Canada further entrenched Wagnerism when it held in *Saskatchewan Federation of Labour v. Saskatchewan* that the right to strike is guaranteed by section 2(d) of the Charter, such that any restrictions on it must be justified under section 1 of the *Charter*. In 2012, the Saskatchewan Court of Queen's Bench declared invalid legislation that restricted government employees' right to strike by requiring them to maintain essential services during a strike. The Court held that this legislation was of no force and effect for unjustifiably infringing employees' freedom of association under section 2(d) of the *Charter*.²⁸⁰ In that decision, the trial judge held that the right to strike is protected by section 2(d) as a fundamental component of meaningful collective bargaining. That ruling was reversed by the Saskatchewan Court of Appeal²⁸¹, but upheld on further appeal to the Supreme Court of Canada.²⁸²

The implications of *Saskatchewan Federation of Labour* for nurse collective bargaining are to limit how far governments can go in restricting the right to strike as the dispute resolution method. Based on my understanding of *Saskatchewan Federation of Labour*, it has two effects. First, in provinces where strikes remain lawful but that have essential services restrictions, those restrictions will be constitutional if they provide for a

²⁷⁸ B. Langille, "Why Are Canadian Judges Drafting Labour Codes – And Constitutionalizing the *Wagner Act* Model?" (2009) 15:1 *Can.Lab. & Emp.L.J.* 101.

²⁷⁹ J. Cameron, "The Labour Trilogy's Last Rites: *B.C. Health* and a Constitutional Right to Strike" (2010) 15:2 *Can.Lab. & Emp.L.J.* 298; B. Etherington, "Does Freedom of Association under the *Charter* Include the Right to Strike after *B.C. Health*? Prognosis, Problems and Concerns" (2009) 15:1 *Can.Lab. & Emp.L.J.* 315.

²⁸⁰ *Saskatchewan Federation of Labour v. Saskatchewan*, 2012 SKQB 62.

²⁸¹ *Saskatchewan Federation of Labour v. Saskatchewan*, 2013 SKCA 43.

²⁸² *Saskatchewan Federation of Labour v. Saskatchewan*, *supra* note 2.

neutral arbiter of what services are to be essential during a strike (e.g. a labour relations board), if the parties cannot agree beforehand. Models where the government alone decides what services are essential – and thus how much the right to strike is curtailed – would not meet this constitutional threshold. Second, in provinces such as Ontario that completely prohibit strikes, this prohibition is only constitutional if it is accompanied and replaced by a system of neutral, binding interest arbitration to decide bargaining disputes.²⁸³ Provisions that allow governments to unilaterally impose terms after prohibiting strikes will now be unconstitutional subject to being saved under section 1 of the *Charter*. In Chapter 6 I will discuss this constraint further in considering reforms to the labour law model that include a departure from the strike mechanism and its replacement with neutral, binding interest arbitration.

Provincial Nurse Collective Bargaining Structures

I now turn to describe the common key features of the nurse collective bargaining models in the six provinces under study. To begin with, all of these models derive from the general private sector labour legislation in each province. This is the case in Ontario, where a mix of private sector labour legislation²⁸⁴ and special legislation (discussed below) mandates interest arbitration to resolve hospital labour disputes.²⁸⁵ The same

²⁸³ The impact of the Supreme Court's *Saskatchewan Federation of Labour* ruling is discussed in depth in a series of articles published at (2016) 19:2 *Can.Lab. & Emp.L.J. Online*, including: R. Chaykowski, "Labour Relations Policy and Practice, and Regulation of the Right To Strike in the Broader Public Sector: The Implications of *Saskatchewan Federation of Labour*"; B. Etherington, "The Right To Strike under the *Charter* after *Saskatchewan Federation of Labour*: Applying the New Standard to Existing Regulation of Strike Activity"; and B. Langille, "The Condescending Constitution (or, The Purpose of Freedom of Association is Freedom of Association)".

²⁸⁴ *Labour Relations Act, 1995*, *supra* note 266.

²⁸⁵ *Hospital Labour Disputes Arbitration Act*, R.S.O. 1990, c. H.14 ("HLDAA").

multi-statute model also exists in Alberta²⁸⁶, British Columbia²⁸⁷, Saskatchewan²⁸⁸, Manitoba²⁸⁹ and Nova Scotia.²⁹⁰

In each province, nurse collective bargaining occurs at a central level. The representatives of government, health employers and nurses negotiate toward a single contract called a collective agreement. This resulting “central” collective agreement sets uniform terms and conditions for nurses across the province who work in a facility covered by that agreement. However, in some provinces there are also “local” or individual facility-based collective agreements, which exist alongside the central agreement. In Ontario, for example, the central agreement does not cover nurse scheduling, which is reserved as a local issue for the nurses’ union and individual hospitals. Thus, in Ontario there is one central collective agreement and approximately 150 separate local agreements between individual hospitals and the Ontario Nurses’ Association.

Employer and Government Bargaining Representatives

Turning now to the employer representatives at the central bargaining table, in every province but Ontario, the legal “employers” of nurses in every province are the regional health authorities. At the central bargaining table, these employers are in turn represented by a bargaining association or representative. In British Columbia, the six

²⁸⁶ (Alberta) *Labour Relations Code*, R.S.A. 2000, c L-1, s. 143, s. 62.

²⁸⁷ (B.C.) *Labour Relations Code*, *supra* note 269; *Health Authorities Act*, R.S.B.C. 1996, c. 180; *Public Sector Employers Act*, R.S.B.C. 1996, c. 384.

²⁸⁸ *Trade Union Act*, R.S.S. 1978, c. T-17; *Regional Health Services Act*, S.S. 2002, c. R-8.2; *Health Labour Relations Reorganization (Commissioner) Regulations*, R.R.S. c. H-0.03, Reg. 1 is the main enactment prescribing the structure of bargaining and the representatives. It was promulgated under the *Health Labour Relations Reorganization Act*, S.S. 1996, c. H-0.03.

²⁸⁹ *Labour Relations Act*, C.C.S.M. c. L.11.

²⁹⁰ *Trade Union Act*, R.S.N.S. 1989, c. 475; *Health Authorities Act*, S.N.S. 2014, c. 32.

health authorities²⁹¹ are the direct employers of almost all the nurses and other health care employees in their area.²⁹² All such health care employers, in turn, are required – like all B.C. public sector employers²⁹³ – to join a single employers’ association for their sector.²⁹⁴ Under the Public Sector Employers Act, the Minister of Labour has the power to designate an employers’ association.²⁹⁵ The designated employers’ association in the case of health care employers is the Health Employers Association of B.C. (HEABC).²⁹⁶ Thus, the HEABC is the single bargaining agent for all health care employers in BC²⁹⁷, all of which are bound by statute to the collective agreements reached by HEABC.²⁹⁸ The HEABC bargains toward several agreements with all the major health care unions in BC within a centralized structure covering more than 100,000 employees. The HEABC is formally independent from the provincial Ministry of Health, but is still heavily influenced by government in several ways: the presence of Ministry and Public Sector Employers’ Council representatives on the HEABC board; and the extensive powers reserved to the Minister to reject any bylaw or provision of the HEABC constitution and appoint an administrator to take over the HEABC if the public interest warrants.²⁹⁹

²⁹¹ *Health Authorities Act*, *supra* note 287, s. 5(1)(d) (power to deliver services through its employees or to enter into agreements with the government or other public or private bodies).

²⁹² *Health Care Employers Regulation*, B.C. Reg. 427/94, enacted under the *Public Sector Employers Act*, *supra* note 287.

²⁹³ *Public Sector Employers Act*, *ibid.*, s. 1(f) defines “public sector employer” to include “a hospital as defined in the *Hospital Act* or an employer that is designated in the regulations as a health care employer”.

²⁹⁴ *Public Sector Employers Act*, *ibid.*, s. 6(4).

²⁹⁵ *Public Sector Employers Act*, *ibid.*, s. 12.

²⁹⁶ Health Employers Association of B.C., online at <http://www.heabc.bc.ca/>.

²⁹⁷ The *Health Authorities Act*, *supra* note 287, s. 19.1 specifically refers to HEABC; it defines “health sector” as “all members of HEABC whose employees are unionized and includes their unionized employees, and consists of the community subsector and the facilities subsector”.

²⁹⁸ *Public Sector Employers Act*, *supra* note 287, s. 12(6) (HEABC has exclusive authority to bind employers to collective agreement); and *Labour Relations Code*, s. 43(5) (same authority if accredited under s. 43).

²⁹⁹ *Public Sector Employers Act*, *supra* note 287, ss. 7(4), 8.1, 9, and 9.1.

Similarly, in Manitoba, the primary nurse employers are the five health authorities.³⁰⁰ At the central bargaining table, a non-profit corporation called the “Regional Health Authorities of Manitoba” (RHAM)³⁰¹ negotiates on behalf of these five health authorities. However, because most of the Manitoba population lives within the Winnipeg RHA, that RHA has tended to negotiate its own collective agreements as do some rural RHAs, stand-alone extended care facilities and other smaller employers. Even for these employers, though, the RHAM plays a modest supporting role in bargaining. The RHAM is entirely governed by member RHAs, each of which has a seat on the Board of Directors. The RHAM has no bargaining mandate set by government, and is entirely voluntary. Still, the practical reality in Manitoba is that the provincial government is typically drawn into bargaining.

In Saskatchewan, the RHAs are represented in the central bargaining structure by the Saskatchewan Association of Health Organizations (SAHO)³⁰², which is designated by regulation as the representative employer organization.³⁰³ SAHO represents all the RHAs as well as a list of long term care and other health employers not directly managed by RHAs.³⁰⁴ The Saskatchewan government also participates in bargaining on the employer side, having one representative on the SAHO bargaining team. The government has no formal role in SAHO, but still has some informal influence on its decision-

³⁰⁰ The *Regional Health Authorities Act*, C.C.S.M., c. R34 establishes the powers and duties of Manitoba’s health regions. Eleven of the RHAs are defined under the *Regional Health Authorities Establishment Regulation*, Man. Reg. 207/97, while the Winnipeg RHA (the largest in the province) is established by the *Winnipeg Authority Amalgamation Regulation*, Man. Reg. 165/99.

³⁰¹ RHAM website online at <http://www.rham.mb.ca/>.

³⁰² SAHO website online at <http://www.saho.ca/index.htm>.

³⁰³ *Health Labour Relations Reorganization Regulations*, R.R.S., c. H-0.03, Reg. 2, s. 2.1.

³⁰⁴ *Health Labour Relations Reorganization (Commissioner) Regulations*, *supra* note 288, Appendix Tables A and B.

making.³⁰⁵ In Alberta and Nova Scotia, there is only one health authority (Alberta Health Services³⁰⁶ and the Nova Scotia Health Authority³⁰⁷, respectively), so that functions as the employer representative.

In Ontario, there are no health regions: it remains the only province in Canada not to have regionalized health care. In 2006, Ontario established 14 regional health authorities called Local Health Integration Networks (“LHINs”).³⁰⁸ However, unlike the regional health authorities in other provinces, the Ontario LHINs do not have status as employers. Their role is confined to funding and integrating the network of hospitals and other facilities in their domain. Therefore, from a labour relations standpoint, the largest and most important nurse employers in Ontario remain its more than 150 hospitals. As noted in the Introduction, nurses obviously work in many different settings such as long term care, home care, nursing homes, mental health facilities, and in the correctional system and military. Still, as noted there, hospitals still employ more nurses than any other part of the health care system.

All publicly-funded hospitals bargain through a single employer representative, the Ontario Hospital Association (OHA).³⁰⁹ The OHA-led central bargaining structure is voluntary. Each hospital wishing to participate in the central bargaining process led by the OHA “opts in” by signing onto a Memorandum of Joint Bargaining in which they agree to

³⁰⁵ There are no government representatives on the SAHO Board of Directors, but three senior government officials from Health, Finance, and the Personnel Policy Secretariat are represented on the organization's Strategic Advisory Committee to discuss strategy and evolve the bargaining mandate.

³⁰⁶ AHS website online at <http://www.health.alberta.ca/services/Alberta-Health-Services.html> .

³⁰⁷ The Nova Scotia Health Authority and the IWK Health Centre are established as employers for the purpose of collective bargaining: *Health Authorities Act*, *supra* note 290, ss. 80A to 80H (repealing and replacing the former *Health Authorities Act*, S.N.S. 2000, c. 6).

³⁰⁸ *Local Health System Integration Act, 2006*, S.O. 2006, c. 4.

³⁰⁹ OHA website online at <http://www.oha.com/Pages/Default.aspx> .

be bound by the resulting master collective agreements negotiated by the OHA with the various unions in health care, including the Ontario Nurses' Association. Within the OHA, the Hospital Employee Relations Service is responsible for collective bargaining, arbitrations and other labour relations support to local hospitals. In practice, only a small handful of hospitals have not joined the OHA process, even though they have always been fully entitled to bargain with the unions on their own.³¹⁰

Because provincial ministries of health are ultimately responsible for managing the health care system, they have an obvious stake in the outcomes of nurse collective bargaining. Especially when bargaining disputes emerge, the bargaining parties can reduce to just the nurses' union and the provincial Minister of Health or even the Premier her or himself. For example, in Alberta's 2003 round of nurse collective bargaining, then-Premier Ralph Klein became directly involved in negotiations. Similarly, as detailed in Chapter 5 and the Appendix, premiers and ministers of health have been routinely drawn into bargaining disputes with nurses' unions, both by their direct participation in negotiations and/or through media pressure that arose from the prospect of a nurses' strike vote or actual strike action.

Nurses' Union Representatives

Turning now to the other side of the central bargaining process, in each province apart from Nova Scotia there has emerged one dominant union for nurses. They are:

Alberta: United Nurses of Alberta (UNA)
British Columbia: British Columbia Nurses' Union (BCNU)
Manitoba: Manitoba Nurses' Union (MNU)
Nova Scotia: Nova Scotia Government and General Employees' Union (NSGEU)
and Nova Scotia Nurses' Union (NSNU)

³¹⁰ As of 2014, approximately 149 hospitals participated in the ONA central bargaining process.

Ontario: Ontario Nurses' Association (ONA)
Saskatchewan: Saskatchewan Union of Nurses (SUN)

The group of employees a union proposes to cover is called a “bargaining unit”. Normally in unionization applications the parties themselves or the labour relations board defines the bargaining unit but in the case of nurses this is defined by statute or regulation.³¹¹ In three of the provinces under scrutiny here (Alberta, Ontario and Saskatchewan) the nurses' union only represents registered nurses (RNs), while those in B.C., Manitoba and Nova Scotia represent both RNs and licensed practical nurses (LPNs). An Ottawa-based organization has formed a national coalition of these provincial nurses' unions, called the Canadian Federation of Nurses' Unions. The CFNU has no formal collective bargaining role, but rather lobbies at a national level on behalf of the member unions.

Dispute Resolution:

Disputes are a recurring fact of life in collective bargaining. The strike mechanism is the preferred method of settling disputes, but in health care and nursing work stoppages pose a danger to patient safety of an immediate kind. As the foregoing discussion explained, governments have been pulled in opposite directions on this issue, asked to preserve patient safety on one hand but preserve free collective bargaining on the other. The results of this tension are that in five of the six provinces in focus here, a legislative

³¹¹ See e.g. British Columbia: *Health Authorities Act*, *supra* note 287, s. 19.4; Saskatchewan: *Health Labour Relations Reorganization (Commissioner) Regulations*, *supra* note 288, ss. 3-5, 7(1), Appendix Table “D”; Nova Scotia: *Health Authorities Act*, *supra* note 290, ss. 80A; 80B; Alberta: *Regional Health Authority Collective Bargaining Regulation*, *supra* note 15, s. 2; Manitoba: Manitoba Labour Board, *Review of Bargaining Unit Appropriateness in Manitoba's Rural Health Care Sector*, January 23, 1998; *Review of Bargaining Unit Appropriateness in Manitoba's Urban Health Care Sector*, December 22, 1998; Information Bulletin No. 15, *Manitoba Labour Board's Decision Respecting Bargaining Unit Restructuring in the Urban Health Care Sector*, online at <http://www.gov.mb.ca/labour/labbrd/infobulletins/info15.html>.

compromise has emerged in which nurses' unions keep the right to strike, but a right that is curtailed by the need to keep sufficient nurses on the job to protect patients from harm if a strike happens. The difficulty in nursing, of course, lies in the fact that a high proportion of nurses' work is essential in nature, leading to higher numbers of nurses that may not strike, which leads in turn to a weakened bargaining position and less incentive for the government/employer side of the table to settle. Critics of the "limited strike" model therefore claim that it is in truth a "no strike" model when applied to nurses and other health sector employees. Despite these critiques, only in Ontario has the right to strike been outlawed completely and replaced with neutral binding interest arbitration.

Provinces with Strike-Based Approaches

In British Columbia, the "limited strike" model gives the nurses' union the right to strike, but is subject to legislative provisions requiring the maintenance of essential services during a work stoppage.³¹² Under those provisions, the B.C. Labour Relations Board, at the direction of the Minister of Labour, may designate "...as essential services those facilities, productions and services that the board considers necessary or essential to prevent immediate and serious danger to the health, safety or welfare of the residents of British Columbia."³¹³ The B.C. Labour Relations Board has, on such occasions, striven to balance the Wagnerist ideal of the strike mechanism with the equally powerful imperative of public safety.³¹⁴

³¹² (B.C.) *Labour Relations Code*, *supra* note 269, ss. 72-73.

³¹³ *Ibid.*, s. 72.

³¹⁴ See e.g. *Compass Group Canada (Health Services) Ltd.* [2009] B.C.L.R.B.D. No. 193, 171 C.L.R.B.R. (2d) 101, BCLRB No. B193/2009; *Health Employers' Assn. of British Columbia (Fraser Health Authority and Burnaby Hospital)* [2002] B.C.L.R.B.D. No. 334, 87 C.L.R.B.R. (2d) 70, BCLRB Letter Decision No. B334/2002; and *Health Employers Assn. of British Columbia* [2001] B.C.L.R.B.D. No. 125, 70 C.L.R.B.R. (2d) 35, BCLRB Decision No. B125/2001.

Manitoba also uses a “limited strike” model. Before any strike action is lawful, the unions and employers involved must make efforts to reach agreements on which services will be designated as essential in the event of a strike.³¹⁵ In the event of disagreement on essential services, either party may refer the dispute to an arbitrator to determine which services must be provided during a strike.³¹⁶ If, during a strike, a dispute arises concerning the application of an essential services agreement, the parties may refer that issue to arbitration as well.³¹⁷

Similarly, under the “limited strike” model in Saskatchewan, unions must first comply with legislative requirements to maintain essential public services.³¹⁸ Introduced in 2008, the essential services legislation defines “essential services” as those which “...are necessary to enable a public employer to prevent ... danger to life, health or safety”.³¹⁹ The legislation sets out an elaborate procedure under which unions and employers must try to reach essential service agreements that specify the levels of staffing required and those employees considered “essential”. Failing agreement, the provincial labour relations board has the power to make such designations. The legislation prohibits essential service employees from participating in a strike, and contains fines and other penalties for contravention. Because of the obvious necessity of many aspects of health care to public health and safety, these restrictions will almost always apply in some way to nurse strike action.

³¹⁵ *Essential Services (Health Care) Act*, C.C.S.M., c. E146, ss. 6, 11.

³¹⁶ *Essential Services (Health Care) Act*, *ibid.*, s. 7.

³¹⁷ *Ibid.*, s. 10.

³¹⁸ *Public Service Essential Services Act*, S.S. 2008, c. P-42.2.

³¹⁹ *Ibid.*, s. 2(c).

In Alberta, the limited-strike model is relatively new, implemented in 2016 by the incoming NDP government.³²⁰ The new Alberta essential services law requires essential service agreements as a precondition to lawful strikes, and provides for neutral “umpires” to decide those issues in the event of impasse. From 1983 to 2015, however, strikes and lock-outs were prohibited writ large in Alberta health care.³²¹ Penalties for illegal strikes and lock-outs were serious. Unions who undertook a strike could lose their right to have the employer deduct and remit dues, and possibly lose their representation rights entirely.³²² In practice, however, the Alberta interest arbitration system was never once used, mainly because the UNA has refused to accept the legitimacy of the “no strike” provisions of the legislation and has bargained with the provincial government as if strikes were lawful. As the union states on its website, “UNA believes any collective agreement it signs must be voluntarily accepted by members in a democratic vote, not imposed by arbitration, or any law or ruling.”³²³ This unique scenario was entrenched in 1988, when the UNA went on an illegal strike, which attracted fines and other penalties on the union, including a contempt of court ruling that was ultimately appealed to the Supreme Court of Canada.³²⁴

Nova Scotia’s limited-strike model for health care is also a recent legal development.³²⁵ Prior to 2014, there were no legislative restrictions on the right to strike

³²⁰ *An Act to Implement a Supreme Court Ruling Governing Essential Services*, S.A. 2016, c. 10 (Bill 4, 2016), amending the *Labour Relations Code*, *supra* note 269.

³²¹ *Labour Relations Code*, *supra* note 269, s. 96(2).

³²² *Ibid.*, ss. 114-116.

³²³ UNA negotiations updates are online at <https://www.una.ab.ca/collectiveagreements/negotiations>.

³²⁴ *United Nurses of Alberta v. Alberta (Attorney General)*, [1992] 1 S.C.R. 901.

³²⁵ *Essential Health and Community Services Act*, S.N.S. 2014, c. 2 (Bill 37, 2014); S. Ross, “Strike law seen as ‘great news’; Nova Scotia had been only province without essential services legislation”, *Chronicle - Herald*, April 5, 2014, A4; M. Gorman, “Bill 37 passes amid noisy protest; Legislation sending NSGEU nurses back to work affects nearly 40,000 workers”, *Chronicle - Herald*, April 5, 2014, A4.

for nurses in Nova Scotia. However, Nova Scotia had on occasion enacted special *ad hoc* legislation to end a health care labour dispute, in some instances requiring the dispute to be resolved by interest arbitration.³²⁶

Ontario: Interest Arbitration

The foregoing shows clearly the continued dominance of the voluntarism belief in Wagnerism, as manifested in the continued use of the strike mechanism – albeit limited – to resolve nurse bargaining disputes. Only in Ontario has the decision been made to reject the strike mechanism altogether and substitute binding interest arbitration in its place. Special legislation enacted in 1965³²⁷ after a commission of inquiry³²⁸ prohibits strikes and lockouts in employers that come within its definition of “hospital”.³²⁹ This definition is broadly framed to cover all public and private hospitals in Ontario, except for the handful of psychiatric hospitals, which are directly operated by the Ontario government.³³⁰

³²⁶ See *e.g.* the legislation that ended a 2001 health care labour dispute by legislating an end to the strike and remitting the outstanding issues to an interest arbitrator: *Healthcare Services Continuation (2001) Act*, S.N.S. 2001, c. 27.

³²⁷ *HLDA*, *supra* note 285. A concise overview of the history around the enactment of the *HLDA* is found in *Canadian Union of Public Employees (CUPE) v. Ontario (Minister of Labour)*, 2003 SCC 29, [2003] 1 S.C.R. 539, paras. 55-64.

³²⁸ Ontario, *Royal Commission Report on Compulsory Arbitration in Disputes Affecting Hospitals and Their Employees* (Toronto: The Commission, 1964).

³²⁹ *HLDA*, *supra* note 285, s. 1(1) defines “hospital” as:

...any hospital, sanitarium, sanatorium, nursing home or other institution operated for the observation, care or treatment of persons afflicted with or suffering from any physical or mental illness, disease or injury or for the observation, care or treatment of convalescent or chronically ill persons, whether or not it is granted aid out of moneys appropriated by the Legislature and whether or not it is operated for private gain, and includes a home for the aged.

Whether *HLDA* applies to a particular facility is sometimes unclear, and in such cases the Minister of Labour decides. In 1992, Section 3(2) was added to *HLDA* which empowers the Ontario Labour Relations Board to advise the Minister on this issue.

³³⁰ Psychiatric hospitals in Ontario are the only hospitals that are part of the “core” (*i.e.* Crown employee) collective bargaining system, since they are directly owned and operated by the Ontario Ministry of Health and

An important point I take up in Chapter 5 relates to how the interest arbitrators in Ontario's scheme are chosen. The statute itself is silent, other than giving the Minister of Labour a wide discretion to appoint interest arbitrators.³³¹ However, the courts have read into this power a requirement that the Minister consider the acceptability and legitimacy of the nominated arbitrators to the parties. This happened in a 2003 Supreme Court of Canada decision, *C.U.P.E. v. Ontario*.³³² The facts of that case illustrate the dominance of Wagnerist labour law tradition in how decisions are made within the labour relations realm – even in health care. In 1997, the Ontario government changed how it selected the individuals to act as interest arbitrators. Until 1997, interest arbitrators were appointed from a group of familiar and trusted labour arbitrators sometimes called the “Section 49” roster.³³³ In the 1997 round, the Minister ignored this unwritten custom and instead appointed retired judges, none of whom were on the Section 49 roster. The hospital unions affected by this decision sought judicial review of the Minister's appointments. After six years of appeals, the Supreme Court of Canada held that the Minister's appointments were patently unreasonable and ordered them set aside.³³⁴ Mr. Justice Binnie held that custom and labour relations history require Ministers to consider three

Long Term Care. As “Crown” employers, they fall under the collective bargaining system constituted under the Ontario *Crown Employees Collective Bargaining Act, 1993*, S.O. 1993, c. 38.

³³¹ *HLDA*, *supra* note 285, s. 6(5) provides:

Where the two members appointed by or on behalf of the parties fail within ten days after the appointment of the second of them to agree upon the third member, notice of such failure shall be given forthwith to the Minister by the parties, the two members or either of them and the Minister shall appoint as a third member a person who is, in the opinion of the Minister, qualified to act.

³³² See, e.g. *Canadian Union of Public Employees (CUPE) v. Ontario (Minister of Labour)*, *supra* note 327, where the Supreme Court of Canada affirmed the use of an established roster of labour arbitrators to decide *HLDA* cases.

³³³ After Section 49(10) of Ontario's *Labour Relations Act, 1995*, *supra* note 266, under which the roster emerged. The evolution of this roster was explained by Binnie J. in *Canadian Union of Public Employees (C.U.P.E.) v. Ontario (Minister of Labour)*, *supra* note 327, paras. 65-68.

³³⁴ *Ibid.*

relevant criteria when exercising their discretion choosing interest arbitrators: (1) independence and impartiality; (2) “relevant labour relations expertise”; and (3) “general acceptability within the labour relations community”. The effect of this decision has been the continuation of the pre-1997 practice of appointing only familiar labour arbitrators to decide hospital bargaining disputes. It effectively prevents the Ontario government from going outside this pool to find qualified, expert arbitrators. This constraint becomes important later in Chapter 5 during my critique the interest arbitration model.

Under the Ontario interest arbitration model for hospitals, the “award” fashioned by the arbitration panel language forms part of the collective agreement and is as legally binding as if it was mutually agreed upon. In a 1996 enactment³³⁵, Ontario’s interest arbitration system was reformed to require arbitrators to consider the following matters when rendering awards:

1. The employer’s ability to pay in light of its fiscal situation.
2. The extent to which services may have to be reduced, in light of the decision or award, if current funding and taxation levels are not increased.
3. The economic situation in Ontario and in the municipality where the hospital is located.
4. A comparison, as between the employees and other comparable employees in the public and private sectors, of the terms and conditions of employment and the nature of the work performed.
5. The employer’s ability to attract and retain qualified employees.³³⁶

Since its inception in 1965, the interest arbitration process in Ontario has been used on many occasions to resolve nurse bargaining impasses, both at the central level and at the local hospital level. In some instances, the arbitrators had to decide only a handful of issues, and in other cases dealt with a wide range of matters in dispute. In this regard,

³³⁵ *Savings and Restructuring Act, 1996*, S.O. 1996, c. 1, Sch. “Q”.

³³⁶ *HLDA*, *supra* note 285, s. 9(1.1).

Ontario stands apart from Alberta and Prince Edward Island, the other two provinces using interest arbitration. In those provinces, while interest arbitration is available, it has seldom, if ever, been used to settle a bargaining dispute.

In its four decades of existence, Ontario's interest arbitration system for hospital collective bargaining has been the focus of periodic study and debate.³³⁷ In 1974, the Ontario minister of labour appointed a Hospital Inquiry Commission to address "mounting dissatisfaction" with the arbitration model in the Ontario hospital sector.³³⁸ The Commission found that arbitrators lacked consistent criteria on which to base their decisions, and that the process tended to encourage reliance on arbitration rather than negotiation to reach a final agreement.³³⁹ However, the Commission did not recommend a turn back to a strike-based model; instead, it recommended three basic reforms: (i) the "establishment and proper functioning of a system of dispute settlement based on legislative criteria"; (ii) a "more rational and orderly bargaining structure", and (iii) "streamlining" the arbitration process and establishing a standing commission of arbitrators who will give greater consistency to decisions.³⁴⁰ The first reform, the addition of legislative criteria for arbitrators to follow, was added in legislation enacted in 1996 and 1997.³⁴¹ The second reform took shape earlier as the Ontario Hospital Association and

³³⁷ Ontario, Department of Labour, Research Branch, "The Impact of the Ontario *Hospital Labour Disputes Arbitration Act*, 1965: A Statistical Analysis", report prepared by Keith McLeod, November 1970; see also J. Solberg, "The Pros and Cons of Interest Arbitration: A Union Perspective" [1994-95] *Labour Arbitration Yearbook* 409; D. Stanley, "The Pros and Cons of Interest Arbitration: An Arbitrator's Perspective" [1994-95] *Labour Arbitration Yearbook* 417; and T. Schulz, "The Pros and Cons of Interest Arbitration: An Employer's Perspective" [1994-95] *Labour Arbitration Yearbook* 429.

³³⁸ Johnston & McKenna, "Public Interest Disputes and Compulsory Arbitration: A Case Study of Hospitals in Ontario", *supra* note 13 at 505.

³³⁹ *Ibid.* at 508.

³⁴⁰ *Ibid.* at 509.

³⁴¹ *Savings and Restructuring Act*, *supra* note 335, Sch. "Q", s. 2; *Public Sector Dispute Resolution Act*, 1997, S.O. 1997, c. 21, Sch. "A", s. 1.

the various unions, which represented the different categories of hospital employees entered into a voluntary central bargaining structure. The third reform, however, has not come to fruition, as Ontario arbitrators continue to be selected on an ad hoc basis from an established pool of former labour lawyers and labour arbitrators and law professors.

In 2012, the “Drummond Commission” on reforming Ontario’s public services also proposed significant changes to the interest arbitration model.³⁴² In doing so, the Commission consulted with policy officials in the Ministry of Health and other ministries and reported a groundswell of discontent for the current model:

The system of interest arbitration is very important. Unfortunately, the system has recently come under increasing scrutiny and attack. The arbitration system thus must not only work, but it must be seen to work.

...

The Commission heard many submissions from employers in the BPS claiming that arbitration is seriously flawed, even broken. Specific charges included the granting of high compensation awards, ignoring “ability to pay” arguments and long delays that are sometimes followed by high retroactive awards that had not been budgeted for.³⁴³

The Commission’s final report (the “Drummond Report”) recommended a series of reforms to the Ontario interest arbitration process. These included:

- Shifting the arbitration system “in favour of more objective analysis, based on objective criteria and supported by systematic data and research.”;
- Using a standing roster of arbitrators assigned to cases rather than have the parties appoint them;
- Time limits for hearing and for rendering decision;
- Developing “specific and well-defined objective criteria that interest arbitrators would be required to account for in formulating their awards/decisions.”;

³⁴² Commission on the Reform of Ontario’s Public Services (Don Drummond, Chair), *Public Services for Ontarians: A Path to Sustainability and Excellence (“Drummond Report”)* at 370-373, online at <http://www.fin.gov.on.ca/en/reformcommission/chapters/ch15.html>.

³⁴³ *Ibid.* at 371.

- Requiring arbitrators to “provide clear assessments and reasons for their awards/decisions based on the specific and well-defined criteria specified in legislation, as well as any others.”;
- Mandatory mediation as a precondition to arbitration;
- “Monitoring” of arbitration awards to ensure “...that decisions reflect clear assessments based on criteria specified.”; and
- Creating “transparency” of decisions through publication and accessibility to the public, stating that “this is a form of external regulation by pressure from the parties and the interested public.”³⁴⁴

In 2012, the Ontario government introduced Bill 55, which in its first reading form, contained several reforms to the interest arbitration legislation which followed the recommendations of the Drummond Report.³⁴⁵ The proposed changes included reforms that would have:

- Required written submissions from both parties in arbitrations;
- Required arbitrators to provide written rationales for decisions upon request by either party; and
- Required arbitrators to render their decisions within 12 months; and where decisions are not released in 12 months, required the case be referred to the Ontario Labour Relations Board for determination.

However, these proposed reforms were strongly opposed by health care unions in Ontario, including the ONA³⁴⁶ and the government ultimately withdrew the reforms from Bill 55.³⁴⁷

Taken as a whole, the Ontario interest arbitration system for hospital collective bargaining has proven to be a durable and workable mechanism. The arbitrators who

³⁴⁴ *Ibid.* at 371-373.

³⁴⁵ *Strong Action for Ontario Act (Budget Measures), 2012* (Bill 55), First Reading, Sch. 30, ss. 4-8, online at http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=2600&isCurrent=&BillStagePrintId=5142&btnSubmit=go.

³⁴⁶ See, e.g., Ontario Nurses' Association, Submission on Bill 55, June 12, 2012, online at https://www.ona.org/documents/File/politicalaction/ONA_Bill55SubmissiontoStandingCommittee_20120612.pdf.

³⁴⁷ *Strong Action for Ontario Act (Budget Measures), 2012*, S.O. 2012, c. 8.

have served under this scheme have been labour relations experts exclusively. They derive their “expertise” from their experience as grievance arbitrators and before that labour lawyers or company HR managers. Binnie J. described this conception of expertise as follows in the 2003 *C.U.P.E. v. Ontario* decision:

... experience has shown that successful "interest" arbitrators come to their task familiar with the "current issues in labour relations" and the "bargaining history of the parties to various collective agreements in relevant public sector industries". Further, "[t]hey are familiar with seniority, compensation and job evaluation systems, work preservation practices, and other work rules. In short, they can readily understand how their judgments in arbitration awards will affect the workplace realities of employees, unions, and management. They do not have to start each arbitration by being 'educated' by the parties as to the intricacies of their particular workplaces."³⁴⁸

However much expertise these arbitrators may have with the specialized field of labour law, this does not necessarily translate into expertise in dealing with patient safety issues. As I discuss more in Chapter 5, it has serious limitations as a mechanism for deciding patient safety issues.

Overview of Nurse Collective Bargaining in Canada, 1999-2014

This study covers a fifteen-year period of collective bargaining experience in the six provinces under review here. However, I focus specifically on how patient safety issues, as defined in Chapter 2, have been processed and resolved in the Wagnerist labour law models just outlined. As context, it will be useful to sketch out some of the broad currents in nurse labour relations in Canada during that time.

The 1999-2014 period was a turbulent fifteen years in nurse labour relations across Canada. Three broad trends contributed to this turbulence: (i) the desire of governments

³⁴⁸ *Canadian Union of Public Employees (C.U.P.E.) v. Ontario*, *supra* note 327 at para 53.

to make the delivery of health services more cost-effective; (ii) government willingness to increase public spending on health services; and (iii) significant political capital held by health professions arising from shortages and other effects of spending restraint in the prior decade. The first two trends operated in tandem. Since 1999, provinces appear to be mostly committed to investments in health care, but they do not want to spend new money in what are perceived as inefficient modes of delivery. Technological advances have created opportunities to shift care to a wider range of settings than those contemplated in the *Canada Health Act*³⁴⁹ -- physicians' offices and hospitals. Innovations to improve the cost-effectiveness of care have taken many forms such as primary care reform, hospital restructuring, tele-health, e-health and a shift of acute care into the home and community sectors. Outside the strictures of the *Canada Health Act*, governments are considering new modes of care delivery such as contracting with for-profit firms – there is nothing in the CHA to stop this within public Medicare. Within the hospital sector, performance measures are linked to funding levels. Across the system, the theme is one of streamlining the delivery of services to preserve the accessibility and comprehensiveness of health services as population need rises.

The third trend was the increased political influence of nurses and other health providers. The funding restraint of the 1990s³⁵⁰ led to large numbers of layoffs and a general stagnation of the health care workforce.³⁵¹ As well, wages and working conditions

³⁴⁹ *Canada Health Act*, *supra* note 151.

³⁵⁰ CIHI, *National Health Expenditure Trends, 1975 to 2015*, *supra* note 125 at 7, “Figure 1: Total health expenditure as a percentage of GDP, Canada, 1975 to 2015”. The report stated “As governments focused on fiscal restraint, total health expenditures grew more slowly than GDP between 1993 and 1997. Consequently, the health-to-GDP ratio fell each year in that period, reaching 8.7% in 1997.”

³⁵¹ Across Canada, there was a decrease of 11% in total paid nursing hours in just one year - between 1994-95 and 1996-97. See J. Ross-Kerr, & M. Wood, *Canadian Nursing: Issues and Perspectives* (Toronto: Elsevier Mosby, 2011) at 274. See also Canadian Nursing Advisory Committee, *Our Health, Our Future: Creating Quality Workplaces for*

- particularly workload - for those that remained in the system, by all accounts, deteriorated. With public support for nurses and other health providers reasonably strong, their unions began spending this political capital, demanding wage increases and lower workloads, and often vehemently criticized government health reforms designed to make health care delivery more cost-effective. Deriving increased political and economic bargaining strength from the current labour shortage, nurses began pressing their demands through collective bargaining. In every dispute, they drew links between their demands and the policy goals of recruitment, and improved quality of care. Mainly, though, nurses' unions focused their demands on recruiting more nurses and attaining higher wages. In this wage-centric context, patient safety issues were often part of the dispute, but not the primary issue dividing the parties.

After 2003, however, economic issues receded somewhat and patient safety-related issues received more attention in nurse collective bargaining. In many rounds, health care employers and provincial governments made demands for "flexibility"-driven changes to scheduling, hours of work and workload provisions, changes that nurses' unions claimed would negatively affect patient safety. Some of the employers' flexibility demands included increased freedom to make individualized scheduling plans with nurses, and relief from the various triggers for payment of shift premiums and overtime wage multipliers.

Canadian Nurses (Ottawa: CNAC, 2002), online at <http://www.hc-sc.gc.ca/hcs-sss/pubs/nurs-infirm/2002-cnac-cccsi-final/index-eng.php>, at 9: "While the number of regulated nurses remains high, the devastating impacts of government funding cuts in the 1990s need to be acknowledged."

Conclusion

As Professor Langille explains, Wagnerism continues to have a strong hold on Canadian labour law practitioners:

Canadian labour lawyers have grown up in a world where, for as long as any of us can remember, we have instantiated freedom of association in the Wagner model, with some Canadian innovations such as mandatory rights arbitration and the no-strike rule during the life of a collective agreement. We cannot, it seems, imagine any other way of “doing” freedom of association. We are stuck with our own local practices, and have no ability to bring to bear any wider or deeper perspective.³⁵²

In Chapters 5 and 6 I will challenge this approach and engage with Wagnerist theory in critiquing and suggesting reforms to the nurse collective bargaining model intended to improve patient safety. In this chapter I have introduced and shown how Wagnerism permeates the Canadian labour law field, and the current design of the labour law frameworks for nurses. In most provinces, the “system” of health sector collective bargaining in which nursing issues are negotiated is a centralized structure built on the foundations of Wagnerist labour legislation. And within those structures, the Wagnerist mainstay for dispute resolution – the strike weapon – continues to dominate. Interest arbitration is the narrow exception, not the rule. Thus, when nurse collective bargaining disputes arise – and they often do – Wagnerist legal theory continues to dominate the methods used to resolve them. As I will show in later Chapters, these features play an important role in how decision-making on patient safety-related issues occurs.

³⁵² B. Langille, “Why Are Canadian Judges Drafting Labour Codes – And Constitutionalizing the *Wagner Act* Model?”, *supra* note 278 at 108.

**CHAPTER FOUR:
PATIENT SAFETY-RELATED TERMS OF NURSE COLLECTIVE AGREEMENTS**

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Introduction

To recall from Chapter 2, I argued that these issues are patient safety-related based on the research evidence to date. I now turn to examine existing collective agreement terms and the outcomes of bargaining on nurse workload and hours of work. As we will see, whilst Canadian nurse collective bargaining has, to date, produced some important contract terms on these issues that advance patient safety interests there are insufficient protections against excessive nurse workload. Moreover, the myriad rules

regulating hours of work, overtime and scheduling are often highly qualified or subject to exemptions.

Sources and Methods

The materials on which I base this Chapter are drawn from current nurse collective agreements and from reported cases called “grievance arbitrations” in which collective agreement terms are enforced. As explained in Chapter 3, in most provinces’ nurse collective bargaining occurs at a central, provincial level. In most provinces, then, there is a single central collective agreement which provides uniform terms and conditions for nurses across health employers and health regions in each province. In some provinces, the central contract is accompanied by local collective agreements dealing with specific issues excluded from central bargaining, or by appendices containing terms specific to various individual health regions or employers.

By law, all collective agreements must be filed with the provincial labour relations board³⁵³, so the nurse collective agreements in each province were available from both those boards and from the websites of the nurses’ union.³⁵⁴ I located and downloaded the

³⁵³ *E.g. Labour Relations Act, 1995, supra* note 266, s. 90: “Each party to a collective agreement shall, forthwith after it is made, file one copy with the Minister.” The Ontario Minister of Labour has placed collective agreements in a searchable database, online at http://www.sdc.gov.on.ca/sites/mol/drs/ca/Pages/default_en.aspx. Similarly, the British Columbia Labour Relations Board has collective agreements online at <http://www.lrb.bc.ca/cas/>.

³⁵⁴ British Columbia Nurses’ Union website online at <https://www.bcnu.org/contracts-and-bargaining/your-collective-agreement/nurses-bargaining-association>; United Nurses of Alberta website online at <https://www.una.ab.ca/collectiveagreements>; Saskatchewan Union of Nurses website online at <http://sun-nurses.sk.ca/labour-relations/collective-agreements>; Manitoba Nurses’ Union website online at <https://manitobanurses.ca/resources/collective-agreements.html>; Ontario Nurses’ Association Hospital Collective Agreements online at https://www.ona.org/ona_members/hospital/collective_agreements.html; Nova Scotia Nurses’ Union website online at <http://www.nsnu.ca/en/home/collectiveagreements/default.aspx>; Nova Scotia Government and General Employees’ Union website online at <http://www.cdha.nshealth.ca/employees/labour-relations/nsgeu-local-97-nurses>.

most current collective agreements from the websites of the nurses' unions in each of the six provinces. British Columbia³⁵⁵, Saskatchewan³⁵⁶ and Alberta³⁵⁷ have one central collective agreement. Ontario has one central and a series of companion local hospital collective agreements.³⁵⁸ Nova Scotia has two collective agreements (the NSNU³⁵⁹ and NSGEU³⁶⁰ nurse agreements), and Manitoba has set of local but uniform collective agreements.³⁶¹ To obtain interest arbitration awards under Ontario's *Hospital Labour Disputes Arbitration Act*, a search of Quicklaw's Labour Arbitration Awards database for "hospital labour disputes" confined to Ontario retrieved all interest arbitration awards issued in Ontario since 2005.³⁶²

³⁵⁵ *2012-2014 Provincial Collective Agreement between Health Employers' Association of British Columbia and the Nurse Bargaining Association*, April 1, 2012 – March 31, 2014, online at <https://www.bcnu.org/Contracts-Bargaining/Documents/NBA%202012-2014%20-%20FINAL%202015-01-30.pdf> (hereinafter "**B.C. Agreement**")

³⁵⁶ *Collective Agreement Between the Saskatchewan Association of Health Organizations and Saskatchewan Union of Nurses*, April 1, 2012 – March 31, 2014, online at http://sun-nurses.sk.ca/+pub/document/Labour/CBA/SUN-SAHO%20CBA%202012-2014_101612.pdf (hereinafter "**Saskatchewan Agreement**").

³⁵⁷ *Collective Agreement Between Alberta Health Services, Covenant Health, Lamont Health Care Centre, The Bethany Group and United Nurses of Alberta*, April 1, 2013 – March 31, 2017, online at https://www.una.ab.ca/files/447/Provincial_AHS_UNA_CA_2013-2017.pdf (hereinafter "**Alberta Agreement**").

³⁵⁸ *Collective Agreement between Participating Hospitals and the Ontario Nurses' Association*, Expiry March 31, 2016, online at https://www.ona.org/documents/File/pdf/cas/hospitals/HospitalCentralAgreement-English_March312016.pdf (hereinafter "**Ontario Agreement**")

³⁵⁹ *Collective Agreement between the Nova Scotia Nurses' Union and South Shore District Health Authority, South West Nova District Health Authority, Annapolis Valley District Health Authority, Colchester East Hants Health Authority, Cumberland Health Authority, Pictou County Health Authority, Guysborough Antigonish Strait Health Authority, Cape Breton District Health Authority, Capital District Health Authority & Izaak Walton Killam Health Centre*, online at <http://www.nsnu.ca/site/media/nsnu/NSNU%20Acute%20Care%20Collective%20Agreement%202012-2014.pdf> (hereinafter "**NSNU Agreement**").

³⁶⁰ *Collective Agreement between the Capital District Health Authority and the Nova Scotia Government and General Employees' Union, Nursing Bargaining Unit*, November 1, 2012 – October 31, 2014, online at <http://www.cdha.nshealth.ca/employees/labour-relations/nsgeu-local-97-nurses> (hereinafter "**NSGEU Agreement**").

³⁶¹ Collective agreements in Manitoba are between the Manitoba Nurses' Union and the various health regions and hospitals in that province (Prairie Mountain Health Region, Interlake Eastern Regional Health, Southern Health Authority, Northern Regional Health Authority, Churchill Regional Health Authority, Winnipeg Regional Health Authority, Concordia Hospital, St. Boniface Hospital, Grace Hospital, Health Sciences Centre, Misericordia Hospital, Riverview Hospital, Seven Oaks Hospital, Victoria Hospital) They are more or less uniform in their terms and conditions. They are available online at <https://manitobanurses.ca/resources/collective-agreements.html>.

³⁶² As mentioned earlier, grievance arbitration and interest arbitration are different. The grievance arbitrator's task is to interpret, apply and enforce existing terms of a collective agreement, not to add, remove or change the

“Patient Safety”-Related Terms in Nurse Collective Agreements

Beginning with the most general observation, the phrase “patient safety” is itself not found in nurse collective agreements. Rather, these agreements contain extensive terms and conditions on the three broad issues identified in Chapter 2 as patient safety-related: (i) workload issues, (ii) hours-of-work issues, and (iii) scheduling issues. For convenience, I will call these issues “patient safety issues” and collective agreement terms on these issues “patient safety terms”. These terms and conditions are the result of negotiated compromises between the nurses’ unions and the bargaining agent for their respective provincial governments.

Obviously, on their own, mere words in collective agreements cannot make patients safer. For that to happen, the parties must be committed to complying with agreed-upon rules or other terms, and there must be a meaningful legal mechanism to enforce terms and/or provide remedies for breach. All collective agreements are required by law to contain terms that provide such an enforcement procedure called “grievance arbitration”. Under grievance arbitration, patient safety terms have been interpreted, applied and enforced through binding orders on employers. With employer compliance, I argue here, the patient safety terms in current nurse collective agreements construct a working environment for nurses that reduces the risk of adverse events. However, I also

agreement in any way. The interest arbitrators’ task is to draft and codify the terms of an agreement itself on issues where the parties are unable to reach agreement themselves. Grievance arbitrators do not settle collective bargaining disputes; they only enforce and interpret the terms that result from disputes. By contrast, interest arbitrators do settle bargaining disputes and effectively write the law (in the form of the collective agreement) that will govern the parties. Thus, only interest arbitrators are of interest to this analysis, because only they, and not grievance arbitrators, play a role in resolving nurse bargaining disputes.

caution that many patient safety terms are qualified and subject to exemptions that dilute, but not eliminate, the patient safety benefit of these clauses.

The Context: Overview of the “Typical” Nurse Collective Agreement

The patient safety terms I focus on here are but a small fraction of a much larger set of contract terms: centrally-bargained nurse collective agreements are typically between 200 and 400 pages, and usually contain numerous appendices, letters, memoranda and other attachments. These agreements create a broad matrix of nurse rights and employer restrictions from wages to vacations to pensions, holidays and many other topics. Thus, like all collective agreements, they have many parts and much complex legal language, but some core features can be sketched out.

To begin with, every nurse collective agreement has what is called a “management rights” clause. The “management rights” clause affirms that the employer has a prerogative - is legally free - to organize and direct its employees howsoever it wishes so long as it does not breach the collective agreement.³⁶³ The Saskatchewan agreement, for example, provides:

MANAGEMENT RIGHTS

Subject to the terms of this Agreement, it is the function of the Employer to:

- (a) Direct the working force;
- (b) Operate and manage its business in all respects;
- (c) Hire, select, transfer and lay-off because of lack of work;
- (d) Maintain order, discipline, efficiency and to establish and enforce reasonable rules and regulations governing the conduct of Employee(s), such rules and regulations shall

³⁶³ Alberta Agreement, *supra* note 357, s. 4, B.C. Agreement, *supra* note 355, s. 3, Saskatchewan Agreement, *supra* note 356, s. 3, NSGEU Agreement, *supra* note 360, s. 5, NSNU Agreement, *supra* note 359, s. 3.

primarily be designated to safeguard the interest of the clients and the efficiency in Employer operations;

(e) Promote, demote, discipline, suspend and discharge any Employee provided, however, that any such action may be subject to the grievance procedure provided herein.³⁶⁴

The labour law rule of “managerial prerogative”, affirmed by such clauses, holds that anything the collective agreement is silent on, employers are free to do, subject only to a “reasonableness” standard when an employer institute a rule or policy that otherwise does not otherwise breach a specific term of the collective agreement.³⁶⁵ Thus, the hospitals and health regions governed by the provincial nurse collective agreements in focus here are free to set nursing schedules, allocate work among nurses and assign overtime, where necessary, limited only by the terms of the collective agreement and the reasonableness standard.

Besides the patient safety terms on workload, hours of work and scheduling, all nurse collective agreements contain a basic bundle of protections and rules. On wages, they fix progressive (i.e. increasing incrementally with seniority) wage rates on detailed grids, and contain extensive language on vacation, holidays, pension contributions and group disability insurance plans. Nurse agreements also prohibit discrimination on all the grounds prohibited under provincial human rights legislation, and require workplace accommodation of injured and disabled nurses.³⁶⁶

³⁶⁴ Saskatchewan Agreement, *supra* note 356, s. 3.01.

³⁶⁵ *KVP Co. Ltd.* (1965) 16 L.A.C. 73 (Robinson). The holding of *KVP* is that rule-making is an inherent right of management, but company rules and regulations must be reasonable and consistent with the terms of the collective agreement. When unions grieve an employer’s introduction of a new policy, the arbitrator’s task is to determine whether the policy is “*KVP* reasonable” or meets the “*KVP* test”. For example, in *Sault Area Hospital v. Ontario Hospital Assn. (Vaccinate or Mask Grievance)* (2015) 262 L.A.C. (4th) 1, [2015] O.L.A.A. No. 339, 124 C.L.A.S. 224 (Hayes) the Ontario Nurses’ Association challenged a vaccination policy under the *KVP* rule.

³⁶⁶ Non-discrimination clauses typically mirror the provisions of human rights legislation: see *e.g.* Alberta Agreement, *supra* note 357, s. 6, B.C. Agreement, *supra* note 355, s. 31, NSGEU Agreement, *supra* note 360, s. 2.03, NSNU Agreement, *supra* note 359, s. 18, Saskatchewan Agreement, *supra* note 356, s. 4.

As in every unionized workplace, nurse collective agreements establish seniority as the governing principle for the purposes of many nursing rights under the collective agreement such as wage rates, layoff rights, bumping rights, and access to vacant positions. Further, all nurse collective agreements restrict the power of health care employers to discipline or terminate the employment of nurses engaged in work-related misconduct, and require employers to justify all discipline or discharge of nurses on a “just cause” standard.³⁶⁷

A final common feature of the typical nurse collective agreement is that they all have the “grievance arbitration” clauses mentioned above, which create the legal process that the nurses’ union must use to enforce the collective agreement. Grievance arbitration is a fundamental part of the labour law system, because all workplace disputes during the life of a collective agreement must be sent to arbitration for enforcement. During the collective agreement’s term (typically two to three years), unions cannot try to enforce it in the courts, nor can they call for a strike to enforce the agreement, as unions once did prior to the advent of modern labour legislation. All disputes arising out of the nursing workplace must be brought before labour arbitrators, who wield important powers to interpret, apply and make orders enforcing one or more terms of the collective agreement. With these powers, as I discuss further below, these arbitrators have played an important role in shaping whether language that appears to promote patient safety does so.

In most of the six provinces under review here, the issues of hours of work, scheduling and workload are addressed both in “central” and “local” agreement terms.

³⁶⁷ B.C. Agreement, *supra* note 355, s. 15, Alberta Agreement, *supra* note 357, s. 23, NSGEU Agreement, *supra* note 360, s. 23, NSNU Agreement, *supra* note 359, s. 22, Saskatchewan Agreement, *supra* note 356, ss. 24, 25.

What do I mean by “central” and “local”? By “central” collective agreement, I mean the province-wide agreement for nurses in each province, applicable to all health regions (or hospitals, in Ontario). By “local” agreements I mean the parallel collective agreements between nurses’ unions and individual health regions or employers. Local agreements deal with matters reserved for local bargaining by statute or (in Ontario) agreement between the nurses’ union and the provincial health employers’ organization. Thus, for example, in Ontario, the central bargaining parties (the OHA and ONA) have jurisdiction to negotiate over wages, benefits, and a range of other monetary items.³⁶⁸ At the same time, local Ontario hospitals and nurses’ union locals who are bound by the central agreement’s terms also have a “local” bargaining jurisdiction to negotiate toward their own collective agreements on scheduling, hours of work and other non-monetary matters.³⁶⁹ Thus, in Ontario, most of the patient safety-related terms are found in local collective agreements. In Alberta and Nova Scotia (NSNU), local collective agreements are not separate from the central agreement but rather are attached to it as appendices or memoranda of understanding. In Saskatchewan and British Columbia, there are no local agreements, while, at the other end of the spectrum, in Manitoba all the collective agreements are local but are closely similar in terms.³⁷⁰

Workload Terms

As shown in more detail in Chapter 5, Canadian nurses’ unions have addressed excessive nursing workloads as a patient safety issue both in collective bargaining and in

³⁶⁸ Memorandum of Joint Bargaining between the Ontario Nurses’ Association and Participating Hospitals, dated

³⁶⁹ Local hospital collective agreements with the Ontario Nurses’ Association are posted online by the ONA, online at https://www.ona.org/ona_members/hospital/collective_agreements.html.

³⁷⁰ MNU collective agreements are found online at <https://manitobanurses.ca/resources/collective-agreements.html>.

their demands on governments for more funding for nursing hires. In the six provinces under review here, nurses' unions have frequently sought contractual language to control the workload of individual nurses by protecting against surges in patient demand with additional nursing staff. Among the most prominent of these demands has been for contract terms requiring employers to adhere to a fixed ratio of nurses to patients, called "nurse-patient ratios".³⁷¹ Nurse-patient ratios exist in some U.S. jurisdictions such as California, and as discussed in Chapter 2 have been the subject of much study and debate in the U.S., particularly in California.³⁷² However, to date there have been no nurse-patient ratios in nurse collective agreements in Canada. Instead, the nurse collective agreement terms directly regulating nurse workload remain general in nature. Some have broad, aspirational clauses committing employers to conform with nursing professional standards. For example, in Saskatchewan, the collective agreement requires that:

The Employer shall have in place nursing policies and procedures which are consistent with the professional associations' standards of practice and legislation that applies to Registered Nurses and Registered Psychiatric Nurses.³⁷³

In the absence of specific nursing-patient ratios, the most common collective agreement workload measures are "professional responsibility" clauses which establish a workload complaints procedure for nurses.³⁷⁴ In some provinces, these "professional responsibility" procedures have been part of the nurse collective agreement for many years, while in

³⁷¹ Nurse-patient ratios were at issue in a 2014 labour dispute between the NSGEU and the Nova Scotia government: see *infra* Appendix: Nurse Collective Bargaining Rounds, Nova Scotia (NSGEU), 2014

³⁷² B. Mark *et. al.*, "California's minimum nurse staffing legislation: Results from a natural experiment", *supra* note 210.

³⁷³ Saskatchewan Agreement, *supra* note 356, s. 58.02.

³⁷⁴ Ontario Agreement, *supra* note 358, s. 8.01, Saskatchewan Agreement, *supra* note 356, s. 57.

others they are a more recent addition. In Nova Scotia, the NSNU and government agreed to add a “safe staffing” provision³⁷⁵, which the NSNU president described as follows:

In October 2013, the NSNU became the first nurse union in Atlantic Canada to negotiate a workload process that includes the use of an Independent Assessment Committee (IAC). When a disagreement about the ability to provide safe patient care cannot be resolved between a nurse and the employer, the matter may be referred to an IAC that makes recommendations on improving the work situation.³⁷⁶

Under the typical “professional responsibility” clause, nurses are to direct their complaints or concerns about staffing, workload or patient safety to a joint union-employer committee often called a Nursing Advisory Committee (“NAC”). If the union and employer cannot resolve the complaint, the agreement provides for adjudication of it by a further joint committee often called an Independent Assessment Committee (“IAC”).

A crucial difference between the specific terms of the professional responsibility clauses in each province is whether they can result in legally binding orders. Under the Saskatchewan nurses’ agreement, for example, they are binding. There, the nurses’ agreement establishes a NAC to “... review and make recommendations relative to client care including staffing for nursing practice based on client needs and other matters of mutual concern.” Nurses may bring issues of workload and patient safety to the NAC. Failing resolution, the nurses’ union may refer the matter to a joint union-employer IAC chaired by an appointee from the School of Nursing at the University of Saskatchewan.

³⁷⁵ J. McPhee, “Nova Scotia Nurses Union, province reach tentative deal”, *The Chronicle Herald (Halifax, NS)*, October 5, 2013, A3.

³⁷⁶ J. Hazelton, “Independent committees to aid nurses, improve patient care”, *The Chronicle Herald (Halifax, NS)*, Opinion, January 25, 2014, E3.

The IAC's written decision is binding on the employer "insofar as it concerns items related to work load" and on the affected nurses.³⁷⁷

However, in most provinces' nurse agreements the IAC's final decision is non-binding. For example, in British Columbia the nurses' agreement provides:

An employee who believes that her workload is unsafe or consistently excessive shall discuss the problem with her immediate supervisor. If the problem is not resolved in this discussion, the employee may seek a remedy by means of the grievance procedure. If the matter is not resolved in the grievance procedure, it may be referred to troubleshooter who shall:

- (a) investigate the difference;
- (b) define the issue in the difference; and
- (c) make written recommendations to resolve the differences.³⁷⁸

Similar provisions for non-binding reports are found in the Ontario and Manitoba nurse agreements.³⁷⁹ In some provinces, the IAC's final decisions on workload-related complaints have been compiled and posted online by the nurses' union.³⁸⁰

Hours-Worked Terms

Nursing hours of work and nursing workload are intertwined concepts. Workload is the amount of patient care responsibility individual nurses have at a given time or on a given shift. It is a function both of the number of patients and the complexity of nursing care they require. Hours of work is a simpler measure of the amount of time nurses spend

³⁷⁷ Saskatchewan Agreement, *supra* note 356, s. 57.17.

³⁷⁸ B.C. Agreement, *supra* note 355, s. 32.06.

³⁷⁹ Ontario Agreement, *supra* note 358, s. 8.01, Manitoba Agreement, s. 1103.

³⁸⁰ The ONA has posted its IAC reports online at http://www.ona.org/professional_practice/IACreports.html. See *e.g.* Ontario Nurses' Association, "Registered Nurses call in expert panel to review patient safety, RN staffing levels at Nipigon District Memorial Hospital" (news release), March 4, 2014, online at https://www.ona.org/news_details/RNs_IAC_Nipigon_20140304.html.

at work. In a sense, hours-of-work issues are a subset of workload issues in that the patient safety risks of excessive workloads can be aggravated or mitigated by the amount of time nurses are actually working. This “hours of work” metric has one caveat made necessary by the fact that the time taken for a nurse to perform tasks is a function also of morbidity, so it is not a one size fits all concept. In my conception of hours of work, the morbidity of the patients under care will be assumed to be constant; that is, the hours worked will translate into greater or less workload only based on the morbidity of the patients treated. Hours of work simply isolates the time dimension out of this scenario.

All nurse collective agreements have extensive and detailed rules governing nurses’ hours of work, including many rules relating to the assignment of overtime.³⁸¹ Described most generally, hours-of-work rules in collective agreements restrict how long nurses can be required to work in each shift, a given sequence of shifts, and a given cycle (typically four week) of shifts. In some provinces, hours-of-work issues are addressed in terms in the central nursing collective agreement. In others, hours of work for nurses are governed by a mixture of central and local collective agreement terms.

The most basic hours-of-work provisions are those establishing baseline norms of shift, tour, day or week length. Nurse collective agreements fundamentally establish the same conventional work schedules and cycles found in traditional private industry. A

³⁸¹ Hours of work terms: see *e.g.* B.C. Agreement, *supra* note 355, s. 26; NSNU Agreement, *supra* note 359, s. 7; NSGEU Agreement, *supra* note 360, s. 14; Ontario Agreement, *supra* note 358, s. 13; Saskatchewan Agreement, *supra* note 356, s. 7; Alberta Agreement, *supra* note 357, s. 7, Letter of Understanding s. 10; overtime rules: see *e.g.* B.C. Agreement, *supra* note 355, s. 27.01; NSNU Agreement, *supra* note 359, s. 7; NSGEU Agreement, *supra* note 360, s. 15; Saskatchewan Agreement, *supra* note 356, s. 8; Alberta Agreement, *supra* note 357, s. 8.01(a).

“shift” is eight hours, and a working “day” is three shifts.³⁸² A “tour of duty” is sometimes defined as one or more consecutive shifts. Shifts starting at approximately 8:00 a.m. are “day shifts”, those starting at 3:00 p.m. are “evening shifts” and those starting at midnight “night shifts”.³⁸³ A typical five day “week” (Monday to Friday), amounting to between 36 and 40 hours, is also prescribed.³⁸⁴ Weekends are often specifically defined to cover shifts from Friday afternoons to Sunday night. These agreements also define and provide for time off on statutory holidays. Together, these baseline provisions establish, through codified rules, work patterns that dovetail with broader social patterns of work, rest and recreation.

Nurse collective agreements also contain a wide array of minimum standards for nursing rest. Some terms require a minimum number of hours off between shifts.³⁸⁵ For example, the British Columbia nurses’ agreement provides:

(f) Except by agreement between the Employer and the employee concerned each regular employee shall receive two (2) clear off-duty shifts when changing shifts and at least forty-eight (48) hours off-duty after completing a tour of night duty.³⁸⁶

Rest-related terms also include provisions for a minimum number of days and hours of rest in a given week or month, and guaranteed days of rest following lengthy (10 or 12 hour) shifts, or evening, night or weekend shifts.³⁸⁷ Some agreements also require days

³⁸² Shift and day definitions See *e.g.* B.C. Agreement, *supra* note 355, s. 26.01, NSNU Agreement, *supra* note 359, s. 7.00, NSGEU Agreement, *supra* note 360, s. 14.01, Saskatchewan Agreement, *supra* note 356, s. 7.01, Alberta Agreement, *supra* note 357, ss. 7.01, 7.02

³⁸³ Day/eve/night shifts defined See *e.g.* B.C. Agreement, *supra* note 355, s. 26.01, NSNU Agreement, s. 7.06, NSGEU Agreement, *supra* note 360, s. 14.01, Saskatchewan Agreement, *supra* note 356, s. 7.01, Alberta Agreement, *supra* note 357, ss. 7.01, 7.02(d).

³⁸⁴ Standard work week defined See *e.g.* B.C. Agreement, *supra* note 355, s. 26.01, NSNU Agreement, *supra* note 359, s. 7.06, NSGEU Agreement, *supra* note 360, s. 14.01, Ontario Agreement, *supra* note 358, s. 13.01.

³⁸⁵ Minimum hours off between shifts: see *e.g.* Alberta Agreement, *supra* note 357, s. 7.02(g).

³⁸⁶ B.C. Agreement, *supra* note 355, s. 25.05(f).

³⁸⁷ Guaranteed minimum rest times per week/month, rest following night/eve/weekend shifts, long shifts, or after overtime was worked: Alberta Agreement, *supra* note 357, s. 7.02(g), NSNU Agreement, *supra* note 359, s. 7.12,

of rest for nurses who are changing from nights or evening shifts back to day shifts.³⁸⁸ In Alberta, for example, the agreement requires that “where possible” nurses be given 48 clear hours of rest during a changeover from night to day shifts.³⁸⁹ Other common rest provisions include requirements for rest after mandatory overtime. For example, the Alberta agreement states:

Where an Employee works overtime immediately following her or his Shift and there is not a minimum of eight (8) consecutive hours off duty in the 12 hours preceding the Employee’s next Shift, at the Employee’s request, the Employee shall be entitled to eight (8) consecutive hours of rest before commencing his or her next Shift, without loss of earnings.³⁹⁰

Nurse collective agreements also cap the number of consecutive hours, shifts and days a nurse may be required to work.³⁹¹ For example, the Alberta nurses’ agreement provides:

No Employee shall be requested or permitted to work more than a total of 16 hours (inclusive of regular and overtime hours) in a 24-hour period beginning at the first hour the Employee reports to work.³⁹²

In a similar vein are provisions that entitle nurses to a minimum number of weekends off per month, and in some cases, limit to three the number of consecutive weekends nurses may be required to work.³⁹³

NSGEU Agreement, *supra* note 360, s. 14.11, B.C. Agreement, *supra* note 355, s. 25.05(f), Saskatchewan Agreement, *supra* note 356, s. 7.08.

³⁸⁸ Guaranteed days of rest for nurses who are changing from nights or evening shifts back to day shifts: See *e.g.* B.C. Agreement, *supra* note 355, s. 25.05(f), Saskatchewan Agreement, *supra* note 356, s. 7.08.

³⁸⁹ Alberta Agreement, *supra* note 357, s. 7.02(g).

³⁹⁰ Alberta Agreement, *supra* note 357, s. 8.07(a).

³⁹¹ Maximum-consecutive shifts, days: see *e.g.* B.C. Agreement, *supra* note 355, s. 25.05(c), NSNU Agreement, *supra* note 359, s. 7.05, NSGEU Agreement, *supra* note 360, s. 14.12, Saskatchewan Agreement, *supra* note 356, s. 7.10, Alberta Agreement, ss. 7.02(g), 8.03.

³⁹² Alberta Agreement, *supra* note 357, s. 8.03.

³⁹³ Weekends-per-month minimums and consecutive weekends worked limits: see *e.g.* NSNU Agreement, *supra* note 359, s. 7.14, B.C. Agreement, *supra* note 355, s. 25.05(e), NSGEU Agreement, *supra* note 360, s. 14.15, Saskatchewan Agreement, *supra* note 356, s. 7.12(a).

Non-standard shift lengths are also contemplated by nurse collective agreements. All the agreements reviewed here provide nurses the opportunity to work “long” (more than 8 hour) shifts in exchange for a shorter work-week. Some scheduling cycles offer four days of 10- and sometimes 12-hour shifts in a week followed by five days’ rest.³⁹⁴ Under this alternative, nurses work longer shifts but have greater certainty about their expected hours of work and more time off from work. In some nurse collective agreements, these alternative scheduling patterns are available for nurses who elect for them, while other agreements provide for a vote of the affected nurses as to whether they wish to shift from a standard to an alternative shift pattern.³⁹⁵ This can restore some predictability to nurse scheduling while meeting some of the need for nurses on non-day shifts. However, simply because an alternative scheduling model improves the quality of nurses’ working lives does not necessarily mean that it leads inevitably to more patient safety. However, these mechanisms do have the benefit of providing a kind of purge valve for employer pressure to use more nurse overtime.

From a patient safety and error reduction standpoint, perhaps the most important hours-of-work rules are overtime rules. In nurse collective agreements, “overtime” is usually defined as all time worked in excess of the “normal” daily (e.g. 7.5 hours) or weekly (e.g. 36 hours) maximums set out above.³⁹⁶ Overtime also often includes any time worked

³⁹⁴ See e.g. B.C. Agreement, *supra* note 355, s. 25.10, Ontario Agreement, *supra* note 358, s. 13.02, Saskatchewan Agreement, *supra* note 356, ss. 721-727, Alberta Agreement, *supra* note 357, s. 37.

³⁹⁵ See e.g. the interest arbitration award in *Campbellford Memorial Hospital v. Ontario Nurses' Assn. (Local Issues Grievance)* [2012] O.L.A.A. No. 460 (Stephens, Hughes, Kuhne), in which the panel awarded language providing for a vote to determine if extended tours would be adopted.

³⁹⁶ See e.g. B.C. Agreement, *supra* note 355, s. 27.01; NSNU Agreement, *supra* note 359, s. 7.16; NSGEU Agreement, *supra* note 360, s. 15.01; Ontario Agreement, *supra* note 358, s. 13.04(g), Saskatchewan Agreement, *supra* note 356, s. 8; Alberta Agreement, *supra* note 357, s. 8.01(a).

when a nurse was otherwise supposed to have time off: on a day off, a statutory holiday or a weekend off.

Of the many kinds of “overtime rules”, the most important are rules restricting how much overtime employers may assign to nurses.³⁹⁷ In Saskatchewan, the collective agreement prohibits overtime outright except in cases of emergency.³⁹⁸ Other provinces’ nurse agreements regulate rather than prohibit overtime. In Alberta, for example, the agreement requires the employer to “endeavour to minimize the use of overtime”.³⁹⁹ Further, the agreement creates a “reasonableness” standard for the use of overtime.⁴⁰⁰ In similarly general terms, the Nova Scotia Capital Health nurses’ agreement requires employers to “make every reasonable effort”:

- (a) to allocate overtime work on a fair and equitable basis among readily available and qualified employees; and
- (b) to give employees who are required to work overtime, adequate advance notice of this requirement.⁴⁰¹

The agreement goes on to provide that “[t]he Union is entitled to consult the Employer or its representative, whenever it is alleged that employees are required to work unreasonable amounts of overtime.”⁴⁰²

The most restrictive but least common overtime rules are those permitting nurses to refuse overtime assignments outright on patient safety or other professional ethical

³⁹⁷ B.C. Agreement, *supra* note 355, s. 27.01, NSGEU Agreement, *supra* note 360, *supra* note 360, ss. 15.02 & 15.03, Alberta Agreement, *supra* note 357, s. 8.04(a).

³⁹⁸ Saskatchewan Agreement, *supra* note 356, s. 8.01.

³⁹⁹ Alberta Agreement, *supra* note 357, s. 8.04(a).

⁴⁰⁰ *Ibid.*, s. 8.04(b).

⁴⁰¹ NSGEU Agreement, *supra* note 360, s. 15.02.

⁴⁰² *Ibid.*, s. 15.03.

grounds.⁴⁰³ The “right to refuse” proviso in the Alberta nurses’ agreement, for instance, reads as follows:

Should the Employee believe that the Employer is requesting the Employee to work more than a reasonable amount of overtime, then the Employee may decline to work the additional overtime, except in an emergency, without being subject to disciplinary action.

An emergency is a circumstance that calls for immediate action.

The Employer shall take reasonable steps to avoid a staffing situation which may become an emergency prior to requiring overtime.⁴⁰⁴

It is unclear how often Alberta health care employers use this “emergency” provision to support nurse overtime, but if the union disputed the employer’s actions under this clause, it would grieve the overtime and argue that the circumstances did not amount to an emergency justifying the overtime. A similar provision is found in the British Columbia nurses’ agreement.⁴⁰⁵ By permitting nurses to raise patient safety issues in this immediate manner, such right-to-refuse provisions are arguably more effective at enforcing collective agreement overtime rules than even the grievance and arbitration processes.

In addition to the above contractual restrictions, cost is also a major disincentive for employers to require nurses to work overtime. All nurse collective agreements contain wage multipliers for overtime hours worked. Nurse collective agreements typically give a 50% per-hour wage increase for the first two or three hours of overtime worked, and a doubling of the hourly rate for hours worked beyond the first two or three. These multipliers apply to overtime arising in each day (more than 8 hours) or in each week

⁴⁰³ See *e.g.* B.C. Agreement, *supra* note 355, s. 27.01, Alberta Agreement, *supra* note 357, s. 8.04(c).

⁴⁰⁴ Alberta Agreement, *supra* note 357, s. 8.04(b), (c), (d).

⁴⁰⁵ B.C. Agreement, *supra* note 355, s. 27.03(A).

(more than 36 hours).⁴⁰⁶ All the foregoing nurse collective agreement terms that define and regulate overtime are beneficial to patient safety by placing limits on the length of time nurses work.

While the hourly multipliers for overtime may deter the use of overtime, they also create a strong monetary incentive for nurses to take overtime shifts, even if they happen to be more tired than is consistent with safe care. They may also lead to more junior and inexperienced nurses – those arguably at greater risk to commit error – taking overtime shifts to compensate for their lower income relative to senior and better paid nurses. Available statistics on nurse overtime do not break down into mandatory or permissive, but do show that overtime remains a constant in every province. In 2014, the highest average weekly share of overtime for nurses was in Quebec (32.5%) and Manitoba (30.5%); Ontario (22.6%) and Saskatchewan (22.9%) had the lowest overtime rates.⁴⁰⁷ The national average of nurse overtime rose from 25.8% in 2012 to 26.6% in 2014.⁴⁰⁸ Thus, the incentives created by the overtime language found in nurse collective agreements may cut both ways from a patient safety standpoint.

Related to hours of work and overtime protections are collective agreement terms that fix nurse schedules. All the nurse collective agreements in focus here have extensive rules relating to the timing of nurse shifts. In some provinces like Ontario, all the scheduling rules are found in local collective agreements, while in others they are found

⁴⁰⁶ B.C. Agreement, *supra* note 355, s. 27.05, NSGEU Agreement, *supra* note 360, s. 15.04, Ontario Agreement, *supra* note 358, s. 14.01(a), Saskatchewan Agreement, *supra* note 356, s. 8.02, Alberta Agreement, *supra* note 357, s. 8.02.

⁴⁰⁷ Canadian Federation of Nurses' Unions, "Trends in Own Illness- or Disability-Related Absenteeism and Overtime among Publicly-Employed Registered Nurses: Quick Facts 2015" (Ottawa: CFNU, 2015) at 2, online at https://nursesunions.ca/sites/default/files/2015-05-05_absenteeism_and_overtime_quick_facts_en.pdf.

⁴⁰⁸ *Ibid.*

in the central nurses' agreement. Conceptually, scheduling terms in nurse collective agreements are related to but distinct from hours-of-work terms. Hours of work refer to length of shifts and use of overtime, whereas scheduling terms govern how employers may allocate day, evening and night shifts among nursing staff, how they may adopt alternative scheduling patterns and how much rest nurses are to have off when changing shifts. In the Saskatchewan agreement, scheduling is dealt with solely in the central nursing collective agreement. In others like Ontario, it is a mixture of central contract language and local (i.e. region-specific or hospital-specific) collective agreement terms.

The baseline rule of scheduling under the nurse collective agreements here is that, subject only to the rules laid out in the collective agreement, employers are free to assign and allocate shifts to nurses as needed to provide safe care regardless of the day or time of day. The primary purpose of scheduling rules is to structure employer decision-making on scheduling to promote predictable and healthy patterns and deter haphazard, unpredictable and likely unhealthy ones. In order that nurses have greater predictability in their work-life balance, Canadian nurses' unions have achieved language that mandates notice of posted shifts.⁴⁰⁹ Nurse collective agreements typically require that nurses be given minimum amounts of notice of their shiftwork patterns. Thus, for example, the Alberta agreement requires that schedules be posted at least four weeks in advance.⁴¹⁰ Available data from 2005 suggests that half of all nurses have unlimited

⁴⁰⁹ B.C. Agreement, *supra* note 355, ss. 25.04, 28.02, NSNU Agreement, *supra* note 359, s. 7.09, NSGEU Agreement, *supra* note 360, s. 14.13, Saskatchewan Agreement, *supra* note 356, ss. 7.03(a)-(c), Alberta Agreement, *supra* note 357, s. 7.04.

⁴¹⁰ Alberta Agreement, *supra* note 357, s. 7.04.

advance knowledge of their schedules, and two-thirds had notice of at least one month ahead of time. Only one in 10 had notice of a week or less.⁴¹¹

Nurse collective agreements also strive to distribute day shifts as equitably as possible among nurses. Of the three shifts, day shifts are usually the most likely to correspond to typical work-life rhythms, and are typically the most popular shift among nurses. Thus, all the nurse collective agreements typically have some provision that allocates day shifts among nurses equitably, or based on seniority.⁴¹² Other nurse collective agreement terms set minimum percentages or numbers of day shifts that nurses are required to work in each month. The Alberta nurses' agreement, for example, requires 40% of shifts be days:

Employees working Shift patterns 7.02(d)(i), (v) and (vii), shall be assigned day duty at least 2/5 of the time during the Shift cycle. For the purpose of applying the foregoing:

(i) Day duty means Shifts where the majority of the regularly scheduled Shift falls between 0700 hours and 1500 hours.⁴¹³

In a similar vein are clauses that allow “evening-only” and “nights-only” shift patterns only at the request of individual nurses.⁴¹⁴

⁴¹¹ CIHI, *Findings from the 2005 Study of the Work and Health of Nurses (2008)*, *supra* note 54 at 22-23, Appendix Table 11.

“Nurses in Ontario, Newfoundland and Labrador, and Nova Scotia were less likely than their colleagues working in other parts of the country to have unlimited advance notice of their work schedule. Only 41% of Ontario nurses had such knowledge. Having no more than a week’s notice was more common in Quebec and Newfoundland and Labrador than elsewhere. About one-sixth (16%) of Quebec nurses and 14% of those in Newfoundland and Labrador reported this situation.”

⁴¹² Provisions requiring equitable assignment of day shifts: see *e.g.* Alberta Agreement, *supra* note 357, s. 7.02(f), Saskatchewan Agreement, *supra* note 356, ss. 7.09 (a),(b).

⁴¹³ Alberta Agreement, *supra* note 357, s. 7.02(f).

⁴¹⁴ B.C. Agreement, *supra* note 355, ss. 25.05(b), 26.01, Alberta Agreement, *supra* note 357, s. 7.02(d), Saskatchewan Agreement, *supra* note 356, s. 7.09(c).

While these provisions may benefit more senior nurses by giving them preferred shifts, it may result in an inordinate proportion of less senior – and more error-prone – nurses working on evening and night shifts. Not only are more junior nurses often relegated by seniority to these non-day shifts, the premiums that often accompany these shifts may create an additional incentive for them to work these shifts. To the extent that many emergencies and high-morbidity patients need care at evenings, weekends or nights, this may create a patient safety problem from the intersection of highly critical patients with junior or intermediate-experience nurses. However, these are unintended consequences of these terms, and are problems that can be ameliorated to the extent that junior nurses are given adequate mentorship and support on evening and night shifts by more senior nurses acting in a supervisory or preceptor role.

The nurse collective agreements reviewed here also require that nurses be given rest time at key junctures in their work patterns. Thus, for example, the Nova Scotia Nurses' Union agreement states that nurses may not be required to work more than 16 hours in a 24 hour period, nor may they be required to work more than seven day shifts or five night shifts without a day off.⁴¹⁵ Another model is in Alberta, where the nurses' agreement requires the employer to “minimize” the rotation of schedules between days, evenings and nights⁴¹⁶, and states that “where possible”, nurses must be given at least 47.75 hours off duty between a night-shift to day-shift change.⁴¹⁷ Another variant of these scheduled rest provisions is in the B.C. nurses' agreement, which provides that nurses:

- may not be scheduled to work more than six consecutive days without a day off,

⁴¹⁵ NSNU Agreement, *supra* note 359, ss. 7.01, 7.08.

⁴¹⁶ Alberta Agreement, *supra* note 357, s. 7.02(d)(i).

⁴¹⁷ *Ibid.*, s. 7.02(f).

- must receive two clear off-duty shifts when changing shifts,
- must receive at least 48 hours off when changing from night shifts to day shifts, and
- may not be required to work three different shifts (day/evening/night) in a seven-day period.⁴¹⁸

Clauses such as these seem consistent with a moderate amount of shift changes reported by nurses. The CIHI 2005 survey of nurses reported one-third (34%) of nurses reported that their shift for their main job had changed at least once in the previous two weeks.⁴¹⁹

Shift Premiums as Penalties

As alluded to above, protections regarding nurse hours of work go some way to normalizing the work-life balance of nurses, lessening the chances of overwork and fatigue that can lead to error. I have also mentioned that overtime rates of pay act as a check of sorts against the assignment of excessive overtime to individual nurses. In a similar way, “shift premiums” and other wage multipliers or top-ups built into nurse collective agreements function as enforcement mechanisms. Because shift premiums increase labour costs, they are the most immediate and enforcement mechanisms for all the protections found in nurse collective agreements. Shift premiums are wage top-ups of a fixed dollar amount. They are usually applicable to evening, night and weekend shifts, and to shifts in which a nurse was called in to work on a day off.⁴²⁰ Shift premiums are often also payable to nurses working a schedule that was not changed within the

⁴¹⁸ B.C. Agreement, *supra* note 355, ss. 25.05(c), (f), 25.11.

⁴¹⁹ CIHI, *Findings from the 2005 Study of the Work and Health of Nurses* (2008), *supra* note 54 at 25, Appendix Table 13.

⁴²⁰ B.C. Agreement, *supra* note 355, s. 28, NSGEU Agreement, *supra* note 360, ss. 34.15, 34.16, Ontario Agreement, *supra* note 358, s. 14.01, Saskatchewan Agreement, *supra* note 356, s. 14.01.

agreement's prescribed notice period.⁴²¹ However, as mentioned above in relation to overtime clauses, these premiums can also have unintended consequences in the form of incentives for less junior nurses to take off-day shifts that, as mentioned above, can often have more complex and morbid patients. However, as mentioned above, these risks can be mitigated or offset entirely if proper mentorship and supervision by senior nurses is available for junior nurses on these shifts.

Efficiency Values at Work: Caveats and Exemptions in Patient Safety Terms

In Chapter 1 I argued that the goal of efficiency exerts a constant pull on all health policy decision-making, including decisions on policies intended to promote patient safety. Nurse collective bargaining is one of the many arenas in which governments and health care employers invoke efficiency as a goal. Typically, they demand loosening of the strictures reviewed above under the mantra of “flexibility”. For example, in Alberta’s 2003 round of bargaining, the provincial government and health authorities demanded the loosening of a wide range of contractual restrictions such as the ones under review here (but which they did not ultimately obtain).⁴²² Similarly, the B.C. government in the 2001 round of nurse bargaining insisted – and obtained by unilateral legislative fiat – on “flexibility”-based changes to that collective agreement.⁴²³ The result has been that most of the patient safety terms discussed above are accompanied by terms that qualify or provide exemptions from the rules they establish.

⁴²¹ Saskatchewan Agreement, *supra* note 356, s. 7.03(d), Alberta Agreement, *supra* note 357, s. 7.02(i), 7.04.

⁴²² See *infra* Appendix: Nurse Collective Bargaining Rounds, Alberta 2003.

⁴²³ See *infra* Appendix: Nurse Collective Bargaining Rounds, B.C. 2001.

Another common exemption found in some hours of work and scheduling terms is in cases where individual nurses agree to working arrangements that would otherwise breach the collective agreement. These exemptions are perhaps the clearest manifestation of efficiency values influencing collective agreement outcomes, because they essentially allow the employer to sidestep the union entirely and deal individually with employees –effectively eliminating the entire role of the union. As with many of the agreement terms discussed in this chapter, these “opt-out” provisions can cut both ways from a patient safety standpoint. On one hand, if nurses feel pressured to work shifts that leave them tired and error-prone, then clauses that allow such pressure are bad for patient safety. On the other hand, there may be instances where nurses and employers agree – due to the unique circumstances or exigencies of a patient’s needs at any given time – to depart from the hours of work or scheduling rules in the collective agreement to provide a safe level of care to patients.

Another common qualification is the use of an “emergency” exception to rules restricting overtime or requiring rest.⁴²⁴ On their face these emergency exceptions are clearly not efficiency-based; however, as mentioned in Chapter 1 there exists the possibility that employers will – faced with tight budgets and a need to use overtime - stretch the boundaries of this definition, putting the burden on the union to resist this practice through the costly and time-consuming grievance process. Conceivably, employers could argue that they would only ask for overtime in situations akin to emergencies, where patient safety would be at immediate risk.

⁴²⁴ Alberta Agreement, *supra* note 357, s. 8.04(b),(c),(d).

“Extended shift” provisions are another approach to balancing efficiency and patient safety in nurse collective agreements. As mentioned, despite all the foregoing protections, the exigencies of demand for health care services ultimately hinders the attainment of ideal scheduling patterns for all nurses in a given setting. As in many contemporary modern workplaces, the ideal pattern would be the familiar 40-hour week: day shifts, five days a week, with weekends off. In reality, seldom is this possible in the health care workplace, especially with a shortage of nurses. And even if there were a full supply of nurses, there would inevitably be some that must work night shifts. Sheer patient care load not only causes more use of overtime, it also can mean a lot of nurses working evening and night shifts, weekend shifts, and – perhaps the worst from a health standpoint - coming in for work on short notice on scheduled off days. Extended shifts have been prevalent for nurses: the 2005 CIHI *Survey of the Work and Health of Nurses* found that one in four nurses reported working 12 hour shifts on a regular basis.⁴²⁵

Some collective agreements that contain alternative models of scheduling provide some consistency to nurses’ working lives while at the same time meeting patient care needs. Since hospitals can face patient complications at any time of day or night, and these kinds of clauses allow those nurses who may prefer alternative schedules to work evenings, weekends or nights. In recognition of this trend, all nurse collective agreements now have extensive provisions enabling alternative scheduling patterns. Some agreements extensively regulate the types of alternatives available, while others leave more discretion to the individual nurse and employer to devise alternative schedules.

⁴²⁵ CIHI, *Findings from the 2005 Study of the Work and Health of Nurses* (2008), *supra* note 54 at 23, Appendix Table 12.

Some of the common alternative patterns include allowances for nurses to elect to work on an all-evenings or all-nights basis as a trade-off for a shorter overall work week.⁴²⁶ In Alberta, for example, the nurses' agreement allows nurses to make this trade-off by agreeing to all-night, all-evening or some combination of night and evening shifts.⁴²⁷ Similar trade-offs are provided for nurses wishing to work "two-day, two-night" shift patterns and for "weekend worker" schedules.⁴²⁸

Aside from "extended shift" arrangements, in some nurse collective agreements, the local employer and individual nurses have a much broader latitude to make flexible and other "innovative" schedules that follow a nurse's personal schedule.⁴²⁹ In Alberta, for example, the agreement states that:

The Employer shall not unreasonably refuse to implement a contractually compliant Shift schedule developed by the Employee(s) and the Local provided the proposed schedule does not result in any additional costs.⁴³⁰

As the foregoing clause shows, cost and efficiency values often find their way into collective agreement language on hours worked. In a similar vein, the Nova Scotia (NSGEU) agreement allows local employers to "experiment" with "flexible" working hour models if "an adequate number of employees have requested" such a measure.⁴³¹ During the time that these alternative scheduling arrangements were implemented in nurse

⁴²⁶ NSGEU Agreement, *supra* note 360, ss. 14.05 & 14.06, Saskatchewan Agreement, *supra* note 356, ss. 7.19 & 7.20, Alberta Agreement, *supra* note 357, s. 7.02(h).

⁴²⁷ Alberta Agreement, *supra* note 357, s. 7.02(d).

⁴²⁸ NSNU Agreement, *supra* note 359, s. 29, NSGEU Agreement, *supra* note 360, ss. 14.05, 14.06, 14.18, Saskatchewan Agreement, *supra* note 356, ss. 7.19, 7.20, 7.28, Alberta Agreement, *supra* note 357, s. 7.02(h), Ontario Agreement, *supra* note 358, s. 13.04.

⁴²⁹ M. MacPhee & L. Borra, "Flexible Work Practices in Nursing" (Geneva: International Centre for Human Resources in Nursing, International Council of Nurses, 2012), online at <http://cna-aiic.ca/~media/cna/files/safe-staffing-toolkit/Flexible-Working-Practices.pdf>.

⁴³⁰ Alberta Agreement, *supra* note 357, s. 17.07, B.C. Agreement, *supra* note 355, ss. 4.04, 25.02, 25.03.

⁴³¹ NSGEU Agreement, *supra* note 360, s. 14.04.

collective agreements, the 2005 CIHI *Survey of the Work and Health of Nurses* found that nearly 4 in 10 nurses (38%) worked mixed shifts for their main job; that is, some combination of days, evenings or nights.⁴³²

Other nurse collective agreements allow individual opt-outs for scheduling and other rules but require the involvement and agreement of the local union. The Ontario nurses' agreement allows for a "special circumstance" scheduling arrangement between individual nurses, the employer and the local of the nurses' union.⁴³³ Similarly, the Alberta central nurses' agreement allows local employers and union officials to devise scheduling patterns that depart from those in the central agreement.⁴³⁴

Enforcing Patient Safety-Related Terms: The Nurse Grievance Arbitration Process

I now turn from what nurse collective agreements currently say to how their terms are enforced. As mentioned in Chapter 3, the grievance and arbitration processes found in all collective agreements are the sole avenue of redress for employees in unionized workplaces who allege that the employer has violated one or more terms of the collective agreement. In the context of patient safety-related terms under nurse collective agreements, it is grievance arbitrators who must ultimately give fuller meaning to the language used in these terms, apply them to alleged employer actions or policies, and make binding orders remedying any breaches that are found to have occurred. Grievance arbitration is a separate and distinct process from the "professional responsibility" and workload complaint processes discussed above. As mentioned, the Independent

⁴³² CIHI, *Findings from the 2005 Study of the Work and Health of Nurses* (2008), *supra* note 54 at 23, Appendix Table 12.

⁴³³ Ontario Agreement, *supra* note 358, s. 13.05.

⁴³⁴ Alberta Agreement, *supra* note 357, s. 7.02(f).

Assessment Committees set up under the nurse collective agreement in some provinces have binding order-making powers, while the IACs in other provinces may only make recommendations.

How well has grievance arbitration served as an enforcement mechanism for patient safety provisions in nurse collective agreements? As I will illustrate, it has some strengths but also some limitations due to its doctrinal underpinnings from the Wagnerist legal theory. As I explained in Chapter 2, under Wagnerist theory the collective agreement is the primary source of the grievance arbitrator's powers, although provincial labour legislation supplements or otherwise confirms these powers with statutory terms.⁴³⁵ The grievance arbitrator's role is to interpret, enforce and apply the rules in the collective agreement.

The first limitation of grievance arbitration as a patient safety enforcement mechanism is the difficult position nurses' unions are placed in when facing a patient safety-related breach of the collective agreement. Only one of the parties to the collective agreement – the union or the employer – can bring a grievance alleging breach of the agreement. Individual nurses may not bring their own grievances under the collective agreement. In the case of nurses, it is the nurses' union that decides whether to file a grievance alleging breach of a patient safety or other term of the collective agreement. If the nurses' union decides there has been no violation, or otherwise decides not to grieve the violation, that ends the grievance process.

⁴³⁵ **Ontario:** *Labour Relations Act, 1995*, *supra* note 266, s. 48; **Alberta:** *Labour Relations Code*, *supra* note 286; **British Columbia:** *Labour Relations Code*, *supra* note 269, s. 89; **Manitoba:** *Labour Relations Act*, *supra* note 289; **Saskatchewan:** *Saskatchewan Employment Act*, S.S. 2013, c S-15.1, s. 6-46; **Nova Scotia:** *Trade Union Act*, *supra* note 290, s. 43B.

Nurses' unions, like all organizations, have budgetary limitations and must make hard choices between competing priorities. Among the hardest choices any union must make is to decide which workplace problems to grieve. They do not have limitless funds to pay expensive lawyers to launch and litigate every grievance individual nurses wish to bring forward. The most difficult choices are often between fighting grievances over discipline and discharge versus fighting grievances on non-monetary terms. They also devote significant resources to grievances alleging human rights violations such as discrimination on the basis of gender, family status and disability.⁴³⁶ Because of the high rates of injury and work-related disabilities suffered by nurses, nurses' unions have devoted extensive resources to advancing grievances on behalf of individual nurses entitled to accommodation of their disabilities by the employer.⁴³⁷ In this context, it is easy to imagine that nursing union resources to advance patient safety issues may be limited.

The cost of grievance arbitration itself, too, is a significant barrier to the full enforcement of the patient safety terms discussed here. Grievance arbitrators are expensive, their costs borne by each side equally in a typical case. Further legal fees arise when either the nurses' union or government seek judicial review or appeal from grievance arbitration awards. Delay is another hallmark of grievance arbitration that is problematic from a patient safety standpoint. Grievance arbitrations are designed to be quasi-judicial processes, with all the features of litigation in the civil courts, including

⁴³⁶ Non-discrimination clauses typically mirror the provisions of human rights legislation: see *e.g.* Alberta Agreement, *supra* note 357, s. 6, B.C. Agreement, *supra* note 355, s. 31, NSGEU Agreement, *supra* note 360, s. 2.03, NSNU Agreement, *supra* note 359, s. 18, Saskatchewan Agreement, *supra* note 356, s. 4.

⁴³⁷ Under provincial human rights codes and jurisprudence, employers have a duty to accommodate disability up to the point of undue hardship: *British Columbia (Public Service Employee Relations Commission) v. B.C.G.E.U. (Meiorin)*, [1999] 3 S.C.R. 3, 176 D.L.R. (4th) 1; and *Hydro-Québec v. Syndicat des employé-e-s de techniques professionnelles et de bureau d'Hydro-Québec, section locale 2000 (SCFP-FTQ)*, 2008 SCC 43, [2008] 2 S.C.R. 561.

discovery, production orders, interim orders, witnesses and cross-examinations. Lawyers dominate the process as they do in the court system. Much delay arises from disputes over procedure: document production, motions for exclusion of evidence, and myriad other possible steps can be taken before a hearing date is even set down. It is not unusual for grievance arbitrations to last more than two years from the time of referral to arbitration to receipt of the final decision from the arbitrator. Grievance arbitrators do have interim order powers, so this problem is alleviated somewhat. However, delay in the enforcement of any patient safety related term is obviously not desirable.

Turning from procedure to substance, there is nothing in the doctrines that grievance arbitrators apply when deciding that is inherently opposed to patient safety. However, they are seldom very proactive in enforcing patient safety terms; instead, they rely on traditional contract doctrines such as intention, ambiguity, plain meaning, estoppel, and mistake.⁴³⁸ Professor David Beatty explained this approach in more depth as follows:

The fact that so many arbitrators served an apprenticeship in administrative regulation as members of labour boards makes it unsurprising that arbitral and labour board jurisprudence have much in common. Especially in the early years, arbitrators developed the law of the collective agreement in the same way labour boards filled in the details of the legislation and the courts wrote the common law. For the most part arbitrators have been strict constructionists and have seen their role as enforcing the parties' common intent. The most important rule of arbitral law, which holds that management is free to run its business as it sees fit except in so far as it has explicitly agreed to some specific constraint on its powers, is itself the product of an arbitrator reasoning from what was understood to be the parties' common intent.⁴³⁹

⁴³⁸ For an overview of the contractual analysis used by Canadian grievance arbitrators, see D. Brown & D. Beatty, *Canadian Labour Arbitration*, 4th ed. (Toronto: Carswell, 2006), looseleaf updated); see also G. Adams, *Canadian Labour Law*, *supra* note 1, Part I, Chapter 2, paras. 2:3800–2:4030.

⁴³⁹ D. Beatty, "Labour Law in a Nutshell: The Influence of a National Casebook", *supra* note 8 at 46.

As strict contractualists, grievance arbitrators reject a policy-driven or purposive approach to interpretation.⁴⁴⁰ This is not to say that a strict contractualist approach is inherently contrary to patient safety values. At the same time, it might be argued that a purposive approach is appropriate, given the heavy policy dimension of the claims made by nurses' unions in support of many of these terms. Purposes such as patient safety can get lost in the details of drafting choices and the tedious work of negotiating plain language terms to accomplish the desired purposes. Unlike in the case of statutory interpretation where the intention of a single entity – the Legislature – can be discerned from legislative debates and other materials leading up to an enactment, collective agreement terms are often the product of competing purposes. The employer and union often have different interpretations of contract terms and advance those divergent meanings before arbitrators. In a grievance arbitration over patient safety-related terms, the union might argue for an interpretation favouring more protections, while the employer will argue from the standpoint of its efficiency needs and strict interpretation of terms.

⁴⁴⁰ Professor Weiler also summarized the traditional task of the of labour arbitrator in the current labour law scheme:

“Their thesis may be summarized as follows. The collective agreement is essentially a written contract. There is nothing that extraordinary about it. It should be interpreted in the standard, literal fashion. The arbitrator should not stray beyond the four corners of the document unless he is absolutely compelled to. But when the surface language used by the parties does not readily supply the answer to a particular grievance, then the arbitrator should have recourse to the background presuppositions supplied from established areas of contract law, in particular the individual contract of employment between the ‘master and servant.’ One central assumption in that legal tradition was management’s freedom to run the business, to exercise the rights of property and capital, to take the initiative in changing the methods of operation if that appeared profitable.”

P. Weiler, *Reconcilable Differences*, *supra* note 7 at 95.

Analysis of Existing Collective Agreement Terms

The foregoing array of workload and time-worked contract terms are the “outcomes” produced by the nurse collective bargaining systems to date on patient safety issues. With this portrayal in mind, I now ask: do these outcomes promote patient safety, and what can be said about the role of the labour law model in which they arose in promoting or detracting from patient safety?

Workload Terms

To recall, in Chapter 2 I established that nurse workload is a patient safety issue. Higher nurse staffing levels and lower patient-to-nurse ratios have been irrefutably linked to lower rates of medical error.⁴⁴¹ I also argued that the science now also establishes a specific patient safety benefit from the introduction of legislated nurse-to-patient ratios.⁴⁴² One recent systematic review, for instance, found that an increase of one additional nurse per shift would lead to a 9% reduction in the odds of death in the ICU.⁴⁴³ However, based on the collective agreement provisions reviewed above, nurses’ unions have had only mixed success at obtaining contract language that addresses the key issue of workload.

⁴⁴¹ T. Lang *et. al.*, “Nurse–Patient Ratios: A Systematic Review on the Effects of Nurse Staffing on Patient, Nurse Employee, and Hospital Outcomes”, *supra* note 175; A. Lankshear *et. al.*, “Nurse Staffing and Healthcare Outcomes: A Systematic Review of the International Research Evidence”, *supra* note 179; R. Kane *et. al.*, “The association of registered nurse staffing levels and patient outcomes: Systematic review and meta-analysis”, *supra* note 183; E. West *et. al.*, “Nursing resources and patient outcomes in intensive care: a systematic review of the literature”, *supra* note 186; D. Aragon-Penoyer, “Nurse staffing and patient outcomes in critical care: A concise review”, *supra* note 187; S. Wilson *et. al.*, “The effect of nurse staffing on clinical outcomes of children in hospital: a systematic review”, *supra* note 190; M. McGahan *et. al.*, “Nurse staffing levels and the incidence of mortality and morbidity in the adult intensive care unit: A literature review”, *supra* note 189; Shekelle, “Nurse-Patient Ratios as a Patient Safety Strategy: A Systematic Review”, *supra* note 193.

⁴⁴² P. Shekelle, “Nurse-Patient Ratios as a Patient Safety Strategy: A Systematic Review” *supra* note 193.

⁴⁴³ *Ibid.*

Instead of nurse-patient ratios or other concrete workload rules, in some provinces the nurses' union has obtained a professional responsibility process in which nurses may raise concerns about workload on a particular shift or as a pattern of staffing. The leading example of this workload-complaint framework is found in the Ontario nurses' agreement, which establishes Independent Assessment Committees (IACs) to hear and give recommendations on nurse workload complaints. Since 2007, there have been fifteen reported decisions of the Ontario IAC.⁴⁴⁴ Their first and most obvious feature is the depth of their written reasons. The IAC typically reviews the evidence submitted and its findings in detail, as well as noting the submissions of the parties. In this regard, they are closer to the structure found in most grievance arbitration awards, in which the arbitrator frames the issues, sets out the evidence followed by the arguments made by the employer and union, and gives detailed reasons that engage with the evidence and make their factual findings clear.

For example, a 2014 IAC report on Humber River Hospital dealt with 152 workload-related complaints from endoscopy ward nurses.⁴⁴⁵ The complaints were about inadequate staffing levels, increased workload from illness-related absences, excessive overtime, a lack of time for regular rest breaks, and nurses having to do non-nursing duties because of insufficient support staff. The IAC consisted of three members, and was chaired by the Director of the York University School of Nursing in Toronto.⁴⁴⁶ The

⁴⁴⁴ All 15 decisions are available online at http://www.ona.org/professional_practice/IACreports.html.

⁴⁴⁵ *Independent Assessment Committee Report Constituted under Article 8.01 of the Collective Agreement Between Endoscopy Program (Finch and Church Street Sites), Humber River Hospital and Ontario Nurses' Association*, July 25, 2014, online at http://www.ona.org/documents/File/professionalpractice/IACReport_HumberRiverHospital_Endoscopy_20140808.pdf (hereinafter "*Humber IAC Decision*").

⁴⁴⁶ The members deciding the Humber IAC Decision were Dr. Claire Mallette, Director, York University School of Nursing (Chair); Barbara Steed RN, MN (Hospital Nominee), and Cindy Gabrielli, RN (EC), MScN (ONA Nominee).

panel toured the workplace, held three days of hearings and solicited briefs from the hospital and union before issuing a 90-page report. The panel began with an extensive review of the hospital, the endoscopy ward, the model of nursing care used, and the process of nursing care. It next reviewed some evidence on nursing workload and the impact of increases in non-nursing tasks⁴⁴⁷ before making 32 recommendations to the hospital covering nine broad areas such as staffing, communication, and safety. Key among the staffing recommendations was to add one full nurse position for all weekday shifts, and staggering the starts and ends of shifts to eliminate late starts and finishes that accumulate overtime. Similar in-depth analyses and recommendations have come from the other IAC reports as well.⁴⁴⁸ IAC decisions stand in stark contrast to the curtness and opacity displayed by interest arbitrators (discussed in Chapter 5) in their reasons for deciding labour disputes.

In part because of the detail and depth of their analyses, the reports of IACs have been afforded “considerable weight” by employers and grievance arbitrators alike. However, they fall short of being compulsory. In a 2014 decision, Arbitrator Barry Stephens explained the IAC’s role as follows:

The Independent Assessment Committee process has the potential to be a valuable tool in addressing professional care issues, including the balance of staff mix that is at the center of the dispute in this grievance. However, the IAC process is nonbinding and recommendations of the IAC are only implemented to the extent they are mutually agreed between the parties as stipulated under Article 8.01(a)(xvi). There was no agreement

⁴⁴⁷ *Humber IAC Decision*, *supra* note 445 at 23.

⁴⁴⁸ See e.g. *Nipigon Memorial Hospital: Independent Assessment Committee Report Constituted under Article 8.01 of the Collective Agreement Between Nipigon Memorial Hospital and Ontario Nurses’ Association*, April 22, 2014, online at http://www.ona.org/documents/File/professionalpractice/NDMH_IACReport_20140422.pdf (25 recommendations on nursing workload including increased RN staff in the ER on weekends and not eliminating a full-time RN position); *Rouge Valley Health System: Independent Assessment Committee Report Constituted under Article 8.01 of the Collective Agreement Between Rouge Valley Health System and Ontario Nurses’ Association*, February 14, 2014, online at http://www.ona.org/documents/File/professionalpractice/ONA_IACReportRougeValley_201402.pdf.

between the parties as to the ongoing mix of RN's to RPN's in the unit arising out of the IAC report. In this sense, the IAC process can be seen as an elaborate and detailed mediation process that did not completely resolve the dispute.⁴⁴⁹

As a “mediation process”, the IAC is not without benefit as a workload regulation tool: clearly, its expertise and commitment to analysis are well recognized and to the extent this makes their findings persuasive, they can be seen as having a kind of “soft” power. Evidently from the reported decisions, many workload concerns and complaints are settled before the IAC renders a final report, much as the parties to litigation settle some issues before trial. Still, little is known about the true extent to which the recommendations of the IACs reported to date have been put into practice.

Hours-Worked Terms

More prevalent than workload provisions are those regulating nursing hours worked in ways that address the risk of adverse events. In patient safety terms, the myriad rules regulating the amount of overtime nurses work would seem the most beneficial. To recall from Chapter 2, numerous systematic reviews have by now reached a consensus that excessive nurse overtime correlates directly with increased rates of medication and other errors.⁴⁵⁰ Based on this evidence, in my view all of the protections limiting overtime and imposing reasonableness requirements on its use are pro-patient safety by guarding

⁴⁴⁹ *Humber River Hospital v. Ontario Nurses' Assn. (Grievance 201306098, Scope, Bargaining Unit Work Grievance)* [2014] O.L.A.A. No. 501 (Stephens) at para. 11.

⁴⁵⁰ See e.g. S. Bae & D. Fabry, “Assessing the relationships between nurse work hours/overtime and nurse and patient outcomes: systematic literature review”, *supra* note 230; V. Lobo *et. al.*, “Integrative review: an evaluation of the methods used to explore the relationship between overtime and patient outcomes”, *supra* note 225.

against excessive nurse working time from shift to shift.⁴⁵¹ In a similar vein, and probably more effective as patient safety mechanisms, are those allowing nurses to question or even refuse their overtime assignment in non-emergency situations on professional grounds.⁴⁵² Because overtime wage rates are often doubled⁴⁵³, cost is a major penalty employers face when assigning nurse overtime. As discussed above, the flip side of these wage multipliers is the incentive it gives to nurses to take on more overtime when they are simply too tired to provide safe care. Thus, by imposing a cost on employers for excessive overtime in respect of any individual nurse, these mechanisms also create an incentive for younger nurses to take on overtime.

However, despite all the foregoing protections, nurse overtime continues to be prevalent.⁴⁵⁴ As discussed in Chapter 2, overtime is a chronic problem in nursing because of the shortage of nurses and the inherent volatility in the day-to-day and shift-to-shift level of patient demand. In British Columbia, for example, a 2014 study by the health employers' association in that province (the HEABC) found that nurse overtime in B.C. had only dropped 0.7% between 2008 and 2014⁴⁵⁵ despite the \$181 million in overtime wages paid to all health workers including nurses during this time.⁴⁵⁶ The president of the

⁴⁵¹ B.C. Agreement, *supra* note 355, s. 27.01, NSGEU Agreement, *supra* note 360, ss. 15.02 & 15.03, Alberta Agreement, *supra* note 357, s. 8.04(a), Saskatchewan Agreement, *supra* note 356, s. 8.01.

⁴⁵² See *e.g.* B.C. Agreement, *supra* note 355, ss. 27.01, 27.03(a) Alberta Agreement, *supra* note 357, s. 8.04(c).

⁴⁵³ B.C. Agreement, *supra* note 355, s. 27.05, NSGEU Agreement, *supra* note 360, s. 15.04, Ontario Agreement, *supra* note 358, s. 14.01(a), Saskatchewan Agreement, *supra* note 356, s. 8.02, Alberta Agreement, *supra* note 357, s. 8.02.

⁴⁵⁴ The CFNU reported that the overtime rate for nurses (measured as percentage of nurses reporting working overtime in a given two-week period) remained mostly constant: 25.8% 2012, and 26.6% in 2014. See Canadian Federation of Nurses' Unions, "Trends in Own Illness- or Disability-Related Absenteeism and Overtime among Publicly-Employed Registered Nurses: Quick Facts 2015", *supra* note 407.

⁴⁵⁵ The HEABC found that nurses in B.C. worked on average 1.8 hours/FTE in 2008, and declined to 1.1 hours/FTE in 2014. See HEABC, "RNs/RPNs Overtime hours per FTE per week (2008-2014)", at "Registered Nurses and Registered Psychiatric Nurses" page, online at http://www.heabc.bc.ca/Page4339.aspx#.V_ak3SRTLZg.

⁴⁵⁶ L. Culbert & R. Shaw, "Health-worker bill for overtime totaled \$181 million last year", *Victoria Times-Colonist*, October 31, 2014, A9.

B.C. Nurses' Union stated: "The system is running on overtime. We are now talking about normalizing the abnormal."⁴⁵⁷

Like the overtime rules, the rules reviewed above on nursing rest, shift patterns and shift predictability also have a patient safety benefit. To recall from Chapter 2, systematic reviews have found a correlation between the amount of rest nurses have between shifts and especially when changing from one kind of shift to another (day, evening or night) and the risk of adverse events.⁴⁵⁸ If this is accepted, then the myriad rest-related terms reviewed above are promotive of patient safety. For example, terms setting minimum rest times in certain time frames⁴⁵⁹, or terms prescribing rest during shift change⁴⁶⁰, all lessen the chance of fatigue-related error. Toward a similar purpose are the clauses capping consecutive hours and shifts.⁴⁶¹

Sleep cycle disruptions, which also cause fatigue-related error, are another patient safety risk that is lessened by the scheduling terms reviewed above. Provisions requiring an equitable distribution of day shifts, or that make evening or night shifts permissible

⁴⁵⁷ *Ibid.*

⁴⁵⁸ S. Bae & D. Fabry, "Assessing the relationships between nurse work hours/overtime and nurse and patient outcomes: systematic literature review", *supra* note 230 .

⁴⁵⁹ Guaranteed minimum rest times per week/month, rest following night/eve/weekend shifts, long shifts, or after overtime was worked: Alberta Agreement, *supra* note 357, s. 7.02(g), NSNU Agreement, *supra* note 359, s. 7.12, NSGEU Agreement, *supra* note 360, s. 14.11, B.C. Agreement, *supra* note 355, s. 25.05(f), Saskatchewan Agreement, *supra* note 356, s. 7.08.

⁴⁶⁰ Guaranteed days of rest for nurses who are changing from nights or evening shifts back to day shifts: See *e.g.* B.C. Agreement, *supra* note 355, s. 25.05(f), Saskatchewan Agreement, *supra* note 356, s. 7.08.

⁴⁶¹ Maximum-consecutive shifts, days: see *e.g.* B.C. Agreement, *supra* note 355, s. 25.05(c), NSNU Agreement, *supra* note 359, s. 7.05, NSGEU Agreement, *supra* note 360, s. 14.12, Saskatchewan Agreement, *supra* note 356, s. 7.10, Alberta Agreement, *supra* note 357, ss. 7.02(g), 8.03; Weekends-per-month minimums and consecutive weekends worked limits: see *e.g.* NSNU Agreement, *supra* note 359, s. 7.14, B.C. Agreement, *supra* note 355, s. 25.05(e), NSGEU Agreement, *supra* note 360, s. 14.15, Saskatchewan Agreement, *supra* note 356, s. 7.12(a); Caps on hours nurses may be required to work in a day, week or month: see *e.g.* NSNU Agreement, *supra* note 359, ss. 7.01, 7.08.

only with the nurses' agreement, strive to make day shifts the norm for most nurses.⁴⁶² Similarly, the schedule setting and posting requirements reviewed above⁴⁶³ lend greater predictability to nurses' working lives, which reduces the negative effects of shift changes on their sleep cycles by giving more notice of those changes.

Addressing Causation and Subjectivity

Taken and combined with the evidence in Chapter 2, nurse collective bargaining has to date produced some important workload and time-worked protections that would appear to lessen the risk of medical error. The "professional responsibility" workload processes set up under most nurse collective agreements provide a reasonably accessible forum for nurses to bring workload concerns. However, concrete terms regulating workload such as nurse-patient ratios are seldom seen. Thus, the protections on workload's impact on patient safety could be more robust. Similarly, the protections found in the rules relating to hours worked, overtime and schedules offer some provisions that steer nurses away from work patterns that have a high risk of adverse events. However, as mentioned throughout, for every deterrence created by these rules and the wage top-ups that accompany irregular work hours, there is created an equal incentive for more junior nurses to take on shifts in circumstances when they should be resting.

⁴⁶² Provisions requiring equitable assignment of day shifts: see *e.g.* Alberta Agreement, *supra* note 357, s. 7.02(f), Saskatchewan Agreement, *supra* note 356, s. 7.09(a), (b); clauses that allow "evening-only" and "nights-only" shift patterns only at the request of individual nurses B.C. Agreement, *supra* note 355, ss. 25.05(b), 2601, Alberta Agreement, *supra* note 357, s. 7.02(d), Saskatchewan Agreement, *supra* note 356, s. 7.09(c).

⁴⁶³ B.C. Agreement, *supra* note 355, ss. 25.04, 28.02, NSNU Agreement, *supra* note 359, s. 7.09, NSGEU Agreement, *supra* note 360, s. 14.13, Saskatchewan Agreement, *supra* note 356, s. 7.03(a)-(c), Alberta Agreement, *supra* note 357, s. 7.04.

However, this argument must confront two broad objections: causation and subjectivity. The causation objection rightly points to the multi-causal nature of adverse events and doubts that any one factor can be isolated as the sole cause of a patient safety outcome such as an infection or medication error. Even more difficult is bridging the gap between adverse events and the nursing labour law model in which collective bargaining occurs. From one to the other, there are potential weak links in the chain of causation. First, the collective bargaining system does not “produce” outcomes. It is more accurate to say it steps aside to affirm and enshrine the process leading to them. The parties’ decisions produced these outcomes. A second possible weak link is that between rule and practice: just because a rule exists does not always mean it results in the desired outcome on the ground. A third possible weakness is in the link between practice and patient safety outcomes: as we know, many factors contribute to medical errors, and it is seldom possible to lay them at the feet of just one. At all these stages, other forces can intervene to produce the undesirable results.

This is a valid and important point: causation must be shown in order to accept any links between nurse collective agreement terms and bottom-line patient health outcomes. These are widely different phenomena, and in many instances too many other equally relevant phenomena come into play to show causation beyond a reasonable doubt. To accommodate this reality, I must adjust my conclusions. Not every overtime rule or mandatory rest rule will definitively lead to more patient safety protections. At the same time, I believe, there exists a spectrum between contract terms with a low likelihood to be crucial to patient safety and those with a high likelihood. Similarly, each rule operates differently in different hospital contexts, so that an overtime rule in the intensive care unit

has much more causal effect on the risk of adverse events than, say, a similar rule would in a geriatric ward. Conceiving the analysis as one of risk management and the assessment of probabilities instead of as a linear cause-and-effect relationship will account for these nuances.

Objections based on “subjectivity” remind us of the potential for politics or self-interest to shape how scientific evidence is produced and used. Certainly, subjectivity is a hallmark of the labour law world. Indeed, subjectivity is fundamental to the Wagnerist labour law model, which posits a labour/management divide permeating every legal and policy analysis. Every contract term, arbitration award, or legislative reform will have a union perspective and an employer perspective. In the nursing realm, there will always be a difference of view between health professionals and managers on nearly every issue.

Political incentives to resist these strictures are equally strong. Governments want to avoid deficit spending and will seize on most opportunities to find greater efficiencies in all public services, health care foremost among them. They will also seize on and try to change the narratives of nurses’ unions and their bargaining demands. Some in government may consider nurses just one of many groups affected by health care policy choices, and view them not as vanguards of patients but as self-interested groups of professional employees. This view is reminiscent of Wellington and Winter’s now-ancient critique of collective bargaining in the public sector.⁴⁶⁴ Arguing as legal scholars and political scientists, they idealized the supremacy of the legislative branch of government,

⁴⁶⁴ Wellington & Winter, “The Limits of Collective Bargaining in Public Employment”, *supra* note 9.

and argued forcefully against collective bargaining for any public-sector employees. They said unions in the public sector distort the democratic process by giving one interest group – unionized employees – a privileged audience with elected officials not enjoyed by the many other groups vying for the government’s favour. The risk they depicted was that self-serving behaviour will defeat the broader public will. Variants of this argument have emerged at times in Canadian health policy, with some pointing out that the income and other contract demands of health professionals can quickly take up resources intended for structural reforms.⁴⁶⁵ From this perspective, all the patient safety protections reviewed here might be viewed more as private economic benefits to nurses.

Acknowledging the inherent subjectivity of all labour relations and health policy issues is crucial. It is also a fundamental tenet of the Wagnerist model of labour law in which nurses collectively bargain. It is not the task of law or the state, on this model, to take sides between these divergent interests. This is where Wagnerism would, in fact, wish the conversation to end. However, I believe it is possible to continue the conversation while being a partisan advocate for or against entrenched interests. It is possible when, as here, there is an established body of objective, scientific evidence linking private working conditions to public patient safety interests. It is possible when this evidence is drawn not from the affected interest groups but from objective, independent, university-based scholars. And it is possible, most of all, because subjectivity and pluralism can be controlled for in a legal framework so long as my analysis is continually alive to the presence of political interests at every stage of the bargaining and policy processes.

⁴⁶⁵ Tuohy, “The Costs of Constraint and Prospects for Health Care Reform in Canada”, *supra* note 247.

Conclusion

Taken as a whole, the nurse collective agreements under review here contain several terms that strive to construct a nursing work environment in which nursing errors are minimized. Based on the scientific literature in Chapter 2, there is obviously no single ideal nursing workplace, but rather minimum standards below which it can be argued patient safety is placed at increased risk. Ideally, nurse-patient ratios should exist that are based on evidence and calibrated to the specific context (critical care, emergency, post-natal, post-surgical) in which nurses work. To the extent that the “professional responsibility” processes discussed above are effective at identifying and eliminating practices where cost control pressures could lead to nursing overwork and increased risk of error, they can be viewed as promoting patient safety. Ideally, extended shifts should be kept to a minimum, and changes between shifts should be avoided where possible. Overtime should also be kept within reasonable parameters, and incentives for nurses to take unsafe levels of overtime must be acknowledged and monitored. Obviously, no plan or rule is ever going to solve the patient safety/adverse event problem entirely. But the recognition that patient safety is a systemic, not individual, problem, inexorably leads us to the conclusion that workplace rules are important and overlooked systemic measures to reduce medical errors. Collective agreements are the best vehicle for those rules, and grievance arbitration provides an accessible mode of enforcement.

Overall, the collective agreements reviewed here go some way to accomplishing these goals, but as I have noted, shortcomings still exist. I have shown there are many qualifiers and exemptions in nurse collective agreements, and the figures on overtime usage suggest that even the high cost to employers in overtime pay has not slowed down

the increase in overtime usage. These qualifiers and exemptions – and any other shortcomings in nurse collective agreements from a patient safety standpoint – arise because of factors specific to the collective bargaining process that have limited the ability of nurses' unions to strengthen the patient safety terms in their collective agreements. In the next Chapter, I review and explore these factors in depth.

**CHAPTER FIVE:
CANADIAN NURSE COLLECTIVE BARGAINING ON PATIENT SAFETY ISSUES**

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Introduction

In the previous Chapter, I began my examination of how patient safety issues have been addressed by the language negotiated by nurses' unions in nurse collective agreements. In this Chapter, I delve into the nurse collective bargaining processes in which patient safety terms (workload, hours of work and scheduling) are proposed,

debated and either adopted or rejected in whole or part in the processes of nurse collective bargaining which have occurred in the six provinces under review here between 1999 and 2014. As the reader will see, I argue that nurses' unions have had some success in advancing patient safety issues through collective bargaining, but that the legal model in which they negotiate makes them vulnerable to government action to end negotiations and impose terms on patient safety issues. The experience in Ontario, however, has been different, as nurses' unions have been able to more effectively advance patient safety issues through collective bargaining under an interest arbitration model of dispute resolution. I further attempt to assess the extent to which governments resist terms that would improve patient safety on the ground of "efficiency", both in its true sense (aka that the money would be better spent elsewhere to improve patient health) and its faux sense of being a smoke-screen for cost-containment.

Research Methods

For my examination of how patient safety issues⁴⁶⁶ are raised, debated and resolved in negotiations between nurses' unions and governments, I accessed publicly available news sources to obtain basic facts and key events in each episode (or "round"⁴⁶⁷) of nurse collective bargaining in the six provinces under review here from 1999

⁴⁶⁶ By "patient safety issue" I mean a collective bargaining issue touching on one or more of the topics of workload, hours of work and scheduling for nurses, and by "patient safety-related round of bargaining" I mean a round in which one or more patient safety issues is raised.

⁴⁶⁷ By a "round" of nurse collective bargaining, I mean a discrete episode of negotiation between a nurses' union and a provincial government. Collective agreements are usually two to five years in length. Two months before they expire, either party may initiate negotiations toward the next agreement. Bargaining ultimately results in a new collective agreement, most often by agreement but sometimes (as will be seen) by the decision of a third party interest arbitrator or by government itself. A "round", then, begins with the start of negotiations and ends when a new collective agreement is reached. I also describe a round by reference to the year in which the round began. Thus, for example, the round beginning in Ontario in 1999 is the "1999 Ontario" round.

to 2014. The main news databases used were CBCA Current, Canadian Newsstand, and Eureka CC. These databases claim coverage of every Canadian daily newspaper. Searches were conducted using broad parameters to ensure that no germane news stories were missed. Thus, for each province, for example, a search was undertaken for articles containing “nurse”, results were sorted and articles related in any way to nurse collective bargaining between provincial nurses’ unions and governments were selected out for inclusion. Further searches were done, for completeness, of any articles containing the names of each of the provincial nurses’ unions in focus here; thus, for example, “Nova Scotia Nurses Union” was searched, and any articles pertaining to its collective bargaining activities were selected. To supplement news databases, I also used, where available news releases provided by the nurses’ unions and/or health employers on their websites for basic facts about particular bargaining rounds.

For the six provinces under review here, I have reviewed news and news releases on 40 total “rounds” of collective bargaining between provincial nurses’ unions and governments between 1999 and 2014. I define “round” of bargaining as a process of negotiation between a provincial nurses’ union and the government that is intended by the parties to result in a renewal of an existing or expired contract. In this study, “rounds” of bargaining start when the union and government first exchange their contract demands for the next agreement, and end when that next agreement is concluded, either by agreement of the parties, by decision of an interest arbitrator, or by government imposition. Thus, each “round” of bargaining typically corresponds to the year in which the new agreement starts. Of these 40 rounds of nurse-government collective bargaining,

I identified 26 in which patient safety-related issues of scheduling, staffing and workload arose.

The data for these rounds are drawn from news media reports as well as self-published online statements by the parties related to the negotiations.⁴⁶⁸ The Appendix to this thesis, *infra*, contains summaries of the salient events in each round of bargaining, and the citations to news articles on which the summaries were based. In Ontario, there were no strikes or lockouts, and little media coverage of bargaining. All disputes were resolved by interest arbitration under the system described in Chapter 3.⁴⁶⁹

The objective of this method was to obtain the most reliable publicly available information on nurse collective bargaining in each of the six provinces under review here. My purpose was not to probe deeply behind the public record to speculate on often-confidential negotiation events. As I explain below, secrecy was and remains a dominant feature of all collective bargaining, and nurse bargaining is no exception. Short of legal compulsion via a court proceeding or freedom of information requests, it is difficult to pierce this veil of secrecy to see exactly what strategies or decisions in bargaining were made, by whom, and why. Message management and public relations tactics played a large role in how nurses' unions and governments portrayed each other and themselves in bargaining. Rather than attempting to decide between competing portrayals, I sought

⁴⁶⁸ I gathered news reports from the Canadian Newsstand, Eureka and CBCA Complete Canadian News services, which catalogue newspaper articles from all major Canadian daily newspapers and allow retrieval of full text articles. Articles were searched using the terms "nurse", "union" and "bargaining" captured all news articles involving nurses' unions, a set from which I drew articles pertaining to rounds of bargaining involving the patient safety-related issues of staffing, scheduling and workload.

⁴⁶⁹ For the Ontario rounds of bargaining which have been resolved by interest arbitration, I have gathered the interest arbitration decisions arising out of these disputes. These decisions are found on the Quicklaw database through a search with the term "hospital labour disputes arbitration act".

to limit my research to the most incontrovertible and basic facts about each round of bargaining that involved patient safety issues. The Appendix, *infra*, thus focuses on a series of distinct questions about each round of bargaining:

- Were one or more patient safety issues (workload, hours of work or scheduling) raised in bargaining?
- What were the top issues in dispute in bargaining?
- Was there a bargaining dispute?
- Was there a threat by the nurses' union of a strike or a strike vote?
- Did the nurses' union hold a strike vote?
- Did the nurses' union engage in any strike action?
- Did the nurses' union use any alternative pressure tactics such as overtime bans or mass resignation threats?
- Did the government warn it would legislate an end to any strike?
- Did the parties settle, and if so what were the basic terms?
- Was the dispute decided by an interest arbitrator? and
- Did the government use legislation to either end a lawful nurses' strike, impose terms on the nurses' union, or both?

Where Were Patient Safety Issues in Nurse Collective Bargaining?

In the rounds of nurse collective bargaining I review here, patient safety was seldom an explicit subject of the publicly available record of nurse collective bargaining. Rather, it arose implicitly whenever the parties bargained about one or more of the issues I have defined as “patient safety-related” – nursing workload, hours of work or scheduling. By this measure, in the six provinces under review, from 1999 to 2014, there were 40 rounds of central bargaining (i.e. between the nurses' union, the provincial government and a representative of health care employers), 10 in Nova Scotia, seven in Ontario, six in Manitoba, five in Saskatchewan, seven in Alberta and five in British Columbia. In Ontario, each individual hospital also has a local collective agreement with the Ontario Nurses' Association local for that hospital, which covers scheduling, hours of work and

other issues not covered by the central collective agreement between the Ontario Hospital Association and the ONA. Thus, there have been numerous rounds of local collective bargaining in Ontario to go along with the central negotiation process. In Nova Scotia, there is a single province-wide health authority, but two different unions representing nurses depending on where they work. The Nova Scotia Nurses' Union has a collective agreement for all Nova Scotia nurses working outside the Halifax area, and the Nova Scotia Government and General Employees' Union has its own collective agreement covering nurses working in Halifax. Thus, in Nova Scotia there were separate rounds of bargaining involving each union, sometimes occurring simultaneously, other times in sequence.

In the 40 total rounds of central nurse collective bargaining observed, 26 were "patient safety-related" as I use the term here, i.e. one in which one or both parties addressed one or more of the patient safety issues of workload/staffing, hours of work or scheduling. More details on these nurse bargaining rounds are set out in the Appendix, *infra*. Here, I will focus on the trends which emerged from my review of the issues, actions and resolutions in these bargaining episodes.

Money Talks (Loudest): The Dominance of Wage Issues

In most of the patient safety-related rounds in focus here, economic (i.e. wage) issues almost always dominated the bargaining agenda. As much as the unions touted patient safety as a basis for some of their non-monetary demands, in all rounds where wages were an issue, the nurses' unions gave lower priority to patient safety issues. Even after the initial flurry of nursing wage increases from 1999 to 2002, nurses' unions

continued to seek wage and other benefit increases. While workload, scheduling and other patient safety issues were on the bargaining table, so too was keeping pace with the nursing wages in neighbouring provinces. In Alberta, for example, the nurses' union attained wage increases of 22% (2001), 3% (2005), 15% (2007) and 4% (2010).⁴⁷⁰ In another large and wealthy province, Ontario nurses saw wage increases of 6.7% (1999-2000), 11% (2001) and 9.25% (2008) respectively.⁴⁷¹ And in British Columbia, which experienced an economic boom of sorts in the years leading up to the 2010 Olympic Winter Games, nurses won wage increases of 17% (2006), 6% (2009) and 3% (2012).⁴⁷² Not all governments were willing to increase nurse wages as much or as often as demanded, however, resulting in an upsurge of labour conflict between nurses' unions and governments between 1999 and 2014. The main problem with a wage-dominant focus is that it leaves patient safety issues with less attention, and makes them more vulnerable to being withdrawn or deferred to a later round. Also, the more resources governments must devote to wage increases, there are less resources to hire more nurses at the new, higher wage rates. This in turn aggravates the shortage of nurses, increases workload and harms patient safety. Below I will argue that the Wagner model steers unions to make difficult choices between demands and often steers them toward economic issues.

Still, though, patient safety issues did arise as points of dispute, especially in bargaining rounds after 2003. Nurses' union demands on workload issues initially took the form of additional hires, but later changed to demands for workload-control

⁴⁷⁰ See *infra* Appendix: Nurse Collective Bargaining Rounds, Alberta 2001, 2005, 2007, 2010.

⁴⁷¹ See *infra* Appendix: Nurse Collective Bargaining Rounds, Ontario 1999, 2001, 2008.

⁴⁷² See *infra* Appendix: Nurse Collective Bargaining Rounds, B.C. 2001, 2006, 2009, 2012.

mechanisms in the collective agreement. In some instances, the workload complaint processes discussed above were agreed to and inserted into the collective agreement.⁴⁷³ In other rounds, the nurses' union demanded relief from mandatory overtime, citing the over-use of overtime as a workload and patient care issue.⁴⁷⁴

Another workload issue, which arose in some disputes was the proposal by nurses' unions for firm nurse-patient ratios to be written into the collective agreement.⁴⁷⁵ Although in agreement about workload problems, governments have not been inclined to agree to nurse-patient ratios on the basis that they are too rigid and that adequate nurse staffing can be achieved through other means.⁴⁷⁶ Similarly, employers rejected union demands in some provinces for a "right to refuse" on professional grounds (i.e. patient safety). However, nurses in Saskatchewan did achieve a new gain – "whistleblower" protection. This language protects nurses from reprisals or discipline for reporting issues of professional concern to relevant authorities such as Colleges of Nurses.⁴⁷⁷ Less prominent union gains on professionalism included language constraining employer decision-making with reference "professional standards", and payment of professional fees.

⁴⁷³ See *infra* Appendix: Nurse Collective Bargaining Rounds, Nova Scotia (NSNU) 2013.

⁴⁷⁴ See *infra* Appendix: Nurse Collective Bargaining Rounds, Saskatchewan 2008.

⁴⁷⁵ See *infra* Appendix: Nurse Collective Bargaining Rounds, Alberta 1997, 2003; Nova Scotia (NSGEU) 2014.

⁴⁷⁶ See *infra* Appendix: Nurse Collective Bargaining Rounds, Nova Scotia (NSGEU) 2014.

⁴⁷⁷ The Saskatchewan Agreement's whistleblower protection provision reads: "the employer shall not penalize, harass, discipline or take legal action against an employee for reporting or publicizing any concerns that present a risk to patient, resident and/or client safety regarding the provision of health care."

Highly Centralized Decision-Making

Another problem in how patient safety issues are addressed in nurse collective bargaining is the highly-centralized structure in which patient safety issues are negotiated. In some provinces like British Columbia and Alberta, issues of workload, scheduling and hours of work are addressed only at the central bargaining table. Any resulting terms on these issues are therefore “central” in nature, and thus apply uniformly across the province to every health care employer in every locale. In this kind of structure, individual hospitals, regions or other employers are not free to bargain with the locals of the nurses’ union toward scheduling, hours of work and other provisions tailored to the precise nature of the services provided. They are all bound to the terms of the one central collective agreement resulting from the process.

By contrast, in provinces such as Ontario or Manitoba, local employers and unions do have the power to reach localized agreements with the nurses’ union on the patient safety issues of scheduling and hours of work. Thus in Ontario, for example, each individual hospital of the more than 150 that agree to participate in the central bargaining process is bound by the central agreement’s terms on wages, vacations and other issues, but also has a local and much shorter collective agreement with their respective nurses’ union local that addresses scheduling and hours of work.⁴⁷⁸ Such local agreements tend to be mostly similar but not entirely identical, which allows for important differences between hospitals’ specialties or geographic locations. In this way, provinces with less centralized collective bargaining structures for nurses are better able to allow individual

⁴⁷⁸ *Memorandum of Conditions for Joint Bargaining between Participating Hospitals and the Ontario Nurses Association*

health care employers and nurses' union locals to balance patient safety and efficiency in the design of schedules and hours of work.

As mentioned in Chapter 3, centralization in nurse collective bargaining arose from a confluence of interests among the parties in provinces that rely on the traditional strike mechanism to resolve disputes. For the nurses' unions, centralization boosts their bargaining power with employers and provincial governments. This is especially important to highly essential public employees such as nurses who must rely on a virtually meaningless right to strike (discussed further below) as a bargaining tactic. Strike actions highly attenuated by essential service laws become at least marginally more effective when taken on a province-wide scale. The government interest in centralized bargaining is simplicity of administration and, more importantly, labour stability. A centralized structure of bargaining with the nurses' unions sweeps most or all local bargaining into one negotiation process, with a single contract expiry date, and eliminates the risk of localized job actions. By contrast, local-by-local bargaining can lead to a nearly perpetual series of disputes as union locals leapfrog each other in bargaining demands.⁴⁷⁹

However, the downside of a centralized model is that patient safety issues are forced into a single mold for all specialties, geographies, demographics and other lines of distinction between nursing practice settings. Because their union is bargaining over a single set of terms on each issue, nurses of different specialties and other distinctions by necessity compete for priority on the central bargaining agenda. Because of its generality,

⁴⁷⁹ Haiven, "Industrial Relations in Health Care", *supra* note 17 at 240; Johnston & McKenna, "Public Interest Disputes and Compulsory Arbitration", *supra* note 13 at 511-512.

central language can also be a barrier to innovative local scheduling, hours of work or workload agreements.

Prevalence of Positional Bargaining Approaches

When nurses' unions raised patient safety issues in bargaining, their proposals were approached as traditional bargaining demands. In the 26 rounds of collective bargaining dealing with patient safety issues, these issues typically competed for attention with the many other bargaining goals the nurses' unions brought to the table. Wages and economic issues tended to dominate the bargaining agenda even when patient safety issues were in the bargaining mix.

Nurses' unions often made demands on workload, hours of work or scheduling issues, but whether the unions carried those demands all the way to a dispute and the prospect of a nurses' strike depended largely on traditional negotiation factors. By "traditional" I mean positional, interest-based negotiations in which each party strives to maximize their respective gains from the bargain. The traditional role of unions has been to push for more compensation and better working conditions, and the employers' is to resist such demands and control labour costs. In the nursing context, while the terms of debate in collective bargaining were always public and policy-driven, the basic narrative of a typical nurse bargaining dispute was familiar to labour relations tradition. Both sides rooted their positions in the public interest. Nurses' unions invoked patient care values and in some cases patient safety as rationales.⁴⁸⁰ Governments were equally emphatic,

⁴⁸⁰ For example, in 2014 the NSGEU regularly invoked patient safety as the ground for its insistence on nurse-patient ratios. The same arose also in earlier rounds in Alberta (2003), British Columbia (2001) and Saskatchewan

constantly linking the cost of nurses' union demands to the economic sustainability of health care.⁴⁸¹

However, aside from this unavoidable political dimension, the parties to nurse collective bargaining reverted mostly to traditional tactical behaviours seen in labour relations. For example, bargaining usually began with a wide gulf between the two sides' positions. This followed the classic negotiation strategy of leaving oneself room to concede.

Obviously in the public sector, as discussed in Chapter 3, the economics of bargaining are different, but fundamentally the basic narrative of the typical round of nurse collective bargaining seen here was familiar to labour law tradition.⁴⁸² After each side finished their opening posturing, most bargaining followed typical concession patterns. Each side relented from their demands and moved toward settlement. Agreements were almost always reached (or terms imposed by legislation) just prior to or after key deadlines, such as a strike vote, a strike date, a round of bargaining by other public sector unions or even a provincial election. The continued use of the strike mechanism in provinces outside Ontario to resolve disputes focuses the parties' decision-making squarely inward, toward choices conducive to winning a contest of wills. In this way, the strike mechanism has a feedback effect. It creates pressure on the parties to focus on power rather than principle as the determining factors in their decisions.

(2005). See *infra* Appendix: Nurse Collective Bargaining Rounds, Alberta 2003, B.C. 2001, Saskatchewan 2005, Nova Scotia (NSGEU) 2014.

⁴⁸¹ The best recent example of governments citing cost as a basis for opposing workload-related demands was in the Nova Scotia 2014 round. Governments in British Columbia (2001, 2012), Alberta (2003) and Saskatchewan (2005) made similar claims in response to nurses' union demands in each of those rounds.

⁴⁸² This positional bargaining pattern was seen in the concession bargaining moves made by the nurses' unions and governments in the British Columbia 2001 round, the Alberta 2003 round and the 2008 Saskatchewan round.

A further problem for patient safety issues is that traditional bargaining customs require unions and governments to prioritize, meaning issues of less importance to the parties are often decided well before the more economic issues make the news headlines. It was common, for instance, for non-monetary issues to be “tidied up” (in bargaining vernacular), or quickly and quietly settled, before the tough bargaining began on economic issues. The problem with this trend is that some of these preliminary issues may matter more to patient safety than is reflected by the profile they are given in bargaining. There was no way to be sure that the issues the parties settled prior to the big issues for them were indeed just minor issues for the public. As it is for all unions, prioritizing bargaining issues has always been a challenge for nurses’ unions. Forced to choose economic issues that are easily costed and translate into short-term economic gain for their constituency on one hand, and patient safety issues that do not share these features, nurses’ unions have incentives to prefer the former over the latter.

Secrecy and Exclusivity of Bargaining on Patient Safety Issues

A further trend related to traditional bargaining tactics in patient safety-related disputes was the cloistered nature of bargaining. As public and politicized as many nursing labour disputes became, secrecy was still a recurring feature of those bargaining rounds. In labour relations, as in any negotiations, confidentiality is thought to best promote settlement because it fosters the free flow of ideas and information between the parties. Some rounds of bargaining involving patient safety issues were very open, public affairs, but only because the unions or governments saw a tactical advantage in

bargaining through the media.⁴⁸³ Each side usually made heavily partisan appeals to citizens through advertising and other media. Hidden, though, were crucial details. Each side sought to control information unless it became tactically useful in bargaining. Regardless of how public the disputes became, however, secrecy still shrouded the crucial final days of bargaining in which key decisions were made.

Ontario was the most shrouded province for nurse collective bargaining. In each round of settlement, the nurses' union in Ontario (the ONA) presented its tentative agreement to nurses as a near *fait-accomplis*. Therefore, no one in Ontario, not even nurses until the eve of the ratification vote, could see how the parties arrived at their joint decision. Unknown were issues dropped and options foregone, as well as precise contract language considered. In every province, though, citizens were seldom able to know the reasons for opening positions, positions taken in bargaining and concessions made. Governments gave scant rationales for their bargaining positions or decisions to settle. Rather than focus on the long-term implications of their choices, governments appealed to public relief at the end of a labour dispute that placed public health care services in jeopardy. Likewise, unions seldom gave detailed rationales to their members in advancing settlements they recommended. It was enough, it seemed to the parties, to say it was a fair deal and seemed the best they could attain in that round, and nothing further.

⁴⁸³ The media covered nursing labour disputes closely, especially as disputes evolved toward strike votes or the setting of strike dates. This was particularly illustrated in the British Columbia 2001 round, the Saskatchewan 2008 round and the 2014 Nova Scotia (NSGEU) dispute. In all cases, the parties announced the basic outlines of their key demands to the media, and in many cases reported their responses to bargaining proposals through the media.

Websites provide further illustrations of the secrecy in nurse collective bargaining. Until 2002, most nurses' unions and government negotiators maintained sites accessible to the public. On them, any citizen interested in the issues could find information on the chronologies of bargaining, discussions of issues, demands and claims, and primary texts – collective agreements, written proposals or proposed language changes. By now, however, most nurses' unions' Internet sites are divided into public and members-only sections. Passwords are required to view most of this information. In some provinces, even collective agreements themselves are unavailable on line.

Governments and health care have followed suit. Websites of employer bargaining associations (such as the HEABC in B.C., the PHAA in Alberta and the SAHO in Saskatchewan) are increasingly members-only. Other health regions and health care employers are contracting with specialized human resource firms to carry out their bargaining and contract administration. Websites set up by such private entities are exclusive to members. Both sides, then, are dimming the citizen's view of nurse collective bargaining in the one medium – the Internet – best suited to inform the public about it.

Besides having bargaining largely concealed from them, patients and patients' advocacy groups are also excluded from any participation in bargaining on patient safety issues. Bargaining outcomes on issues of workload, hours of work and scheduling can have significant impacts on patient safety, yet there was no representative of patients in bargaining. Rather, it was left to nurses' unions to advance those patient safety interests through their demands at the bargaining table. Governments were also quick to cite patient interests in support of their proposals and of course – as discussed below – in support of legislating an end to a dispute.

Insufficient Evidence-Based Decision-Making

In the patient safety related rounds of bargaining observed here, evidence of the kind I discussed in Chapter 2 seldom found a place in the debate. In some disputes, the parties inundated the public with academic evidence and claims based on supposedly objective indicators. For example, in the 2014 Nova Scotia dispute over nurse-patient ratios, the media did some feature stories containing commentary on nurse-patient ratios from academics and health policy experts.⁴⁸⁴ However, because the media tended to oversimplify their portrayal of the issues in a nursing labour dispute, and the parties themselves were bound to be partial on the issues, there was little avenue for objective evidence to be used to guide bargaining and possibly lead to agreement.

Emergency Decision-Making

Perhaps the most troubling trend in how patient safety issues were addressed in nurse collective bargaining is what I will call the “emergencification” of patient safety disputes in those provinces that use the strike mechanism to resolve disputes. That is, a public emergency context often arises when a round of nurse collective bargaining does not result in a quick settlement. Because of the Wagnerist insistence on the strike mechanism as the dispute resolution method, a lack of settlement leads immediately to public discussion of risk of a work stoppage in health care. This rapidly heightens the political stakes and creates a near-emergency atmosphere in which governments have a pretext to act to impose their terms on the unions. In this context, governments have been tempted to override nurses’ unions’ collective bargaining rights, and in any event essential

⁴⁸⁴ See *infra* Appendix: Nurse Collective Bargaining Rounds, Nova Scotia (NSGEU) 2014.

patient care is nevertheless disrupted. The result, I argue, is that nurses' unions in these provinces are greatly hampered in their ability to achieve contractual terms that improve patient safety.

Certainly, the designers of the legislative "limited strike" models in the four Western Canadian provinces did not intend this outcome. As explained in Chapter 3, all except Nova Scotia have legislative restrictions on strikes in health care. Nurses' unions, employers and governments are expected to agree to these restrictions and set them out in a strike-protocol agreement before bargaining begins. The idea is that, if nurses' unions reach impasse in bargaining and the membership votes to go on strike, they can do so in a way that protects patients from a drop in medical services. However, the 1999-2014 experience suggests that this idea is simply far-fetched. This experience shows that nursing is simply too essential a part of the medical care system to be withdrawn even in part. Regardless of these standing legal restrictions, all the strike-protocol agreements and all the potential penalties for breach of the rules, even the slightest hint of a nurses' strike vote, much less a strike, was sufficient to create the very kind of emergency atmosphere the designers of the "limited strike" models had hoped so fervently to avoid.

To advance a patient safety issue such as workload, for example, a nurses' union would typically make its demand, the government and health care employers would object on cost and efficiency grounds, and the parties would reach impasse. At that point, and especially if governments were publicly intransigent, in many cases the nurses' union would have no option but to begin taking the many steps typically required of them to begin a lawful strike. In some disputes, a mediator became involved and undertook a

confidential mediation resulting in a recommended settlement. If this did not produce a settlement, the union would in some instances threaten or schedule a strike vote.

In nine of the 26 patient safety-related rounds, the nurses' union threatened or scheduled a strike vote to back their demands.⁴⁸⁵ In some cases, these moves prompted a concession from the government and health care employers.⁴⁸⁶ For example, in the 2003 round of bargaining in Alberta, "flexibility" demands were at the core of the dispute.⁴⁸⁷ The provincial employers wanted freedom to create multi-site positions and provisions to allow some nurses to agree to permanent night shifts. This was intended to address the shortage of nurses to work nights. Another demand was to reduce the weekly minimum percentage of day shifts for nurses. Under the collective agreement as it stood, every nurse was entitled to day shifts on at least two of five days, or 40%; the PHAA sought 25%. The employers also wanted to remove "nurse in charge" language (requiring that only RNs could oversee a hospital unit). The UNA stridently resisted these demands, calling them "rollbacks" that would give employers a free hand to disrupt nurses' work-life balances and regularity of schedules. After mediator Alan Beattie recommended a settlement that included many of the PHAA's proposals, the UNA voted it down by a near unanimous margin. After further negotiations failed, a second mediator (Andrew Sims) proposed a new settlement that omitted most of the "flexibility" proposals, and the UNA overwhelmingly accepted it.

⁴⁸⁵ See *infra* Appendix: Nurse Collective Bargaining Rounds, Alberta 1999, 2003; B.C. 2001; Manitoba 1999, 2002; Saskatchewan 1999, 2008; Nova Scotia (NSGEU) 2001, 2014.

⁴⁸⁶ See *infra* Appendix: Nurse Collective Bargaining Rounds, Alberta 1999, 2007; Manitoba 2002, Saskatchewan 2008.

⁴⁸⁷ See *infra* Appendix: Nurse Collective Bargaining Rounds, Alberta 2003.

In this emergency context, the terms of the debate over patient safety issues are distorted. The problem is reframed from how to advance patient safety interests through protections in the collective agreement, to how to simply end the disagreement, above all else. Emergency is a poor context for fair, inclusive and evidence-based decision-making. The paramount priority in such a context is agreement. Far behind it is attaining an outcome that can be explained with reference to evidence. The labour law imperative of promoting settlement becomes the overarching norm, and decision-making on patient safety issues quickly fades in importance. One common outcome was that the nurses' union would accept a settlement providing a wage increase even if it did not achieve gains on patient safety issues.⁴⁸⁸

In just three of the patient safety-related rounds under review here did the nurses' union engage in any kind of strike action.⁴⁸⁹ In these instances, governments used their legislative prerogative to enact legislation ending the dispute and/or imposing its contract terms. The emergency context gave provincial governments a free hand to legislate an end to bargaining and to impose a final offer.⁴⁹⁰ The 2001 round of bargaining in British Columbia was a prime example. After the 2001 round of bargaining, the Campbell government enacted legislation that voided several key provisions of all collective agreements in the B.C. health sector. The legislation, Bill 29⁴⁹¹, voided provisions in nurse and other collective agreements on contracting out, work assignments, job security and

⁴⁸⁸ See *infra* Appendix: Nurse Collective Bargaining Rounds, Saskatchewan 2007.

⁴⁸⁹ See *infra* Appendix: Nurse Collective Bargaining Rounds, B.C. 2001, Saskatchewan 1999; Nova Scotia (NSGEU) 2001, 2014.

⁴⁹⁰ See *infra* Appendix: Nurse Collective Bargaining Rounds, Nova Scotia (NSGEU) 2001, Manitoba 1999.

⁴⁹¹ *Health Care Services Continuation Act*, S.B.C. 2001, c. 23 (Bill 2, 2001); *Health Care Services Collective Agreements Act*, S.B.C. 2001, c. 26 (Bill 15, 2001); *Health and Social Services Delivery Improvement Act*, *supra* note 276; *Health Sector Labour Adjustment Regulation (Health and Social Services Delivery Improvement Act)*, *supra* note 276.

layoffs. It also prohibited any future bargaining between health care unions and the government on those matters.

Not only did nurses' unions see a precipitous drop in their voice when disputes came close to a strike vote, patients still suffered. In every case where a strike vote was taken, a kind of public health crisis set in, as hospitals cancelled elective surgeries, moved patients out of the province and otherwise reduced services. In almost every dispute involving even the hint of a nurses' strike, the risks to the accessibility and safety of the health care system were significant.⁴⁹²

Thus, even as they fail to protect patients from a disruption in services, the "limited strike" models have failed nurses' unions by, time and again, failing to prevent governments from acting in *ad hoc* unilateral manners to impose their will on bargaining in disputes on patient safety issues. An "emergency" political context always arises, and from nurses' unions have lost significant bargaining power in their efforts to advance patient safety interests. Yes, nurses' unions can exert a significant amount of pressure on governments through use of the strike weapon, regardless of the legal strictures on it. However, they are only able to gain this power at great potential cost in ethical, professional, legal and personal terms. This alone makes the strike a difficult tactic to even contemplate for nurses' unions. However, in all provinces except Ontario, it remains the only viable option for advancing patient safety issues.

Granted, the prospect of a work stoppage, and all the disruption and cost that entails, is contemplated and intended by the current labour law model. To recall from

⁴⁹² See *infra* Appendix: Nurse Collective Bargaining Rounds, Alberta 2003, Nova Scotia (NSGEU) 2001, 2014, Manitoba 2008, Saskatchewan 1999.

Chapter 3, Wagnerist labour law models use the strike mechanism as a tool to prod settlement: the right to strike must be used, goes this theory, or else labour conflicts will never be settled. Yet it has equally been established as a labour law principle that the rights of patients to essential services must take precedence over the right to strike, where a balance cannot be struck.

Ontario: How do Interest Arbitrators Decide Patient Safety Issues?

The foregoing critiqued how bargaining trends under strike-based labour law models are contrary to patient safety. Ontario, however, has used interest arbitration to process bargaining disputes over patient safety and other issues, and I now turn to the observed trends in how patient safety issues have been addressed in that dispute resolution method. As Chapter 3 explained, Ontario and Alberta both prohibit strikes in health care, but only in Ontario has the system of interest arbitration been accepted and applied on a regular basis. In Alberta, the nurses' union (and others in health care) continue to bargain as if they have the lawful right to strike. In Ontario, however, the parties have used interest arbitration quite regularly to resolve bargaining disputes. As discussed in Chapter 3, the Supreme Court of Canada's 2015 *Saskatchewan Federation of Labour* decision held that restrictions on the right to strike are unconstitutional, except where the right to strike is replaced with binding, neutral, independent interest arbitration.⁴⁹³ The Ontario model meets these standard, so it is very likely constitutional.

In Ontario's centralized nurse collective bargaining structure, individual hospitals have the exclusive jurisdiction to negotiate scheduling and hours of work issues with the

⁴⁹³ *Saskatchewan Federation of Labour v. Saskatchewan*, *supra* note 2.

corresponding local of the Ontario Nurses' Association. Thus, while more than 150 Ontario hospitals have agreed to be bound by the terms of the central collective agreement on issues like wages, benefits, and other matters, each of them individually also has a separate, usually much shorter, collective agreement on issues the union and OHA have agreed should be negotiated at the local level. Thus, when a local bargaining dispute arises over scheduling or hours of work issues, it is resolved by an interest arbitrator who issues a decision typically called an "award". Since hours of work and scheduling are patient safety issues, in Ontario most patient safety-related disputes have happened at the local level, resulting in a series of local arbitration awards.

Based on the search method used above, I located 45 total reported interest arbitration awards between 1999 and 2014 resolving disputes between the Ontario Nurses' Association and Ontario hospitals. Five of these awards decided disputes between the ONA and OHA at the central bargaining table, and 40 of them involved individual hospitals.

[Who is Deciding?](#)

The first trend of note from a patient safety standpoint is how the decision-makers are chosen to begin with. The interest arbitrators deciding patient safety disputes are all drawn from the ranks of Canadian labour lawyers. Labour arbitrators – those doing both grievance and interest arbitrations - are a closed and exclusive group of labour lawyers who are familiar to the union and government officials involved in bargaining. Within this closed circle, arbitrators "graduate" to a career as a mediator or arbitrator after several years practicing as a lawyer on either the union or employer side of the labour law bar.

Many labour arbitrators have been vice-chairs at provincial labour relations boards, and many are or have been labour law professors. In 2003, the Supreme Court of Canada elevated the custom of using this select group of labour arbitrators to the status of a binding principle by quashing the Ontario government's attempt to appoint an interest arbitrator from outside the traditional pool of arbitrators.⁴⁹⁴

By this convention, the class of persons eligible to act as a decision-maker in patient safety disputes is unduly narrowed. Rationality and evidence-based decision-making in patient safety disputes are offended by this undue narrowing of the pool of candidates to act as interest arbitrators. Surely, as the Supreme Court held in *CUPE v. Ontario*⁴⁹⁵, independence and impartiality are essential characteristics for any arbitrators. But they need not mandate so narrow a definition of suitability for adjudication. From a Wagnerist labour law perspective, this custom seems essential to the legitimacy of the entire labour law system yet from a health policy perspective, choosing decision-makers solely because of their expertise in a field entirely foreign to health policy – grievance arbitration – likely means that critical issues of patient safety will continue to be subjugated to the conventions of labour law.

Interest arbitration is obviously driven primarily by the immediate parties. However, given the wider social importance of the patient safety issues that are raised and decided upon in interest arbitration, there is a lack of participation by patients' groups, which deprives the interest arbitrators of important perspective. Arbitration boards are deluged with reams of evidence by the union and government lawyers, but no intervention or other

⁴⁹⁴ *Canadian Union of Public Employees (C.U.P.E.) v. Ontario (Minister of Labour)*, *supra* note 327.

⁴⁹⁵ *Ibid.*

submissions by patient safety groups or patients' rights groups more broadly. Thus, in my view, the interest arbitration process – both in terms of who decides and who participates – is too exclusive given the public interests at stake in how it unfolds.

How Are They Deciding? Over-Generality of Principles of Decision

I turn now to the problem of over-generality in the legal principles interest arbitrators use to decide. What are these principles? The first is essentially a reluctance to decide unless necessary. Interest arbitrators see their function as promoting settlement where possible, and are very reluctant to decide for the parties unless they absolutely must. A clear example of this was in a 2009 award in which the arbitration board simply refused to decide the scheduling issues remitted by the parties, ordering them to return to bargaining. In terse language, they ruled:

It is hoped that the parties will be able to discuss and agree to provisions drawing from each of the predecessor agreements that will create a comprehensive and mutually agreeable code for scheduling to provide certainty and stability for the employees, both the nurses and the managers who will have to implement these scheduling provisions.

We do not see that is intended to precede the referral of difficult to resolve issues to arbitration has been fully exercised in this case. We remit the matter back to the parties for a more fulsome discussion of the merits of individual scheduling provisions, with the opportunity to return to the Board with those (hopefully) fewer issues, where the parties are unable to resolve these residual matters. Accordingly, we remain seized.⁴⁹⁶

When they do reluctantly craft language for the parties, arbitrators retreat to the most general of tests: “replication” and “reasonableness”.⁴⁹⁷ “Replication” was succinctly explained by one arbitrator as follows:

⁴⁹⁶ See e.g. *Muskoka Algonquin Healthcare v. Ontario Nurses' Assn. (Collective Agreement Grievance)* [2009] O.L.A.A. No. 529 (Reilly, Kuhne, Hughes) paras. 6-7.

⁴⁹⁷ *Building Service Employees, Local 204 and Welland County General Hospital (Re)* (1965) 16 L.A.C. 1 (Arthurs, Wren, Cromarty); *Canadian Union of Operating Engineers, Local 101 and Grace Hospital, Toronto (Re)* (1966) 17 L.A.C. 233 (Arthurs, Miller, Middleton); *Canadian Union of Public Employees, Local 576 and Trustees of Ottawa Civic Hospital (Re)* (1969) 23 L.A.C. 145 (Schiff, Wright, Reid).

The process of collective bargaining is the best process available to the parties for achieving an enduring and harmonious workplace environment. The task of an interest Board of Arbitration is not to impose terms and conditions that seem fair or attractive. Instead, the task of the Board is to design a collective agreement that comes as close as possible to what the parties could have expected to achieve if they had been forced to impasse. Interest arbitration is imposed upon these parties to preserve the health and wellbeing of the general populace. Accordingly, we embark on our analysis with a goal of replicating free and unfettered collective bargaining as if this imposition did not exist.⁴⁹⁸

The “reasonableness” principle calls for an analysis of the parties’ positions. To decide the “reasonableness” of a given proposal, interest arbitrators have used three further sub-principles: “comparability”, “ability to pay” and “conservatism”.⁴⁹⁹ In my view, these principles are so general as to be virtually of no assistance in deciding patient safety-related disputes. They direct the arbitrator’s attention away from policy analyses, asking instead for a prediction. Prediction distracts from the normative policy questions at stake, and substitutes speculation about the future for a frank and open analysis of patient safety values, the proposed contract changes, and available evidence.

(Dis)use of Statutory Criteria

Further, even though statute dictates that interest arbitrators apply legislative criteria, it has become a custom among interest arbitrators to resist applying them in any depth.⁵⁰⁰ Specific, concrete rules, standards or guidelines would be much more useful as principles of decision for interest arbitrators deciding patient safety related issues. Yet

⁴⁹⁸ *Cornwall Community Hospital v. Ontario Nurses' Assn. (Collective Agreement Grievance)* [2009] O.L.A.A. No. 517 (Reilly, Kuhne, Hughes) para. 2; see also *Strathroy Middlesex General Hospital v. Ontario Nurses' Assn. (Collective Agreement Grievance)* [2012] O.L.A.A. No. 47 (Goodfellow, Girvan, King) paras. 15-17.

⁴⁹⁹ “Comparability” calls for equality in wage terms across relevant regions within a province or across provinces in a region of the country. Arbitrator Thomas Kuttner described comparability as: “...but another way of saying that the interest arbitration process takes place within the general climate of the market in much the same way as does the collective bargaining process.”: *Halifax (Regional Municipality) and I.A.F.F., Loc. 268 (Re)* (1998) 71 L.A.C. (4th) 129, [1998] N.S.L.A.A. No. 12 (Kuttner), at para. 31.

⁵⁰⁰ *Newfoundland (Treasury Board) and N.A.P.E.* (1995) 52 L.A.C. (4th) 250 (Buffett); *McMaster University and Faculty Ass'n* (1990) 13 L.A.C. (4th) 199 (Shime).

from the experience to date it appears that interest arbitrators would refuse to apply such rules. To recall, the Ontario criteria are generally framed:

The employer's ability to pay in light of its fiscal situation.

The extent to which services may have to be reduced, in light of the decision or award, if current funding and taxation levels are not increased.

The economic situation in Ontario and in the municipality where the hospital is located.

A comparison, as between the employees and other comparable employees in the public and private sectors, of the terms and conditions of employment and the nature of the work performed.

The employer's ability to attract and retain qualified employees.⁵⁰¹

Certainly, these arbitrators refer to the criteria, but beyond a brief mention do little more with them in their reasons. The most that interest arbitrators do, from my review of the patient safety-related awards from Ontario, is pay lip service to the statutory criteria before moving on to delivering their final decision. It is hard to imagine any other legal setting where applicable legal rules are given so little weight. The traditional reason arbitrators cite is that the criteria somehow make them biased in favour of the employer or government in the dispute, so that to apply them would be to lose the cloak of neutrality and objectivity required of labour arbitrators.⁵⁰²

In my view, the integrity of interest arbitration is surely important, but it does not follow necessarily that only customary principles (replication or reasonableness) – and not legislative factors – can ensure integrity. In my view, structuring discretion in a more

⁵⁰¹ *HLDA*, *supra* note 285, s. 9(1.1).

⁵⁰² R. Jackson, "Ability to Pay and the Independence of Arbitration: An Arbitrator's Perspective", in W. Kaplan *et. al.* eds., [1995] *Labour Arbitration Yearbook* at 341; C. Santry, "Lawyer decries limited judicial scrutiny of arbitration decision" *Canadian Lawyer*, August 14, 2013, online at <http://www.canadianlawyermag.com/legalfeeds/1625/lawyers-decries-limited-judicial-scrutiny-of-arbitration-decisions.html?print=1&tmpl=component>.

detailed way does compromise the integrity by the decision-maker. Interest arbitrators therefore ought not to be hesitant to apply legislative criteria. This is especially desirable because criteria and standards – such as those I propose in Chapter 6 centered on patient safety values – are a crucial vehicle for ensuring that patient interests are adequately represented in the interest arbitration process. It might be possible to persuade interest arbitrators to reverse course on this issue if different criteria were used. For example, instead of the broadly framed factors presently in the Ontario legislation, more detailed guidelines could be formulated, perhaps jointly by the nurses' union and government. If the criteria arbitrators must apply are developed in a common manner such as this, there should be no objection from arbitrators that applying them would somehow jeopardize their neutrality.

Lack of Intelligible Reasons

The failure to apply legislative criteria is part of another larger problem with how interest arbitrators decide patient safety issues: the utter lack of any meaningful written analysis in their reasons. In almost all awards, the arbitrators make little or no reference to evidence or submissions, and often give just bottom-line results, without any reasons. To illustrate this tendency toward sparseness and opacity, I quote from a 2007 Ontario central arbitration award. On the two patient safety-related issues before it, the panel simply recited the proposal and its decision:

ONA's first proposal, amending Article 14.01(a), for full-time nurses only, is that if a nurse is required to work on a day they are not scheduled to work, and the day is a paid holiday, the nurse will be paid double their straight time hourly rate. We award this proposal, effective April 1, 2007.

ONA next proposes the following change to Article 14.06: ONA wishes to have a qualification to an entitlement removed. The provision guarantees 4 hours' minimum pay if a nurse is required to work outside their scheduled hours. The qualification limits the entitlement to time-and-one-half times the hourly rate for the hours worked, with no 4-hour minimum, if the work period overlaps with the nurse's scheduled shift. We decline to award this proposal.⁵⁰³

Sometimes, interest arbitrators do give reasons, but even then, they are generally framed and often simply repeat the replication principle.⁵⁰⁴ For example, in a 2015 award, the panel stated:

The employer proposes language that would, in effect, remove the requirement to schedule employees off three out of six weekends, and would also delete the requirement to pay a premium in event that a nurse works more weekends. While the employer characterized this proposal as an attempt to clarify issues around weekend work, it would be more properly characterized as a cost-cutting proposal that would enhance the employer's scheduling flexibility. There is no question that such a change would represent a major issue for the members of this bargaining unit and the Board is of the view that awarding the employer's proposal would not replicate the likely outcome of free collective bargaining. As a result, the proposal is denied.⁵⁰⁵

In all the local interest arbitration awards reviewed, the arbitrators gave no more than two and in most cases one paragraph of reasons. In *Guelph General Hospital* (2012), for example, the employer had requested some additional exceptions to the payment of weekend and long shift premiums. The arbitrator's analysis was as follows:

The union opposes the change on the basis that it restricts the payment of a premium designed to act as a deterrent to the increasing pressure on nurses to work weekends.

⁵⁰³ *Participating Hospitals v. Ontario Nurses' Assn. (Collective Agreement Grievance)* [2007] O.L.A.A. No. 101 (Albertyn, Filion, McIntyre) paras. 42-43.

⁵⁰⁴ *Grey Bruce Health Services v. Ontario Nurses' Assn. (Collective Agreement Grievance)*, [2015] O.L.A.A. No. 173 (Stephens (Chair), Hughes, Kuhne), para. 4; *Lakeridge Health Corp. v. Ontario Nurses' Assn. (Grievance 201400337, Local Issues)*, [2015] O.L.A.A. No. 70 (Stephens (Chair), Hughes, Kuhne), para. 9; *Peterborough Regional Health Centre v. Ontario Nurses' Assn. (Grievance 201400793, Local Issues)*, [2015] O.L.A.A. No. 68 (Stephens (Chair), Hughes, Kuhne), paras. 4-5; *Chatham-Kent Health Alliance v. Ontario Nurses' Assn. (Collective Agreement Grievance)*, [2012] O.L.A.A. No. 362, paras.5-6.

⁵⁰⁵ *Lakeridge Health Corp. v. Ontario Nurses' Assn. (Grievance 201400337, Local Issues)*, [2015] O.L.A.A. No. 70 (Stephens (Chair), Hughes, Kuhne), para. 9.

The Board declines to award this proposal.⁵⁰⁶

There have been occasions where an interest arbitrator discusses the purposes behind patient safety-related proposals. In *Campbellford Memorial Hospital* (2012), for example, the panel considered the hospital's request to add a qualification to weekend premiums for nurses. In declining to award this proposal, the arbitrator wrote:

The Board is of the view that the current provision is within the norms of similar provisions found in other ONA collective agreements in the province. Such provisions, in our view, are intended to act as a penalty to limit the scheduling of individual nurses to numerous weekends, thus avoiding the disruption to participation in activities outside the workplace. In other words, if such provisions work properly, nurses will not be paid such premiums on a regular basis because they will not be scheduled to work additional consecutive weekends. The employer is in something of a bind because of the difficulty in sustaining funding in order to staff at a level that will permit more efficient scheduling. However, it is the Board's view that, from the perspective of the replication of collective bargaining alone, it is difficult to accept that in this circumstance the Association would have agreed to relinquish the premium in free collective bargaining. As a result, the proposal is denied.⁵⁰⁷

However, this passage illustrates that interest arbitrators, even when opining about the purpose of a patient safety-related clause, will always revert to an explanation in terms of a private benefit to nurses.

One explanation for the reluctance of interest arbitrators to give reasons is their desire not to seem partial to one side or another. A better reason, though, is likely that interest arbitrators simply do not see their process as judicial in nature; rather, they see it as simply an extension of the contractual wishes of two private parties, with no wider importance. Arbitrators' spare reasons not only preserve their acceptability to the parties

⁵⁰⁶ *Guelph General Hospital v. Ontario Nurses' Assn. (Renewal Collective Agreement Grievance)*, [2012] O.L.A.A. No. 176 (Stephens, Kuhne, Hughes), paras. 10-11.

⁵⁰⁷ *Campbellford Memorial Hospital v. Ontario Nurses' Assn. (Local Issues Grievance)*, [2012] O.L.A.A. No. 460 (Stephens, Kuhne, Hughes), para. 12.

for future work, but also preserve the opacity of the true reasons underlying their decisions.

In my view, this is an impoverished and insufficient view of interest arbitration on patient safety-related nursing issues. Arbitrators' reasons are all the citizen has to explain what are important health policy decisions. Wagnerist labour law theory exerts a strong pressure on these arbitrators to bring a sense of modesty and sparseness to their decisions, so these tendencies can be understood. But if interest arbitration is to transform into the evidence-based, transparent forum I propose in Chapter 6, at a minimum these Wagnerist tendencies must be rejected in favour of a practice of fulsome reasons and a strong regard for the public interest as expressed by mandatory criteria and standards they are to apply.

No Review Mechanism

My final observation about the limits of interest arbitration at deciding patient safety disputes is the lack of any legal mechanism to review such decisions. It is a curiosity that so many decision-makers of one kind (interest arbitrators) have so often refused to follow legislative norms on such important policy issues, but have almost never attracted judicial review on substantive grounds. Certainly, governments or unions could invoke some or all the doctrines of abuse of discretion (in that the arbitrator failed to consider factors deemed by the legislature to be vital) unreasonableness (ignoring the criteria is a “palpable and overriding” error) or natural justice (affected parties are entitled to reasons why the criteria did not matter). However, there have been just a handful of cases involving a judicial review of an Ontario hospital interest arbitration award. In every

reported case in which an arbitrator's award was challenged based on reasonableness, the courts dismissed the challenge based on the wide discretion granted to the arbitrators and the expertise they are deemed to bring to their decisions.⁵⁰⁸

Certainly, insulating decision-makers like arbitrators and labour relations boards from judicial review or appeal is a fundamental theme in labour law, because of the long-held beliefs that the courts are inherently hostile to the interests of unions and that they lack expertise in labour relations. Wagnerism demands finality and stability in decisions, whereas democratic values demand accountability on decision-makers where they fail to act within the bounds of rationality. In Wagnerism, a final decision is sufficient; in health policy, a good decision – or at least one justifiable with reference to health policy values - is essential.

In my view, Wagnerian principles do not have the same weight when broader public interests are at stake in these decisions. In the case of workload, hours of work and scheduling issues, I believe that wider patient safety interests are affected by the decisions interest arbitrators make. Therefore, an avenue of appeal or review is vital to ensure that decisions are aligned with evidence as well as any legislative criteria or guidelines that have been enacted to apply to a given patient safety issue.

⁵⁰⁸ *Komoka Nursing Home Ltd. v. London and District Building Service Workers' Union, Local 220* [1976] O.J. No. 11 (Ont. Div. Ct.); *Brockville Psychiatric Hospital v. Ontario Public Service Employees Union, Local 439* [2007] O.J. No. 40, 158 L.A.C. (4th) 385, 220 O.A.C. 154, 153 A.C.W.S. (3d) 1128 (S.C.J.); *Service Employees International Union, Local 1 Canada v. Participating Nursing Homes*, 2013 ONSC 4650, [2013] O.J. No. 3304 (Div. Ct.); *St. Gabriel's Villa of Sudbury v. Ontario Nurses' Assn.*, 2015 ONSC 3459, [2015] O.J. No. 3049 (Div. Ct.).

Analysis and Critique

In Chapter 2 I argued that nursing workload and time worked are matters of public interest, and as such should be decided in the same ways we ideally wish all health policy decisions to be made: in open, evidence-based ways that involve the participation of patient advocates. Utilizing the labour law model in which nurses' unions bargain with provincial government is a poor forum for deciding issues of nursing workload and time worked. Decision-making in nurse collective bargaining under the current model occurs according to distinct customs and traditions specific to that labour law model – one that even in the public-sector realm takes no larger interest beyond the parties to the agreement. Decision-making on issues of patient safety should according to evidence-based decision making, transparency and participation – all features lacking in the labour law model.

The primary focus of collective bargaining is upon wages and patient safety issues were too often marginalized in bargaining to the point where they vanished entirely by the time negotiations concluded. From 1999 to 2014 in the six provinces under study, collective bargaining resulted in significant wage increases, which the unions argued were necessary for recruitment. The Wagnerist labour law model creates incentives to prefer economic issues, and collective bargaining has almost always been wage-centric. Nurses' unions must mediate between a wide variety of nursing employment issues, and make difficult choices about which ones are most important. Because collective bargaining forces patient safety issues into a structure of adversarial negotiation in which difficult trade-offs must be made by both unions and employers, giving equal priority to all issues is simply not possible for either side. Forced to choose between what are classic

private, economic issues that are easily costed and translated into short-term economic gain for their constituency on one hand, and mixed professional/economic issues that do not share these features, nurses' unions have incentives to prefer the former over the latter. Thus, under the current labour law model there will always be issues that ought to be raised in a transparent institutional forum but that are of necessity left unaddressed.

The highly centralized, multi-employer nature of nurse collective bargaining, which emerged from tactical incentives built into Wagnerism, also limits decision-making on patient safety issues. As mentioned in Chapter 3, centralization emerged from the wishes of each side to consolidate the bargaining process to maximize their bargaining leverage within the Wagnerist labour law model. However, it is far from ideal as a structure for deciding complex, often site-specific workload and time-worked issues. Certainly, many terms and conditions such as wages and benefits may warrant uniformity across each province. Yet just as many others, including patient safety issues, are unsuitable for centralized decision-making, which cannot possibly be responsive to all the different contexts in which nurses practice. The centralized structure also forces hospital employers' views and interests into a single set of demands that cannot possibly respond to all their diverse needs. Local employers such as hospitals are best situated to identify and prioritize their proposals for promoting cost-effectiveness and accessibility in acute care services. But in negotiations, higher levels of government typically come to dominate the bargaining agenda. Issues of great importance at a local hospital level can disappear from the central bargaining agenda, traded off by government negotiators for short-term political motives. Patient safety issues are most likely to be decided in ways most

responsive to local distinctiveness and specialization in a decentralized bargaining structure.

The secrecy of bargaining on patient safety issues was also a problem. Given the importance of the issues in dispute to the public interest, the decisions of both nurses' unions and governments leading to disputes and settlements ought to be publicly known so that they may be held accountable for them. However, the predominant trend was for the level of secrecy to increase with the level of dispute. During disputes, bargaining was always conducted in private, with few but the most basic details leaking to nurses and the public. Information about bargaining was only disclosed selectively and tactically. Some rounds were very open, public affairs, but only because the unions or governments saw a tactical advantage in bargaining through the media. Regardless of how public the disputes became, however, secrecy still shrouded the crucial final days of bargaining in which key decisions were made. All this secrecy accorded with typical negotiation customs under the Wagnerist labour law model.

To make informed judgments about the rationality of the decisions by each side in the disputes, citizens should be aware of the issues in bargaining, the disputed issues, the parties' positions and the claims (especially performance claims supported by evidence) each advance in support. Ideally, citizens should not have to depend on the mass media to give clear explanations of key issues and positions in the dispute such as agreement terms, legal terms, proposed changes. However, current practice in the nurse collective bargaining system is very much contrary to these ideals.

Because of the parties' reticence about sharing their bargaining decisions with the public, the task of informing the public fell to the media. However, the typical media

approach to nurse bargaining disputes did little to enlighten the public about internal decisions made by the parties, and focused more on the potential for a highly-politicized dispute that could affect the continuity of services. Only as the prospect of a strike affecting essential services grew more real did media coverage begin to focus on the substantive issues in dispute. Some news outlets did in-depth analyses of the issues in dispute, using the strikes to produce large feature pieces on the nursing shortage.

Wagnerist labour law theory is also at work in the minimization of evidence-based decision making on patient safety issues in bargaining. In traditional collective bargaining, external parties are unwelcome at the negotiating table, and the same applies to any findings, scientific or otherwise, external parties might wish to apply to a dispute. Thus, evidence of the type reviewed in Chapter 2 appears only sporadically if at all in the public discourse on patient safety issues during labour negotiations. Rather, sheer bargaining power in the form of political and economic leverage, becomes the determining factor. This axiom applies in patient safety disputes that are both settled and arbitrated: as described below, interest arbitrators have made as the basis of their decisions a prediction about which of union or employer would “win” in a free bargaining context.

The “emergencification” of nursing labour disputes discussed above arises directly from the Wagnerist insistence on the strike mechanism as the method of settling disputes. And since the strike mechanism has been constitutionally enshrined since the 2015 Saskatchewan Federation of Labour decision of the Supreme Court of Canada⁵⁰⁹, it will be that much more difficult to craft a strike-based model that avoids this

⁵⁰⁹ *Saskatchewan Federation of Labour*, *supra* note 2.

“emergencification” tendency, because there is simply no avoiding the fears that arise when the concept of a nurses’ strike is floated in public discourse. The essentiality concerns that arise every time a nurses’ strike becomes even possible further push decision-making toward a speedy, rather than rational, settlement. The emphasis on immediate patient protection during a strike – the classic dispute resolution method mandated by Wagnerism – changes the form of the political discourse from one between professional and managerial values to one between public health policy interests and private employment interests. The main priority in this context is to reach an agreement, above all else. When governments act to end a nurses’ strike, public attention – and that of industrial relations experts - tends to taper off, because the restoration of hospital services increases confidence in the system.

More troubling is that the continued use of the strike mechanism has the effect of leaving nurses with insufficient voice on patient safety issues. The experience reviewed above shows that the “limited strike” experiment – trying to maintain the right to strike while protecting patients during strikes – is too formidable a task to be achieved, because nursing work is simply too essential to be interrupted even in part. The effect of this failure is to leave nurses’ unions with a level of voice far below that which the public would expect them to have under the labour law model. Certainly, in some rounds of bargaining nurses’ unions have been able to extract significant wage increases and other gains, including on patient safety issues. The problem is that to achieve these gains, the unions had to skate close to the line of a lawful strike, whether by calling a strike vote or any other job action leading up to a lawful strike. The risk of running afoul of the “limited strike” laws in place

in each of the strike-based provinces cannot help but have placed a chill of sorts on the willingness of the unions to press their demands aggressively.

Thus, the experience from 1999-2014 in Canadian nurse collective bargaining suggests that, in practice, nurses' unions have seen their bargaining power rapidly disappear once it is exercised, and have been forced into an impossible choice between their bargaining interests and compliance with the law. A cruel footnote to this is that, in almost every dispute involving even the hint of a nurses' strike, the risks to the accessibility and safety of the health care system were significant. Whether legal or illegal, threatened and actual job actions caused employers to take often-drastic measures: removing patients, cancelling surgeries, closing beds.⁵¹⁰ It is difficult to estimate with absolute precision how many patients were placed at risk because of these measures, but certainly they numbered in the thousands in each round in which these measures were used. Little of it, though, involved actual refusals to provide nursing care within normally scheduled working hours. Most of it arose due to the pre-emptive measures taken by employers. Most of the pre-emptive measures taken by employers were not based on independent assessments of risk but the subjective fears of the employers. With tort liability concerns and defensive medicine prevalent in health care generally, it is not a stretch to suppose that employers sometimes over-reacted, closing and cancelling more than was needed to avoid patient harm.

⁵¹⁰ These measures occurred in many of the rounds in which the prospect of a work stoppage grew to become plausible. Specifically, it happened in the 1999 Alberta round, the 1999 Saskatchewan round, the 2001 British Columbia See *infra* Appendix: Nurse Collective Bargaining Rounds for more details on these disputes.

Conclusion

The collective bargaining and interest arbitration experiences reviewed in this Chapter suggests that, as a patient safety advocacy mechanism, nurse collective bargaining as it is presently structured has important limitations. Fundamentally, this is because of the legal underpinnings of the labour law systems in which nurse bargaining takes place, which I reviewed in Chapter 3. The customs and traditions of Wagnerism inform all the trends witnessed between 1999 and 2014 in nurse labour relations in the six provinces in focus here. Patient safety issues are most often subordinated to economic issues, and it has proven difficult for nurses' unions to achieve strong patient safety protections in provinces that continue to use the strike mechanism to resolve disputes. When nurses' unions have a strong case to make in favour of a particular patient safety demand, they should not be forced – as they are in five of the six provinces under review here - to use the strike mechanism, a tactic that places them in legal and ethical peril, and creates an emergency atmosphere of decision-making out of even the prospect of a strike vote. This is not merely bad for nurses; it is bad for patient safety. With the critiques in this Chapter in mind, I turn now in Chapter 6 to suggesting reforms that will improve nurse collective bargaining as a decision-making forum for patient safety issues.

CHAPTER SIX: LABOUR LAW REFORMS TO PROMOTE PATIENT SAFETY

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Introduction

In the preceding Chapters I argued that the current Wagnerist labour law models for nurse collective bargaining at the provincial level are poor forums for the resolution of patient safety issues of nursing workload and time worked. In this Chapter I propose some changes intended to remedy those problems. I argue that these issues should instead be decided in separate, locally-based forums which I suggest be called “patient safety committees”. A “patient safety committee” framework will be a better forum than the current labour law model for raising, debating and deciding workload and time-worked issues. In this forum, I argue, patient safety issues will be decided in a more open, evidence-based and polycentric way than they presently are under the Wagnerist labour law model. In such a process, the issues will be treated like policy problems, and patients’ interests will be the primary organizing principles, rather than as derivatives of the interests of health providers such as nurses. After outlining the elements of this proposed “patient safety committee” scheme, I turn to consider and respond to some objections that might be levelled at this scheme.

Proposed Reforms: a “Patient Safety Committee” Model

My proposed reforms are as follows:

Remove Patient Safety Issues from Collective Bargaining: In each province, all nursing employment issues related to nursing workload or time worked (hereinafter called “patient safety issues”) will be removed from the current nurse collective bargaining structures. This can be accomplished through legislative measures that define these issues and provide that any agreements between the parties are void and do not form part of the collective agreement.

I should pause here to elaborate briefly on the broader criteria I use to support the transfer of nursing workload and time worked issues from the scope of collective bargaining to a policy process such as I describe here. These criteria are vital for the assessment of future claims that other issues may also warrant such a transfer out of the realm of “normal” collective bargaining. In this spirit, to be appropriately removed from collective bargaining to a policy process, the issue(s) in question must meet three criteria:

(1) Is there a clear and convincing evidentiary basis causally connecting outcomes on the issues in question with a vital public interest of citizens? There mere existence of studies suggesting such links is not enough to overcome the strong presumption in favour of leaving issues in collective bargaining. The standard of scientific consensus required should be very high, such that systematic reviews of studies have emerged confirming the link between the bargaining issue and the public interest. Here, as I have argued, the issues of nurse workload and time worked met this evidentiary threshold.

(2) Has the government undertaken meaningful consultation about the proposed removal of issues with the affected unions and employee groups and sought agreement from them for such removal? For the sake of labour relations stability alone, governments considering removing issues from collective bargaining must undertake meaningful consultation and negotiation with the affected unions. As laid down in the *Health Services*⁵¹¹ decision and followed by the Supreme Court of Canada in subsequent cases⁵¹², governments must engage in such consultation before legislating to remove of any issues from collective bargaining. In my view, this is not only a legal requirement but also a sound policy criteria, because unilateral government action to reform the collective bargaining system itself likely creates more labour relations conflict and casts doubt on the integrity of the labour law model.

(3) Will the removal of the proposed issue from collective bargaining significantly impair the ability of the affected union(s) to bargain collectively on the issues that remain within the scope of bargaining? Here again I borrow from the Supreme Court's freedom of association analysis in *Health Services*. There, the Court held that only if an issue removed from collective bargaining is vital to the union's fundamental ability to exercise meaningful bargaining rights will that removal infringe freedom of association.⁵¹³ In the same spirit, the test I propose for whether

⁵¹¹ *Health Services*, *supra* note 2.

⁵¹² *British Columbia Teachers' Federation v. British Columbia*, *supra* note 276 .

⁵¹³ *Health Services*, *supra* note 2 at paras. 93-95. McLachlin C.J. and LeBel J. held for the majority that the issue removed from bargaining must be more than just important to workers; it must go further and affect "the capacity of the union members to come together and pursue collective goals in concert." At para. 95, they further elaborated on this point:

Interference with collective bargaining over matters of lesser importance to the union and its capacity to pursue collective goals in concert may be of some significance to workers. However, interference with

to transfer an issue from collective bargaining to a policy process focuses on whether the union still has meaningful bargaining power in the main negotiation process after such an issue has been removed from its jurisdiction. In the present case, since many key issues such as wages remain within the ambit of collective bargaining, the removal of workload and time worked from that process would not leave the nurses' unions with a meaningless bargaining process.

These three criteria are aimed at ensuring that only those issues with a clear and convincing policy dimension are removed from collective bargaining, and ensuring that the negative effects on the legitimacy and credibility of the bargaining process that remains after such a removal are minimized.

Create "Patient Safety Committees": Patient safety issues of nursing workload and time worked will instead be decided in locally-based policy frameworks – possibly called "patient safety committees" - which blend elements of negotiation and public policy structures. Proposals for nurse-patient ratios, for example, could be removed from the current nurse bargaining processes and determined instead in patient safety committees.

Structuring Patient Safety Committees: These "patient safety committees" would function like traditional collective bargaining, by proposals and responses by the nurses' union and local employers, but incorporate participation by patient representatives and an emphasis on the use of evidence such as systematic reviews to guide negotiation and debate. The consensus of all parties – including patient representatives – would be

collective bargaining over these less important matters is more likely to fall short of discouraging the capacity of union members to come together and pursue common goals in concert. Therefore, if the subject matter is of lesser importance to the union, then it is less likely that the s. 2(d) right to bargain collectively is infringed.

necessary before any resulting terms become legally enforceable. In their polycentric design, patient safety committees could borrow elements from the existing Nursing Advisory Committee models for determining workload complaints under the Ontario nurses' agreement.

Localizing Patient Safety Issues: All outcomes of patient safety committees will be local. In provinces with regionalized health care delivery, these committees could operate at the regional or even sub-regional level. The idea behind localizing patient safety issues is that finding the best workload or time-worked policies and rules for reducing adverse events is most likely at a local, not provincial, level. Nurse-patient ratios that reduce error in one context, like intensive or critical care units, might for example be excessive and needlessly costly in another context such as palliative care. Taking patient safety issues out of the realm of central union-government relations will eliminate all the difficulties created by centralization mentioned in Chapter 5.

Specialized Arbitration to Resolve Patient Safety Disputes: There will be no lawful right to strike or lock out in any dispute that arises in a patient safety committee. Patient safety issues will be decided like policy issues, with rigorous consultation and the use of evidence in deliberations. Disputes within the patient safety committee will be resolved by an adjudication process based on interest arbitration on the Ontario model but with significant modifications. These modifications, which parallel some of the Drummond Commission's 2012 suggested reforms to the Ontario interest arbitration model for hospitals, are as follows.

Who Decides? Like the existing Ontario framework, disputes would be decided by a tripartite panel of arbitrators. If the parties cannot agree on a chair, then a minister

will have an appointment power, but be restricted to choosing from a standing roster of adjudicators.⁵¹⁴ This standing roster will be comprised partly of existing labour arbitrators but also experts in nursing, health policy, and patient safety. Such experts could be drawn from the existing ranks of researchers and analysts at provincial health quality councils. Appointments to my proposed roster of arbitrators would be made by the Minister after mandatory consultation with nurses' unions, citizen groups and other interested parties. Appointments to particular disputes would ideally be on a random basis, so that neither the Minister nor the unions know who will be deciding until a dispute is remitted to arbitration. Measures will be needed to protect the independence of appointees to such a roster, otherwise the entire arbitration model could easily lose legitimacy as a mere arm of the government. Such measures could include fixed term appointments or other security of tenure measures that would greatly foster apprehended and actual impartiality of decision making.

Patient Safety-Centered Criteria: Vague criteria such as those used in Ontario now (e.g. “replication” and “reasonableness”) are of little use as norms of decision for patient safety disputes. In my view, two reforms are necessary. First, governments, in consultation with nurses, employers and patients' rights groups, should formulate comprehensive, detailed criteria for interest arbitrators to use, and that are centered around promoting outcomes on workload, hours of work and scheduling which the most current evidence suggests are best at reducing the risk of medical error. Second,

⁵¹⁴ The Drummond Commission recommended using a standing roster of arbitrators assigned to cases rather than have the parties appoint them: *Drummond Report, supra* note 342 at 371.

legislation should mandate that arbitrators follow these guidelines and make explicit reference to them in their reasons, the failure of which would be an error of law.

Mandatory Use of Evidence: Arbitrators must be required to solicit from the parties and other interested groups academic, scientific and other expert evidence bearing on issues in dispute. In some instances, arbitrators may even properly call, or allow a party to call, an expert witness for testimony. Legislation should also impose clearer duties on arbitrators to follow applicable standards and make reasonable findings of fact based on the evidence before them.

Openness and Activism: Presently, interest arbitration is a cloistered process, tending to exclude all but the immediate negotiating parties. As well, interest arbitrators seldom if ever embark on inquiries at their own instance. They rely, as in traditional labour arbitration, on the parties to frame the issues and carry out fact-finding analyses. In my view, these trends impede the transparency and participative nature of interest arbitration. I propose allowing intervenors and other modes of participation in the interest arbitration process leading to the resolution of patient safety issues.⁵¹⁵

Mandatory and Detailed Reasons: Arbitrators will be required to provide fulsome written reasons for their decisions on patient safety issues. By “fulsome”, I mean reasons that connect their conclusions to the criteria and evidence before them. Presently, arbitrators are hesitant to explain their conclusions, preferring to state only their bottom line decision without elaboration. Written reasons will enhance confidence in the parties

⁵¹⁵ The Drummond Commission recommended creating “transparency” of interest arbitration decisions through publication and accessibility to the public, stating that “this is a form of external regulation by virtue of pressure from the parties and the interested public.”: *Drummond Report, supra* note 342 at 371.

and public that objective criteria and evidence have guided decision making. If required to provide reasons, arbitrators will of necessity must address and evaluate the submissions and evidence led by each side. The resulting format of reasoning - the 'facts-submissions-decision' format familiar in labour arbitration – will reflect a careful consideration of the issues that lends greater legitimacy to the outcomes as policy decisions. Reasons are vital to any rights of appeal or review from the arbitration decision that a party may seek.

Review Mechanism: To date, review of interest arbitration awards – by either courts or administrative tribunals - has been virtually nonexistent. Despite their failure to apply criteria, to supply reasons, or any other potential grounds for review in particular cases, judicial reviews of interest arbitrators have been rare and never successful on reasonableness grounds, in large part because of the extensive deference shown to labour arbitrators and the resultantly low (reasonableness) standard of review applicable to judicial reviews of their decisions. In my view, however, legislation to create a limited but accessible review process would democratize the entire arbitration process.⁵¹⁶ The prospect of review would act as a useful check on arbitrators' tendencies to ignore applicable standards, and on their tendencies to furnish insufficient written reasons. In my view, however, it is crucial to the function of this appeal mechanism that it be available only in narrow instances and show the highest deference to the decision of the interest arbitrator known to administrative law. Decisions should not be susceptible to review except where they can be characterized as unreasonable. An arbitrator's supposed

⁵¹⁶ The Drummond Commission recommended "[m]onitoring" of arbitration awards to ensure "...that decisions reflect clear assessments based on criteria specified.": *Drummond Report, supra* note 342 at 371.

misapplication of a standard, for instance, would not be reviewable error, whereas a failure to consider the standard entirely would.

Interest Arbitration Reforms in Sum: The purpose of the foregoing reforms is to create a dispute resolution mechanism for patient safety issues guided by comprehensive, detailed policy criteria based on the best available evidence. In my view, such a mechanism would have a salutary feedback effect on the patient safety committee process. It will move nurse collective bargaining away from the model of a politically dramatic election campaign and toward a democratic, evidence-based health policy process. If the parties on patient safety committees know which norms and evidence will control results in arbitration, they will have more incentive to use those norms and evidence in their committee strategies.

Implementation and Enforcement: Decisions of these patient safety committees – whether by agreement or arbitration on the model above - would be translated to specific workplace rules or policies applicable to the local employer. They would not be treated as terms of a collective agreement, but rather as subordinate legislation like bylaws or regulations. For providing a binding enforcement mechanism, these workplace rules or policies would be accompanied by a mandatory grievance and “rights” arbitration process similar in structure to that found under existing nurse collective agreements. Such arbitrators would be drawn from the same pool of adjudicators used for the interest arbitration process described above.

This patient safety committee model will share some features with the Wagner model but will fundamentally be a policy process rather than a negotiation. As such, it is designed to remedy the problems outlined in Chapter 5 related to the customs and

traditions of Wagnerist collective bargaining. By removing patient safety issues from the cut and thrust of positional negotiation tactics and ploys, it removes the influence of those customs on decision-making. Instead, patient safety issues are treated like public policy matters. Separating out patient safety issues will also lessen the chances of important evidence-based patient safety rules being discarded or passed over as a concession in bargaining. By involving patient representatives and giving them a meaningful voice at the policy table, and by opening the process up to public view, proposals that would improve patient safety will have a better chance of becoming law in the nursing workplace.

Removing the resolution of disputes on patient safety issues from the realm of the strike mechanism will remove all the mischiefs I identified in Chapter 5 associated with the continued use of the strike mechanism to settle patient safety disputes. An emergency context, and one in which nurses rapidly lose political voice, will be replaced by an evidence-driven, multiparty policy debate between local parties. Nurses, like all health professions, must have a voice in health policy decisions. In my view, their voice is stronger under a system of principles and evidence bolstered by the interest arbitration model I propose below, than under the existing Wagnerist model, where raw political power and tacticality govern the results.

In line with the shift away from the strike mechanism, patient safety committees will be required to make systematic use of evidence in their debates and decisions. As Chapter 2 showed, evidence on nursing and patient safety is vast and constantly being updated, reviewed and synthesized. Health care administrators are always seeking evidence on the systemic factors leading to adverse events, and nursing workload and time-worked research reviewed in Chapter 2 is but a sliver of the entire body of knowledge

available on a wide range of nursing-related patient safety issues. Further, the invitation of comment from health policy observers, nurse professional bodies, and other professions would enhance the base of evidence available to the committees.

The “patient safety committee” model I propose will bring greater transparency to how patient safety decisions are made. Transparency is a key aspect of accountability. Increasingly, citizens and interest groups are demanding to know more about the health care system in general: how much it costs, where we choose to allocate resources in it, and myriad other operational issues. The need for accurate information is directly rooted in accountability. As Senator Kirby noted in 2002:

Fundamentally the underlying issue is one of accountability. In order to establish who is to be held accountable for the deficiencies (and also the strengths) of the health care system, the Committee has repeatedly pointed out that detailed and reliable information on the performance of the system and on health outcomes is essential.⁵¹⁷

Similar principles apply to the determination of patient safety issues. The model I propose will infuse patient safety values into the parties’ decisions and debates. The proposals, counterproposals and claims made by each side would be publicly visible, so that the patient safety-related claims each side makes to the public can be better evaluated and compared. Presently, the parties often give the public widely differing accounts of the events inside the bargaining room, accounts that typically conform to their broader bargaining proposals. Greater transparency of such events would bring greater discipline to the discourse that takes place during bargaining. In a similar vein, decisions on difficult patient safety issues will have more legitimacy with patients and the public if patients are represented. There is ample precedent for grassroots citizen involvement in Canadian

⁵¹⁷ Kirby Report, *supra* note 165, Part 1, Chapter 1.

health policy. In some provinces, accountability mechanisms now feature participation by citizens in regional health board decision-making.

It is not without precedent in public sector labour relations for governments to take certain subjects outside the purview of collective bargaining because those decisions on those subjects are public policy decisions for which governments are accountable. In Quebec, for example, the statutes that create its public sector bargaining structure specify that wage rates are not a subject of collective bargaining, but rather are to be set by the Cabinet through a regulation.⁵¹⁸ Under the Quebec government collective bargaining statute, “salaries and salary scales” must be negotiated by the government in good faith⁵¹⁹, but ultimately government retains the prerogative to set wages.⁵²⁰ In practice, the Quebec government and its public sector unions negotiate over wages in the sense of the government consulting the unions before fixing them in regulation.

In Canada, the closest analogue to my proposed carving-out of patient safety issues from nurse collective bargaining has also come from the public education sector. In 2002, the British Columbia government enacted legislation, Bill 28⁵²¹, which removed a series of listed subjects, including class size, from the realm of teacher-government

⁵¹⁸ *An Act Respecting the Process of Negotiation of the Collective Agreements in the Public and Parapublic Sectors*, CQLR c R-8.2 (the “*Quebec Public Sector Labour Statute*”), ss. 53-56.

⁵¹⁹ Section 53 of the *Quebec Public Sector Labour Statute*, *supra* note 518, provides: “the Conseil du trésor, in collaboration with the management negotiating committees established under this chapter, shall negotiate with the groups of associations of employees or, as the case may be, the associations of employees in view of reaching an agreement on the determination of the salaries and salary scales.”

⁵²⁰ Sections 54 to 56 of the *Quebec Public Sector Labour Statute*, *supra* note 518, dictates that wages are to be set by regulation drafted, reviewed in the National Assembly and enacted. Section 56 provides: “Once fixed by regulation, the salaries and salary scales shall form part of the collective agreement and have the same effect as clauses negotiated and agreed at the national level.”

⁵²¹ *Public Education Flexibility and Choice Act*, S.B.C. 2002, c. 3 (“Bill 28”).

collective bargaining in that province.⁵²² The government's stated purpose for removing the listed subjects from teacher collective bargaining was that these subjects were matters of education policy, which should be decided not in private collective bargaining but in open, public consultative processes. British Columbia's central teachers' union, the B.C. Teachers' Federation, challenged Bill 28 on the basis that, by removing these subjects from collective bargaining, the government had infringed the teachers' freedom of association guaranteed by section 2(d) of the *Charter*. However, the union's *Charter* challenge was adjourned until after the Supreme Court of Canada had decided the *Health Services* case in 2007. In *Health Services*, to recall, the Court held that section 2(d) guarantees a meaningful process of collective bargaining, and struck down legislation, enacted with Bill 28, which removed certain subjects from central health care collective bargaining. In 2011, the trial judge from the B.C. Supreme Court struck down Bill 28⁵²³, but was reversed on appeal to the B.C. Court of Appeal, which held that the province had provided a meaningful process of consultation to the teachers' union before enacting Bill 28, thus satisfying the requirements of section 2(d) of the *Charter*.⁵²⁴ This ruling was,

⁵²² Bill 28, *ibid.*, provided, in part:

27 (3) There must not be included in a teachers' collective agreement any provision

...

(d) restricting or regulating a board's power to establish class size and class composition,

(e) establishing or imposing class size limits, requirements respecting average class sizes, or methods for determining class size limits or average class sizes,

(f) restricting or regulating a board's power to assign a student to a class, course or program,

(g) restricting or regulating a board's power to determine staffing levels or ratios or the number of teachers or other staff employed by the board,

(h) establishing minimum numbers of teachers or other staff,

(i) restricting or regulating a board's power to determine the number of students assigned to a teacher, or

(j) establishing maximum or minimum case loads, staffing loads or teaching loads.

(4) Subsection (3) does not prevent a teachers' collective agreement from containing a provision respecting hiring preferences for teachers who have previously been employed by the board.

(5) A provision of a teachers' collective agreement that conflicts or is inconsistent with subsection (3) is void to the extent of the conflict or inconsistency.

⁵²³ *British Columbia Teachers' Federation v. British Columbia*, 2011 BCSC 469.

⁵²⁴ *British Columbia Teachers' Federation v. British Columbia*, 2015 BCCA 184.

however, itself reversed by the Supreme Court of Canada in 2016, which agreed with the trial judge's finding that there had not been meaningful consultation before Bill 28 was introduced.⁵²⁵ The message from these decisions is that governments must engage in truly meaningful consultation with affected unions before removing any subjects from collective bargaining by statute, and that the courts will hold them to a high evidentiary standard on the consultation issue. Assuming this requirement has been met, governments may remove subjects from collective bargaining without offending the *Charter*.

“Wagnerist” Objections to Reforms

Clearly, Wagnerism continues its dominance as the last word, doctrinally, about employment regulation. Thus, any government moves against Wagnerism will bring swift rebuke. Those who would presume to radically change labour law defiantly ignorant of Wagnerist tradition must heed the lessons of history and the grim fate of many past ambitious labour law reform projects that have not respected tradition. In Chapter 3 I touched on some of the underlying values and purposes ascribed to law in Wagnerist theory, and these become relevant again here as the basis for a series of objections to my proposed reforms. I turn now to consider these objections and attempt to address them by reference to an alternative, contextualized theory of Wagnerism.

⁵²⁵ *British Columbia Teachers' Federation v. British Columbia*, *supra* note 276 . By a 7-2 majority, the Supreme Court reversed the B.C. Court of Appeal's ruling that there had been sufficient consultation with the teachers' unions before Bill 28, and adopted the dissenting opinion of Donald J.A. as the majority opinion of the Supreme Court (at para. 1).

To start with, the threshold idea of turning collective bargaining issues into public policy questions immediately clashes with the voluntarism principle. The starting point of voluntarism is that the private, subjective preferences of the parties govern outcomes. Issues such as workload and time worked are fundamental to the employment bargain, leaving aside their impact on patient safety outcomes. Taking such notionally private issues outside of collective bargaining invites unilateral government action to set employment terms and conditions. Government “consultations” leading up to such actions can simply be seen as a government repudiation of the entire labour relations process. The specter of state control of work looms large in this objection.

Also on voluntarism grounds, Wagnerist labour law theory would object to opening bargaining to public view and inviting participation from notional “outsiders” to the process. Under Wagnerism, collective bargaining is an inherently private affair, and that exposing it to public view will interfere with the timely settlement of disputes by discouraging frank and creative dialogue. The art of negotiation is thought to flourish best in a cloistered environment, one in which the two parties are free to consider as many possibilities for agreement as possible without fear of embarrassment or other prejudice to their interests. Seen from this perspective, more transparency will diminish the resulting legitimacy of the collective agreement to the parties. An agreement resulting from a “public” process cannot have lasting credibility with the parties governed by it.

Voluntarism and associational freedoms are also arguably infringed by the presence of notionally external parties in the bargaining process. Interference by outside interests in notionally private bargaining matters will, from a traditional Wagnerist perspective, doom the labour law system to certain failure. Citizens, expert or not, have

no place scrutinizing the private realm of collective bargaining. Their only valid concerns are with the maintenance of services during work stoppages. Beyond that, they must wait, so to speak, outside the process for results.

In a similar vein, Wagnerism might also object to the use of evidence and criteria. From a Wagnerist perspective, however, increasing the use of evidence and objective standards lessens the importance of the subjective preferences of the bargaining parties, and thereby weakens the voluntarism of bargaining outcomes. Wagnerism cherishes privacy and sees outside participation, whether by persons or ideas, as interference corrosive to the legitimacy of their ultimate decisions. From the Wagnerist perspective, then, as well-intended as evidence-based standards may be, they will still lessen the legitimacy of bargaining outcomes to the immediate parties.

The loudest objections, however, will be to my dispute resolution ideas, starting with my proposal to reject the use of the strike mechanism to resolve disputes on patient safety. This would not foreclose the use of the strike for all other bargaining issues, but it would eliminate it in relation to patient safety issues. Clearly, even limited in this way, this reform would be a very radical change to the nursing labour law model. As noted in chapter 3, the work stoppage – albeit often in restricted form- remains the predominant dispute resolution method in the Canadian nursing labour law system.

Finally, for the same reasons, the changes I suggest to the interest arbitration process would also find some detractors. Under Wagnerism, to recall, interest arbitration is a reluctantly-made concession to the need to preserve essential public services during labour disputes. From this starting point, my proposal to change how arbitrators are chosen would be met with the objection that only labour law “experts” should be chosen.

This is based on the *CUPE v. Ontario* decision mentioned above, in which expertise was defined essentially as prior experience with labour arbitration and acceptability to the parties. Wagnerism would also frown on the idea of requiring arbitrators to apply more legal criteria. To be independent, in Wagnerist theory, interest arbitrators must be free from any but the most general and incontrovertible of standards: thus, “reasonableness” and “replication” are the dominant principles of decision. The standards I propose, no matter how scientifically or pluralistically formulated they may be, are still external criteria. Criteria, according to Wagnerist theory, are impermissible. Arbitrators must be entirely free to decide, which includes freedom from rules of decision. My proposal to open the interest arbitration process to public view and patient participation would offend the principle that interest arbitration be a closed proceeding. And the objection to my proposals to require reasons and a review/appeal process is that these measures will only create more instability in the labour relations system. They will, on this objection, mire interest arbitration awards – and collective bargaining in general – in a malaise caused by a lack of finality in decision-making.

Responses

How do I respond to these Wagnerism-based critiques? By recasting what Wagnerism means in the context of nursing and patient safety, rather than presuming to upend, discard or ignore Wagnerist traditions. My approach will try to work within Wagnerism to find a way its general principles can be adapted to the specific context of nursing work, having regard to the links I have pointed out between nursing workload, time worked and the risk of adverse events.

I challenge the core assumption that the Wagner theory and model of labour relations is the natural, or at least ideal, labour law theory for all contexts. Once it is accepted that labour law is a dynamic entity, rather than one dominated by one theory to the exclusion of all others, the path is clear for doing what has not been done before: analyzing labour law for its impact on social policy and for devising context-specific labour law models. This is not a radical departure: labour law has been undergoing an increasing balkanization in practice and study since its very inception. Labour law is practiced, studied and thought of in its subspecialties rather than as an integrated whole. Some better-known ones are education labour law, public sector labour law, municipal and firefighter labour law, and agricultural employee labour law. Thus, it is now appropriate to embrace the context-specificity of labour law and see it as comprised of various subspecialties with distinct values. This allows for alternative possibilities for labour law system design.

A newer vein of labour law scholarship, however, offers some promise for alternative approaches to labour law design.⁵²⁶ This literature might be called “post-Wagnerist” since it shares the idea that the Wagner model has proven to be ineffective at its traditional goals, but it also seeks to ground labour law in a coherent theory of justification akin to but not identical to Wagnerism. Professor Langille, for example, has argued for evolving new theories of justification for labour law, because the traditional theory – inequality of bargaining power – no longer holds the normative force it once

⁵²⁶ See e.g. H. Collins, “The Productive Disintegration of Labour Law” (1997) 26:4 *Ind.L.J.* 295-309; H. Arthurs, “Labour Law After Labour”, Ch. 1 in Langille & Davidov eds., *The Idea of Labour Law*, *supra* note 258; M. Weiss, “Re-Inventing Labour Law?” Ch. 3 in Langille & Davidov eds., *The Idea of Labour Law*, *supra* note 258; K. Stone, “The New Psychological Contract: Implications of the Changing Workplace for Labor and Employment Law” (2001) 48 *UCLA L. Rev.* 519-661.

did.⁵²⁷ In his view, a new labour law theory ought to posit it as a mechanism for structuring “human capital deployment”.⁵²⁸

In Europe, legal scholars have sought to link the interests of citizens in social policy rights and services with the labour and employment law models used for the workers in those social policy program sectors. For example, U.K. scholar Mark Freedland argued that the emergence and growth of a third “public service sector” in which private firms deliver public services has broken down the traditional public/private divide in labour law and led to a crisis of labour law theory for this emerging sector.⁵²⁹ He explained:

Historically labor law has primarily been seen as a balancing of the interests of employers and employees, with the state figuring in the role of employer in the public sector. There has of course been a consideration of the public-interest for the interests of the community; but this has on the whole played a secondary role. In this new kind of labor law, that third set of interests, newly conceptualized as the interests of the market or consumer citizen, become part of the central balancing process, sometimes even coming into a direct theoretical and practical opposition to the interests of the workforce, especially in the arena of the public service sector.⁵³⁰

Professor Alain Supiot expanded on this theme, arguing that work of public importance carries with it special rights for those who perform it.⁵³¹ Supiot observed the devolution of social service delivery from the state to the private sector across Europe, and the consequent shift in labour law from the public to the private models governing workers in those sectors. He argued that labour law on the contractual, private-sector model was inadequate to the purpose of regulating employment in these sectors, and that there is a

⁵²⁷ B. Langille, “Labour Law's Theory of Justice”, Ch. 7 in Langille & Davidov eds., *The Idea of Labour Law*, *supra* note 258 at 110.

⁵²⁸ *Ibid.* at 112.

⁵²⁹ M. Freedland, “Law, Public Services, and Citizenship – New Domains, New Regimes?”, ch. 1 in M. Freedland & S. Sciarra eds., *Public Services and Citizenship in European Law* (Gloucestershire, UK: Clarendon Press, 1998) at 1-35.

⁵³⁰ *Ibid.* at 25.

⁵³¹ A. Supiot, “Employment, Citizenship, and Services of General Public Interest”, chapter 9 in Freedland & Sciarra eds., *Public Services and Citizenship in European Law*, *supra* note 529 at 157-172.

special link between the interests of the employees in those sectors and the citizen's interest in those services.⁵³²

Having regard to all the foregoing literature, in responding to the Wagnerist critiques of my reforms raised above, my choice seems to be: either dismiss Wagnerism entirely as outdated and ill-suited to health care policy issues, or work within Wagnerist legal tradition. I choose to work within Wagnerism. I believe patient interests, including patient safety, can be incorporated into the Wagnerist labour law theory for nurses to account for the strong evidentiary connection between nursing workload, time worked and adverse events.

Before explaining this “contextualized” approach to justification of my reforms, however, I must explain in more depth the fundamental value of Wagnerist labour law theory within the context of health care policy. This value has three dimensions.

The first dimension of Wagnerism's unique value to health policy is the deeper affinity between labour law and health policy as related components of the larger mosaic of social policy. Both fields are concerned in different ways with the vulnerability of the individual citizen⁵³³ in a capitalist economy. Labour law is concerned with the vulnerability of the citizen as a worker/producer relative to their employers, and health policy with the vulnerability of the citizen in the health care insurance market. Both fields are concerned with an imbalance of power: in labour law, that between employers and employees; and in health policy, that between citizens and health care insurers. Both fields have their own

⁵³² *Ibid.* at 168.

⁵³³ Here, I use “citizen” broadly to mean any person or migrant present in Canada, not narrowly only to those with actual Canadian citizenship.

values and bodies of rights designed to remedy this vulnerability. Labour law is concerned with workplace justice, whereas health policy is concerned with issues of justice and accessibility for all citizens in the supply of health services. Both fields thus aim at removing the economic barriers that injustice in work and access to medical care impose on the citizen's pursuit of self-realization. A living wage and a humane work-life balance is important to allowing individuals self-fulfillment, a modicum of income security and enough time for their families. Similarly, having the state subsidize medically required services frees individuals from the economic barriers created by having to divert personal income to pay for health care.

A second dimension of labour law's value to health policy is functional, in that it improves the conditions of work for health care professionals such as nurses, which in turn can promote greater productivity (as, e.g., urged by the 2002 Kirby Report⁵³⁴) and patient safety. Any concerns about nurses' unions or other unions in health care having too much political influence are can be responded to at least in part by pointing to the benefits of promoting democracy and the rule of law in the workplace. Among these benefits are the increased attractiveness of health care as a career, as well as possible productivity gains. Improved productivity and workforce commitment have been cited as two benefits of paying what have been termed "efficiency" wages. The "efficiency wage" theory in economics holds that firms which pay higher wages realize gains in productivity and employee commitment that can improve firm performance over the long term.⁵³⁵

⁵³⁴ Kirby Report, *supra* note 165 at 187.

⁵³⁵ G. Bulkley & G. Myles, "Trade Unions, Efficiency Wages, and Shirking" (1996) 48:1 *Oxford Economics Papers* 75-88; P. Mühlau & S. Lindenberg, "Efficiency Wages: Signals or Incentives? An Empirical Study of the Relationship between Wage and Commitment" (2003) 7:4 *Journal of Management and Governance* 385-400.

The third and final dimension of labour law's value to health care is that it provides an institutional check against the subsidization of one vulnerable group by another. As Chapter 1 explained, the efficiency imperative in health policy exerts a constant pressure on hospitals, clinics and other facilities to serve more patients – be more productive – while spending remains constant. Pressure to improve performance always devolves downward to the workplace; in health care, downward to the nursing workplace. Imagine for a moment that there was no collective bargaining or labour law applicable in the health care system. Over time, the constant pressure to serve patients would be passed on to front-line nurses and other staff, who have no legal mechanism to resist and demand that management and government invest more in their workplaces in the form of more staff. By providing such a mechanism, the Wagnerist labour law model – imperfect as it may be in health care – provides a vital layer of resistance against this devolution of efficiency demands from government to the nursing workplace. The ideal sought by labour law as a resistance mechanism of this sort is to lessen or eliminate the cross-subsidization of one vulnerable group (patients) at the expense of the other vulnerable groups (workers) in the system. And more symbolically, a meaningful collective bargaining regime for health care expresses the aspiration that justice in employment and justice in health care are harmonious, not contradictory, values.

With the foregoing understanding of the value of Wagnerist legal tradition in health care, I now turn to explain how I contextualize Wagnerist labour law values to the nursing/patient safety context. To recall from Chapter 3, Wagnerism rests on four basic ideals: (i) voluntarism, (ii) associational activity, (iii) relative equality of bargaining power, and (iv) promotion of harmonious labour relations. Each of these has been described in

general terms, but they can be adapted to the specific context of nursing and its connection to patient safety. Since all parties to the nurse collective bargaining process consistently invoke patient interests, it makes logical sense that those interests could be used to explain or justify adaptations to the values governing that process.

Voluntarism, the most fundamental of all values, can be recast to account for patient interests. Both parties in nurse collective bargaining already routinely, by their strategies and discourse, invoke the views and interests of patients within collective bargaining. In doing so, they draw the citizen into the nurse labour relations process equally as much as the citizen pushes for such participation. Voluntarism, if understood as comprised of the parties' likely preferences, must therefore make room within it for the idea that the nurse collective bargaining process is partly a public policy process.

Similar context-specific adaptations can be made to the values of associational activity, redressing worker vulnerability and stability. Associational activity is understood primarily as that of employees: it seeks to protect their ability to join as a collective to advance common interests. Yet if the employees are nurses, their associational interests are a mixture of private and public (i.e. patient) elements. Part of their purpose for associating, in other words, is to advance patient interests and specifically patient safety. As discussed in Chapter 1, nurse ethical codes speak directly to patient safety, containing specific duties on nurses to advocate for patient safety and be transparent about errors.⁵³⁶ The Canadian Nurses' Association's *Code of Ethics*, for example, under the rubric of

⁵³⁶ Canadian Nurses Association, *Code of Ethics for Registered Nurses* (2008 Centennial Edition), *supra* note 40 at 8-9.

providing “safe, compassionate, competent and ethical care”, specify nurse duties around patient safety and medical errors.⁵³⁷

The value of remedying worker vulnerability, understood in context, can be similarly adapted to account for patient interests. Here, the vulnerability of nurses to excessive workload or hours worked is also in part a vulnerability of the patients they serve. A contextual vision of the “stability” value of Wagnerism, finally, would reach beyond the attainment of labour peace to the broader safety and reliability of the health care system itself. Stability, in the patient safety context, means supporting measures that promote patient safety not only during labour strife but also in the actual decisions made within collective bargaining.

These contextualized understandings of Wagnerism’s basic tenets are the basis for my responses to the Wagnerist objections to my reforms outlined above. In brief: Wagnerism has objections to my reforms, but the contextualized Wagnerism I have proposed is in harmony with them. To begin with, making nursing workload and time worked matters of public policy follows logically from a voluntarism anchored in a concern for patient safety. The subjective motivations of the parties are said by them to be similarly anchored, so their “voluntarism” is presumed to incorporate a first-order concern for patient safety. Making them policy issues is a logical step from this conclusion. So too are the reforms of opening the bargaining process on patient safety issues to include patient representatives and requiring the use of evidence and standards in bargaining. My proposal to introduce more participation and transparency mechanisms for citizens and

⁵³⁷ Canadian Nurses Association, *Code of Ethics for Registered Nurses* (2008 Centennial Edition), *supra* note 40 at 8-9; see also College of Registered Nurses of Nova Scotia, “Standards of Practice for Registered Nurses”, *supra* note 40, s. 3.13 at 10.

knowledgeable experts finds support from my contextual vision of voluntarism, which accounts for the patient interests in participation, transparency and evidence-based policy.

A context-specific vision of Wagnerism can also tolerate a shift away from the strike weapon as the dispute resolution method for patient safety issues. Voluntarism – the fundamental reason for the strike’s continued use in labour law – takes on a shade of meaning in the patient safety context that would demand more than mere consensus. A mechanism for resolving disputes should strive to emulate a policy process like any other in a democratic, inclusive society. Given the obvious haphazardness of decision-making under strike mechanisms, voluntarism in the patient safety context is vindicated, not offended, by a shift to interest arbitration.

Finally, my contextualized Wagnerism provides a theoretical grounding for the reforms to interest arbitration in the “patient safety committee” model I propose. Expanding the pool of people eligible to act as interest arbitrators, for example, will be grounded in this contextualized theory. Contrary to the Wagnerist objection, I believe all candidates from this larger pool will have legitimacy in the eyes of the parties. I base this, again, on my claim above that the contextual vision of voluntarism in nursing labour law comprehends more factors than simply the subjective views of the parties. It also allows for decision-makers from outside the traditional labour law culture, and the possibility that a range of perspectives could be brought to bear on how they decide. In voluntarism terms, it can be presumed that the parties would consent to the prospect of a wider pool of candidates. To the extent they appeal to non-traditional labour law values in their dialogue, they can be assumed to accept the appointment of non-traditional labour law

decision-makers. If voluntarism in the nursing context carries with it a heavy regard for the public interest, then it can also underpin a custom of selection of interest arbitrators that does the same.

Can external standards ever be acceptable in interest arbitration, or in labour law generally? My contextualized view of Wagnerism allows for them. Criteria unilaterally imposed once and for all in legislation certainly cannot be acceptable, because they arise from a unilateral process and are so static. However, if criteria are the product of an ongoing, multiparty norm-setting process, they will be acceptable. Norms that are dynamic and the subject of consensus are not corrosive to the integrity of adjudication. To the contrary, they enhance its sophistication and credibility in the eyes of those adjudication affects. As I argued above, legitimacy and voluntarism take on more public and democratic meanings in the nursing context. My contextual vision of voluntarism in nursing is one where contract terms arising from the application of shared norms to a dispute are as acceptable as those arising from a direct agreement. It is a type of voluntarism which accepts that, for evidence based policy to work, specificity must come to the standards used for bargaining and advocacy and ultimate dispute resolution. If so, then timely, specific standards arrived at through a multiparty process are welcome, not objectionable, elements of an interest arbitration model. Also, such standards can have a valuable feedback effect on the parties' decisions in bargaining. They can steer the parties – as they do arbitrators – to channel their decision-making processes through the analysis they require.

To sum up my defence of my interest arbitration reforms, I envision them as part of a very activist and pluralist interest arbitration process, one that brings external parties

and norms to bear on its decision-making functions. The model I propose proceeds from a context-specific understanding of how interest arbitration fits into the nurse collective bargaining system. This model has no such in-built self-loathing, no timidity about its task. However, finding acceptance of it is likely to be a monumental challenge. As the Drummond Report stated in 2012 about the reforms it proposed:

As with any change, some groups will be negatively affected and thus will resist change. In the case of the changes proposed above, the community of arbitrators in Ontario will likely be displeased with the additional conditions imposed on their profession. In addition, the imposition of an independent tribunal/commission to create, maintain and manage a roster of independent arbitrators and mediators may limit arbitrators' ability to determine which work they take on and thus may directly affect their livelihoods.⁵³⁸

These were prophetic remarks: the legislation which would have implemented the Drummond Report's reforms was never ultimately passed.

As discussed above, the Wagnerist literature on public sector collective bargaining has tended to posit a tension between the interests of public employee unions and citizens on the other, with the unions representing employee interests and government representing the citizen. My analysis rejects this Wagnerist premise as it applies in the context of nursing and the citizen interest in patient safety. The evidence from Chapter 2 shows that the interests of nurses in lower workloads, reasonable hours of work and predictable scheduling align with patient interests in safe care. As such, the limitations of the Wagner model at promoting workplaces with these features work against the improvement of patient safety. Therefore, the reforms I propose are intended to remedy those shortcomings and better situate nurses' unions to advance patient safety interests

⁵³⁸ *Drummond Report*, *supra* note 342 at 373.

when engaging with governments in negotiations on issues of workload, hours of work and scheduling.

Conclusion

In this Chapter I have proposed a series of reforms to the nursing labour law models that will take patient safety issues out of the realm of traditional Wagnerist collective bargaining and into the realm of evidence-based policy. The purpose of these reforms is to improve decision-making on patient safety issues while striving as much as possible to minimize the impact on the effectiveness of the labour law model from which these issues are removed. I have tried to articulate a legal theory – a contextualized version of Wagnerism – to explain and support these reforms, and try to overcome the doctrinal resistance that Wagnerism presents to them. To the extent this theory can be adopted, the “patient safety committee” model of decision-making I propose will improve patient safety issue management and, ultimately, improve patient safety itself.

CONCLUSION CHAPTER

In this thesis, I have called for labour law reforms for nurses that I believe will promote patient safety. A unique aspect of this thesis is that it urges law reform in one social policy field – labour law – to promote public welfare benefits in an entirely different field – health law and policy. As noted in the literature in my Introduction, labour law reforms and the critiques from which they flowed have always striven to further one or more of the core values of the Wagner model of collective bargaining I outlined in Chapter 3, namely increasing employee bargaining power, voluntarism and industrial peace. Thus, for example, the “limited strike” models of dispute resolution found in five of the six provinces in focus here are aimed at promoting free and meaningful collective bargaining in a context where the full and unfettered exercise of the right to strike would put patients in harm’s way. Never has labour law reform been directed at anyone but the immediate actors – employers, employees and trade unions – that live and work in the labour relations world every day. Here, however, I do precisely this. The interests I seek to advance through the programme of reforms outlined in Chapter 6 are not those of governments, unions, employers or nurses; rather, the interests of patients in safe care are the focus.

In this Conclusion, I recap the journey this thesis has taken, from the realm of health policy and patient safety, through nurse collective bargaining experiences, and to its arrival at reforms I believe will improve how patient safety value and interests are processed in nurse collective bargaining. I finish by outlining the implications of my subject, approach and conclusions for the future of both health policy and labour law.

The argument advanced here is a weaving of the previous six Chapters that can be encapsulated briefly. Chapters 4 and 5 contain critiques of the nursing labour law model for nurses, and Chapter 6 proposes reforms to overcome those flaws. Those critiques are that the nursing labour law model provides a sub-optimal modality for decision-making on “patient safety issues” as I defined those in Chapter 2. In Chapter 2, I define “patient safety issues” as issues related to nurse workload and hours worked, and that are established by scientific evidence as causally related to the rate of adverse events. The critiques in Chapters 4 and 5 are that the collective bargaining models for nurses – as measured by outcomes and the events in negotiations themselves – create poor conditions for the evidence-based and transparent resolution of patient safety issues. These models not only distort decision making on patient safety issues, they also allow governments to engage in opportunistic behaviour by legislating over nurses’ bargaining rights, thus lessening the ability of nurses’ unions to advance patient safety issues. I attribute these poor conditions to the dominance of Wagnerist labour law theory in nurse collective bargaining, which Chapter 3 explains, particularly as manifested in the continued use of the strike mechanism (albeit limited) to resolve and model for collective bargaining. Thus, the reforms in Chapter 6 suggest modifications to the Wagner model currently in place for nurses, and answer objections to these reforms from Wagnerist legal theory. The intention of these reforms is to improve how patient safety issues are raised, debated and decided in nurse collective bargaining, with a view to reducing medical error and improving patient welfare overall.

Circling back to the beginning, Chapter 1 set the broad policy context. There, I argued that the widespread concern for patient safety in Canadian health policy exists

alongside the equally pervasive goal of efficiency. There is a tension between the urge to invest more public dollars to improve the safety of care and the urge to do so in the most efficient manner. As well, there is an incentive for governments to use efficiency cynically as a rhetorical device to mask raw cost-cutting policies. This tension shows up in Chapter 4 as an explanation for the many caveats and other provisos which accompany nurse collective agreement terms on workload and hours of work. The efficiency-patient safety tension also drives the labour disputes reviewed in Chapter 5, with efficiency operating to constantly pressure governments to resist nurses' unions proposals such as nurse-patient ratios. The reforms I suggest in Chapter 6 are aimed in large part at checking governments' attempts to misuse efficiency in collective bargaining to oppose patient safety proposal, and to ensuring that evidence and transparency drive decisions on patient safety issues.

Chapter 2 advanced an essential premise of my argument: that nurse workload and hours worked can be isolated out from collective bargaining and conceived of not as private contract issues but as public policy issues. In traditional Wagnerist labour law theory (explained in Chapter 3) on which nurse collective bargaining structures are based, it is axiomatic that collective bargaining issues and disputes be treated like private contractual matters. A heavy evidentiary burden thus lies on anyone wishing to argue that some of these issues and disputes move from the realm of private contract to public policy. A strong link must be established between outcomes on such issues and some broader public interest beyond the interests of the immediate contracting parties before it is justifiable for law or government to intrude on collective bargaining to critique or steer outcomes. The "limited strike" models explained in Chapter 3 only represent a concession

to a very limited conception of public interest: the interest in protecting patients from risks that would arise from a full work stoppage. The public interest I posit in Chapter 2, however, is much wider. I argue, based on in-depth research and review of scientific evidence, that nurse workload and hours worked are public policy issues because of the ongoing (i.e. not merely during labour disputes) public interest concerns for patient safety. I am thus able to bracket these issues as the “patient safety issues” in nurse collective bargaining I examine in Chapters 4 and 5.

The role of Chapter 3 was to explain the historical/legal basis for the current legal frameworks for nurse collective bargaining in Canada. It explains how the legal tradition of Wagnerism has dominated the design of the current nurse collective bargaining models, particularly in the persistence of the strike mechanism as the preferred mode of dispute resolution. To critique Wagnerism and propose reforms to Wagnerist labour law models, it is necessary to understand it. My discussion of Wagnerist labour law models is a necessary preface to the critiques of those models in Chapters 4 and 5. As well, the Wagnerist theory underlying those models becomes a doctrinal obstacle with which I reckon while defending the reforms in Chapter 6.

Chapters 4 and 5 critique how the patient safety issues defined in Chapter 2 have been raised, debated and decided in nurse collective bargaining. Chapter 4’s critique is focused on the outcomes of bargaining on patient safety issues as manifest in the terms of nurse collective agreements on workload and hours worked. My overall finding is that these outcomes leave much to be desired from the standpoint of improving patient safety. The agreements in focus all contained some provisions on workload, but for the most part these consisted of clauses creating a parallel complaint and adjudication process for

nurse workload complaints. Concrete rules about nurse workload, such as nurse-patient ratios, are almost nonexistent. Further, rules that mandate reasonable shift lengths, restrict the use of overtime and give premiums for evening, night and weekend shifts, all create a structure of incentives and penalties that regulate the scheduling and lengths of shifts worked. However, these rules in many cases are highly qualified, and furthermore may create unanticipated incentives for junior and less skilled nurses to take on evening and night shifts when patient morbidity can suddenly spike in the event of an accident or other mishap.

Chapter 5 shifts focus from the outcomes of bargaining to the events and decisions in bargaining on patient safety issues. The limitations and weaknesses of the terms outlined in Chapter 4 can be explained in large part by the interplay between governments and nurses' unions in collective bargaining disputes over a series of rounds of bargaining. In the disputes between 1999 and 2014 on patient safety issues, the values of patient safety and efficiency were often in conflict in the form of union proposals on workload or hours worked and government counterproposals resisting these terms. The Wagnerist insistence on the strike mechanism, I argue, leads to a distortion in how patient safety issues are decided. The emergency contexts that arose from every dispute in which a nurses' union mentioned the idea of a strike were poor conditions for decisions on patient safety issues, most notably because of the hurried and evidence-poor way decisions had to be made by both sides. It also had the effect of allowing governments to impose terms – pressed onward to do so by efficiency – to end a labour dispute, ostensibly to protect patients from the risks of a strike, but actually to advance a cost-cutting agenda. By lessening the voice nurses' unions have in collective bargaining, the continued insistence

on the strike mechanism leaves them less able to advance patient safety interests in the bargaining process.

My argument finally arrives at the programme of reforms in Chapter 6. These reforms are offered as solutions to the critiques in Chapters 4 and 5. They are intended to isolate patient safety issues from all other collective bargaining issues and channel disputes on these issues into an evidence-based interest arbitration process. There will be no blanket prohibition on strikes, but there will be no strikes over patient safety issues. By removing their resolution from the strike-based context, it is my hope that patient safety issues can be resolved in ways that avoid all the pitfalls identified in Chapter 5 with decision-making under strike-based models. At the same time, the interest arbitration model I propose for patient safety issues will be markedly different from the Ontario hospital interest arbitration model outlined in Chapter 3. Reforms to interest arbitration on patient safety issues will strive to place evidence at the forefront of decision-making, and to require arbitrators to apply detailed, comprehensive guidelines while deciding patient safety issues. These guidelines will flow from the core value of patient interests, and treat the resolution of patient safety issues not as private bargaining issues but as complex public policy issues with direct implications for citizens.

This study has some possibly beneficial implications for health policy. As first mentioned in the Introduction, this subject – the impact of nurse labour law structures on patient safety - is both novel and worthwhile. Much has been studied and written on “health human resource” issues in health policy, including issues such as the nursing shortage, excessive workloads and an aging workforce. Many HHR studies have also focused on the patient safety impact of these issues. However, there has been an undue

inattention to the legal frameworks in which the rules and rights which constitute the health care workplace are determined. Terms and conditions of work for nurses and other providers are analyzed out of context, in my view. This study proceeds from this belief; it is focused on the surrounding legal context for HHR trends, and specifically trends in nurse workload and hours worked. That surrounding context consists of the Wagnerist labour law models for nurse collective bargaining found at the provincial level. These models shape how decisions are made in collective bargaining, and reforms to them can alter how decisions are made. The broader benefit of this approach for health policy is to open the previously off-limits world of labour law to health policy analysis. Analyses could be done on other provider groups and the bargaining structures they negotiate in, but only so long as they are able to demonstrate – as I have tried to do in Chapter 2 – that evidence supports treating one or more notionally private issues in bargaining as public policy issues. Without this nexus, reforms such as removing the right to strike will not have the bipartisan legitimacy needed for labour law reforms to succeed; they will be seen simply as government trying to override collective bargaining for sheerly cost cutting purposes. If this nexus is established, then it is possible to obtain bipartisan support for reforms.

Another implication of this study for health policy lies in its potential to inspire further exploration of possible points of intersection between the private economic interests of health care professionals and the patient interests in quality and safe care. This study rests on a posited commonality of interest between nurses and their patients. This commonality rests in turn on the science in Chapter 2; without it, the claim that nurses are advocating for patients when they advocate for reasonable workloads and hours of work carries little weight. But where the evidence provides a connection point between

those conditions and one or more features of the health care workplace – whether that be hospital, primary care, home care, long-term care or any other setting – it is possible to analyse the legal frameworks in which these conditions are determined and meaningfully critique them based on whether they promote outcomes on these issues that benefit patients. Studies based on these kinds of connection points could lead to similarly critical analyses of the labour law models in which they emerge.

A final implication of the conclusions herein for health policy is the usefulness of following the inquiry into labour law's impact on nurse bargaining outcomes deeper into one focused on whether employment itself is the optimal modality for nurses or other regulated health professionals to work in the system. As noted in Chapter 3, the Wagner model of collective bargaining is directed at remedying the vulnerability of the individual employee in the hierarchical relationship of employment. However, nurses – as professionals and as health professionals in short supply – do not perfectly fit this model because they are not as vulnerable as lower-skilled and more replaceable employees in industrial settings. From here, most studies including this one have looked at the legal models – Wagnerist collective bargaining – that are applicable when employment is the mode of contracting. But one could instead (or also) ask if independent contracting or some other form of contracting besides employment would be better suited to the professional health care employee. The only reason nurses are channeled into traditional Wagnerist labour law models is that they work as employees. If, like doctors, they worked on a fee-for-service or other basis, there would be room to fashion a variety of negotiation models for these providers that are not tied down to Wagnerist legal dogma.

I conclude with the implications of this study for labour law as a field. As the Introduction noted, Wagnerist legal theory has long dominated the field of employment and labour law. Wagnerism tells us that labour law's functions are fixed and narrow: protecting vulnerable employees from the imbalance of power inherent in employment, voluntarism in whether and how to bargain collectively through a union, and the promotion of industrial peace. The experiences recounted in Chapter 5 with dispute resolution under "limited strike" models show the policy dangers of the failure of this model. On one hand, the "limited strike" model requires nurses' unions to use the crude, blunt mechanism of the withdrawal of services as a voice mechanism, while on the other hand effectively handcuffing nurses' from the exercise of that mechanism. It embodies the pretense of voluntarism placed side by side with the concrete reality of legislative restrictions to render that voluntarism an illusion.

In my view, a study such as this allows a larger vision of labour law that takes its purposes and techniques not from history and uncritically-received tradition but from contemporary values about certain kinds of work and the wider social impact of the regulation of such work. This involves moving from the familiar contractual paradigm of employment to a social paradigm of work, by which I mean an understanding of work as a bundle of relationships involving consumers and beneficiaries (in the case of public services) of services with the people that combine skill and effort to provide those services. Presently, labour law is walled off from these wider relationships by relying on traditional lines between work obligations, "personal life" and community life. If, as I have tried to do here, science can be used to establish connections between the private world of work and the wider web of obligations in which it occurs, then labour law can be "about"

more than it has been to date. The justice pursued by labour law has long been that of the employee. This study, I believe, opens the way for studying labour law as an enterprise devoted to social justice more broadly. In this study, that broader concept of social justice encompasses justice for patients in the process of providing health care services. Potential exists for further studies of the connections between the regulation of work and the wider social impact of work.

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BOOKS

- Adams, G., *Canadian Labour Law* (Aurora, Ont.: Canada Law Book, current: loose-leaf updated)
- Adell, B. *et al*, *Strikes in Essential Services* (Kingston, Ont.: Industrial Relations Centre Press, Queen's University, 2001)
- Beatty, David, *Putting the Charter to Work: Designing a Constitutional Labour Code* (Montreal: McGill-Queen's Press, 1987)
- Carrothers, A. *et al*, *Collective Bargaining Law in Canada* (2nd ed. Toronto: Butterworths, 1986)
- Davies, P. & Freedland, M., *Kahn-Freund's Labour and the Law* (London: Stevens and Sons, 1983)
- Evans, Robert, *Strained Mercy: The Economics of Canadian Health Care* (Toronto: Butterworths, 1984)
- Hirschman, A., *Exit, Voice and Loyalty: Responses to Decline in Firms, Organizations, and States* (Cambridge, MA.: Harvard University Press, 1970)
- Solow, R., *The Labor Market as a Social Institution* (Cambridge: Basil Blackwell, 1990)
- Stein, J., *The Cult of Efficiency* (Toronto: Anansi Press, 2001)
- Tuohy, Carolyn, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (Oxford: Oxford University Press, 1999)
- Weiler, Paul C., *Reconcilable Differences: New Directions in Canadian Labour Law* (Toronto: Carswell, 1980)

ARTICLES IN PUBLISHED COLLECTIONS

- Adell, B. *et al*, "The System of Labour Dispute Resolution in Ontario Hospitals and Its Application at Kingston General Hospital", in Hanami & Blanpain eds., *Industrial Conflict Resolution in Market Economies* (London: Kluwer, 1987)
- Beatty, D., "Labour is Not a Commodity", chapter 9 in K. Swan & B. Reiter eds., *Studies in Contract Law* (Toronto: Butterworths, 1983)
- Arthurs, H., "Labour Law After Labour", ch. 1 in Langille & Davidov eds., *The Idea of Labour Law* (Oxford: Oxford University Press, 2011)
- Weiss, M., "Re-Inventing Labour Law?" ch. 3 in Langille & Davidov eds., *The Idea of Labour Law* (Oxford: Oxford University Press, 2011)
- Freedland, M., "Law, Public Services, and Citizenship – New Domains, New Regimes?", chapter 1 in Freedland M. & Sciarra S. eds., *Public Services and Citizenship in European Law* (London: Clarendon Press, 1998)

Fudge, J., "Labour as a 'Fictive Commodity': Radically Reconceptualizing Labour Law", ch. 8 in Langille & Davidov eds., *The Idea of Labour Law* (Oxford: Oxford University Press, 2011)

Gordon, R., "Law as a Vocation: Holmes and the Lawyer's Path" in *The Path of the Law and Its Influence* (Cambridge: Cambridge University Press, 2000)

Suptot, A., "Employment, Citizenship, and Services of General Public Interest", chapter 9 in Freedland M. & Sciarra S. eds., *Public Services and Citizenship in European Law* (London: Clarendon Press, 1998)

Epps, T., "Regulation of Health Care Professionals", ch 2 in Downie, J., Flood, C. & Caulfield T. eds., *Canadian Health Law and Policy* (4th ed., 2011)

Langille, B., "Labour Law's Theory of Justice", ch. 7 in Langille, B. & Davidov, G. eds., *The Idea of Labour Law* (Oxford: Oxford University Press, 2011)

JOURNAL ARTICLES (PR AND NON-PR)

Adell, B., "Regulating Strikes in Essential (and Other) Services after the 'New Trilogy'" (2013), 17(2) *Canadian Labour & Employment Law Journal Online*

Aiken, L. *et al*, "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction" (2002), 288(16) *Journal of the American Medical Association* 1987-1993

Aragon Penoyer, D., "Nurse staffing and patient outcomes in critical care: A concise review" (2010), 38(7) *Critical Care Medicine* 1521-528

Arkin, N. *et al*, "The association of nurse-to-patient ratio with mortality and preventable complications following aortic valve replacement" (2014), 29 *Journal of Cardiac Surgery* 141-148

Arthurs, H., "Labour Law Without the State" (1996), 46 *U.T.L.J.* 1-49

Arthurs, H., "National Traditions in Labor Law Scholarship: The Canadian Case" (2002), 23 *Comp.Lab.L.& Pol'y J.* 645-676

Arthurs, H., "Public Interest Labor Disputes in Canada" (1967), 17 *Buff. L.Rev.* 39-64

Ash, M. & Seago, J., "Registered Nurse Unions and Patient Outcomes" (2002), 32(3) *Journal of Nursing Administration* 143-151

Ash, M. & Seago, J., "The Effect of Registered Nurses' Unions on Heart-Attack Mortality" (2004), 57(3) *Industrial and Labor Relations Review* 422-461, available at http://courses.umass.edu/econ340/AshSeago_ilrr.pdf

Ash, M. *et al*, "What do Health Care Unions Do? A Response to Manthous" (2014), 52(5) *Medical Care* 393-397

Bae, S. & Fabry, D., "Assessing the relationships between nurse work hours/overtime and nurse and patient outcomes: systematic literature review" (2014), 62(2) *Nursing Outlook* 138-156

Baker, R. & Norton, P., "The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada" (2004), 170 *Canadian Medical Association Journal* 1678-1686

- Baumgart, A., "The Conflicting Demands of Professionalism and Unionism" (1983), 30(5) *International Nursing Review* 150
- Beatty, D., "Labour Law in a Nutshell: The Influence of a National Casebook" (1996) 75 *Can.Bar Rev.* 35-67
- Beebe, M., *What do Nurses' Unions Do? Implications for RN Wages, the Patient Care Environment, and Patient Outcomes* (Thesis, Ph.D. Economics, Clark University, Worcester, MA, 2008), online at <http://gradworks.umi.com/33/05/3305595.html>
- Belisario, J. *et al*, "Search strategies to identify observational studies in MEDLINE and EMBASE" (2013) Cochrane Library, at <http://onlinelibrary.wiley.com/enhanced/doi/10.1002/14651858.MR000041>
- Birch, S. *et al*, "Human Resources Planning and the Production of Health: A Needs-Based Analytical Framework" (2007), 33 *Canadian Public Policy* (Special Supplement on Health Human Resources), pp. S1-S16
- Budd, K. *et al*, "Traditional and Non-traditional Collective Bargaining: Strategies to Improve the Patient Care Environment" (2004), 9(1) *Online Journal of Issues in Nursing*, at <http://gm6.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume92004/No1Jan04/CollectiveBargainingStrategies.html>
- Bulkley, G. & Myles, G., "Trade Unions, Efficiency Wages, and Shirking" (1996) 48:1 *Oxford Economics Papers* 75-88
- Cameron, J., "The Labour Trilogy's Last Rites: *B.C. Health* and a Constitutional Right to Strike" (2010), 15(2) *Can.Lab.& Emp.L.J.* 298
- Chaykowski, R., "Canadian Labour Policy in the Aftermath of *Fraser*" (2012), 16(2) *Can.Lab.& Emp.L.J.* 291-312
- Cho, S. *et al*, "The effects of nurse staffing on adverse events, morbidity, mortality and medical costs" (2003), 52(2) *Nursing Research* 71-79
- Cho, S. & Yun, S., "Bed-to-nurse ratios, provision of basic nursing care, and in-hospital and 30-day mortality among acute stroke patients admitted to an intensive care unit: Cross-sectional analysis of survey and administrative data" (2009), 46 *International Journal of Nursing Studies* 1092-1101
- Clendon, J. & Gibbons, V., "12 h shifts and rates of error among nurses: A systematic review" (2015), 52(7) *International Journal of Nursing Studies* 1231-1242
- Collins, H., "Labour Law as a Vocation" (1989), 105 *L.Q.R.* 468-484
- Collins, H., "The Productive Disintegration of Labour Law" (1997), 26(4) *Ind. L.J.* 295-309
- Daud-Gallotti, R. *et al*, "Nursing workload as a risk factor for healthcare associated infections in ICU: a prospective study" (2012), 7(12) *PLoS One* E52342, at <http://journals.plos.org/plosone/article/asset?id=10.1371%2Fjournal.pone.0052342.PDF>
- Dobrow, M. *et al*, "Evidence-based health policy: context and utilisation" (2004), 58 *Social Science & Medicine* 207-217

Donabedian, A., "Evaluating the Quality of Medical Care" (2005), 83(4) *The Milbank Quarterly* 691-729

Dorsey, J., "B.C.'s Health Sector Collective Bargaining Restructuring: An Unfolding Story" (1997), 5 *Can.Lab.& Emp.L.J.* 85-117

Dube, A. *et al*, "Nurse Unions and Patient Outcomes" (Bonn, Germany: Institute for the Study of Labor, Discussion Paper No. 8259, 2014), online at <http://ftp.iza.org/dp8259.pdf>

Dubois, C. *et al*, "Associations of patient safety outcomes with models of nursing care organization at unit level in hospitals" (2013), 25(2) *International Journal for Quality in Health Care* 110-117

Duffield *et al*, "Nursing staffing, nursing workload, the work environment and patient outcomes" (2011), 24(4) *Applied Nursing Research* 244-255

Dukes, R., "Otto Kahn-Freund and Collective Laissez-Faire: An Edifice without a Keystone?" (2009) 72:2 *Mod. L. Rev.* 220-246

Elfering, A. *et al*, "Workflow interruptions, cognitive failure and near-accidents in health care" (2015), 20(2) *Psychology, Health & Medicine* 139-147

Ellis, J. *et al*, "Staffing for Safety: A Synthesis of the Evidence on Safe Staffing and Patient Safety" (Ottawa: Canadian Health Services Research Foundation, 2006), at <http://www.cfhi-fcass.ca/SearchResultsNews/06-09-01/e1b9468c-dafe-4ccf-b4f3-3f29ee0cb7e6.aspx>

Estabrooks, C. *et al*, "Effects of shift length on quality of patient care and health provider outcomes: systematic review" (2009), 18(3) *Quality and Safety in Health Care* 181-188

Etherington, B., "Does Freedom of Association under the Charter Include the Right to Strike after *B.C. Health?* Prognosis, Problems and Concerns" (2009), 15(1) *Can.Lab.& Emp.L.J.* 315

Evans, D., "Systematic reviews of nursing research" (2001), 17 *Intensive and Critical Care Nursing* 51-57

Evans, D. & Pearson, A., "Systematic reviews: gatekeepers of nursing knowledge" (2001), 10(5) *Journal of Clinical Nursing* 593-599

Fafard, P., "Evidence and Healthy Public Policy: Insights from Health and Political Sciences" (Ottawa: National Collaborating Centre for Healthy Public Policy, May 2008), online at http://www.cprn.org/documents/50036_EN.pdf

Flood, C., "*Chaoulli's* Legacy for the Future of Canadian Health Care Policy" (2006), 44 *O.H.L.J.* 273

Friese, C. *et al*, "Hospital Nurse Practice Environments and Outcomes for Surgical Oncology Patients" (2008), 43(4) *HSR: Health Services Research* 1145-1163

Frith, K. *et al*, "Effects of Nurse Staffing on Hospital-Acquired Conditions and Length of Stay in Community Hospitals" (2010), 19(2) *Quality Management in Health Care* 147-155

Garg, A. *et al*, "Systematic Review and Meta-analysis: When One Study Is Just Not Enough" (2008), 3(1) *Clinical Journal of the American Society of Nephrology* 253-260

Gartner, F. *et al*, "Impaired work functioning due to common mental disorders in nurses and allied health professionals: the Nurses Work Functioning Questionnaire" (2012), 85(2) *International Archives of Occupational and Environment Health* 125-138

Geiger-Brown, J. *et al*, "The Impact of Work Schedules, Home, and Work Demands on Self-Reported Sleep in Registered Nurses" (2011), 53(3) *Journal of Occupational and Environmental Medicine* 303-307

Gravel, A. *et al* and the Canadian Nosocomial Infection Surveillance Program, "Point Prevalence Survey of Health Care—Associated Infections Within Canadian Adult Acute-Care Hospitals" (2007), 35 *Journal of Hospital Infection* 157-162

Griffiths, P. *et al*, "Nurses' shift length and overtime working in 12 European countries: the association with perceived quality of care and patient safety" (2014), 52(11) *Medical Care* 975-981

Hall *et al*, "Nurse staffing models, nursing hours, and patient safety outcomes" (2004), 34(1) *Journal of Nursing Administration* 41-45

Hamilton, N., "Results Show Canadian Hospitals Improving Patient Safety", Healthcare Insurance Reciprocal of Canada, April 12, 2012, at <https://www.hiroc.com/News-Media/News/Results-show-Canadian-hospitals-improving-patient.aspx>

Harris, R. *et al*, "Impact of 12 h shift patterns in nursing: A scoping review" (2015), 52(2) *International Journal of Nursing Studies* 605-634

Hassen, P. *et al*, "The Canadian Patient Safety Institute: Building a safer system and stronger culture of safety" (2006), 48(7) *B.C. Medical Journal* 334-338

Hollingsworth, B., "The measurement of efficiency and productivity of health care delivery" (2008), 17(10) *Health Economics* 1107-1128

Holopainen, A. *et al*, "Systematic review – a method for nursing research" (2008) 16(1) *Nurse Researcher* 72-83

Johnston, D. & McKenna, I., "Public Interest Disputes and Compulsory Arbitration: A Case Study of Hospitals in Ontario" (1975), 7 *Ott. L.Rev.* 503

Kane, R. *et al*, "The association of registered nurse staffing levels and patient outcomes: Systematic review and meta-analysis", (2007), 45(12) *Medical Care* 1195-1204

Kruger, A., "Collective Bargaining in Ontario Public Hospitals" (1985), 40 *Relations Industrielles* 48

Lake, E. *et al*, "Patient falls: association with hospital Magnet status and nursing unit staffing" (2010), 33 *Research in Nursing and Health* 413-425

Lang, T. *et al*, "Nurse–Patient Ratios: A Systematic Review on the Effects of Nurse Staffing on Patient, Nurse Employee, and Hospital Outcomes" (2004), 34(7-8) *Journal of Nursing Administration* 326-337

Langille, B., "Labour Law is a Subset of Employment Law" (1981) 31:2 *U.T.L.J.* 200-230.

Langille, B., "Why Are Canadian Judges Drafting Labour Codes – And Constitutionalizing the Wagner Act Model?" (2009), 15(1) *Can.Lab.& Emp.L.J.* 101

Lankshear, A. *et al*, "Nurse Staffing and Healthcare Outcomes: A Systematic Review of the International Research Evidence" (2005), 28(2) *Advances in Nursing Science* 163-174

Liu, L. *et al*, "Exploring the association between nurse workload and nurse-sensitive patient safety outcome indicators" (2012), 20(4) *Journal of Nursing Research* 300-309

Lobo, V. *et al*, "Integrative review: an evaluation of the methods used to explore the relationship between overtime and patient outcomes" (2014), 71(5) *Journal of Advanced Nursing* 961-974

Manthous, C., "Labor Unions in Medicine: The Intersection of Patient Advocacy and Self-Advocacy" (2014), 52(5) *Medical Care* 387-392

Marchildon, G. & Mou, H., "A Needs-Based Allocation Formula for Canada Health Transfer" (2014), 40(3) *Canadian Public Policy* 209-223

Marcin, J. *et al*, "Nurse staffing and unplanned extubation in the pediatric intensive care unit" (2005), 6(3) *Pediatric Critical Care Medicine* 254-257

Mark, B. *et al*, "Nurse Staffing and Adverse Events in Hospitalized Children" (2007), 8(2) *Policy, Politics & Nursing Practice* 83-92

Mark, B. *et al*, "An Examination of Technical Efficiency, Quality, and Patient Safety in Acute Care Nursing Units" (2009), 10(3) *Policy, Politics & Nursing Practice* 180-186

Mark, B. *et al*, "California's minimum nurse staffing legislation: Results from a natural experiment" (2013), 48(2-1) *Health Services Research* 435-434

Matlow, A. *et al*, "Adverse Events among Children in Canadian Hospitals: The Canadian Paediatric Adverse Events Study" (2012), 184(13) *Canadian Medical Association Journal* 709-718

McGahan, M. *et al*, "Nurse staffing levels and the incidence of mortality and morbidity in the adult intensive care unit: A literature review" (2012), 25(2) *Australian Critical Care* 64-77

McGillis Hall, L. *et al*, "Nurse Staffing Models, Nursing Hours, and Patient Safety Outcomes" (2004), 34(1) *Journal of Nursing Administration* 41-45

Mühlau, P. & Lindenberg, S., "Efficiency Wages: Signals or Incentives? An Empirical Study of the Relationship between Wage and Commitment" (2003) 7:4 *Journal of Management and Governance* 385-400

Needleman, J. *et al*, "Nurse Staffing and Inpatient Hospital Mortality" (2011), 364(11) *New England Journal of Medicine* 1037-1045

Patrician, P. *et al*, "The association of shift-level nurse staffing with adverse patient events" (2011), 41(2) *Journal of Nursing Administration* 64-70

Pittman, J., "Registered Nurse Job Satisfaction and Collective Bargaining Unit Membership Status" (2007), 37(10) *Journal of Nursing Administration* 471-476

Ponak, A. & Haridas, T., "Collective Bargaining Attitudes of Registered Nurses in the United States and Canada: A Wisconsin-Ontario Comparison" (1979), 34(3) *Relations Industrielles* 576

- Ponak, A., "Unionized Professionals and the Scope of Bargaining: A Study of Nurses" (1981), 34(3) *Industrial & Labor Relations Review* 396
- Rogers, A. et al, "The Working Hours of Hospital Staff Nurses and Patient Safety" (2004), 23(4) *Health Affairs* 202-212
- Schulz, T., "The Pros and Cons of Interest Arbitration: An Employer's Perspective" (1994-95) *Labour Arbitration Yearbook* 429
- Seago, J. & Ash, M., "Registered Nurse Unions and Patient Outcomes" (2002), 32(3) *Journal of Nursing Administration* 143-151
- Seago, J. et al, "Hospital RN Job Satisfaction and Nurse Unions" (2011), 41(3) *Journal of Nursing Administration* 109-114
- Shekelle, P., "Nurse-Patient Ratios as a Patient Safety Strategy: A Systematic Review" (2013), 158(5) *Annals of Internal Medicine* 404-409
- Solberg, J., "The Pros and Cons of Interest Arbitration: A Union Perspective" (1994-95) *Labour Arbitration Yearbook* 409
- Spetz, J. et al, "The effect of unions on the distribution of wages of hospital-employed registered nurses in the United States" (2011), 20(1-2) *Journal of Clinical Nursing* 60-67
- Stanley, D., "The Pros and Cons of Interest Arbitration: An Arbitrator's Perspective" (1994-95) *Labour Arbitration Yearbook* 417
- Steyrer, J. et al, "Attitude is everything? The impact of workload, safety climate, and safety tools on medical errors: a study of intensive care units" (2013), 38(4) *Health Care Management Review* 306-316
- Stimpfel, A. & Aiken, L., "Hospital staff nurses' shift length associated with safety and quality of care" (2013), 28(2) *Journal of Nursing Care Quality* 122-129
- Stone, K., "The New Psychological Contract: Implications of the Changing Workplace for Labor and Employment Law" (2001), 48 *UCLA.L.Rev.* 519-661
- Stone, P. et al, "Nurse working conditions and patient safety outcomes" (2007), 45(6) *Medical Care* 571-578
- Summers, C., "Public Employee Bargaining: A Political Perspective" (1974), 83 *Yale Law Journal* 1156-1200
- Summers, C., "Public Sector Bargaining: Problems of Governmental Decisionmaking" (1975), *Faculty Scholarship Series*, paper 3911
- Tourangeau, A. et al, "Nursing-related determinants of 30-day mortality for hospitalized patients" (2002), 33(4) *Canadian Journal of Nursing Research*, 71-88
- Trinkoff, A. et al, "Nurses' Work Schedule Characteristics, Nurse Staffing, and Patient Mortality" (2011), 60(1) *Nursing Research* 1-8

Tucker, E. & Fudge, J., "The Freedom to Strike in Canada: A Brief Legal History" (2010), 15(2) *Can.Lab.& Emp.L.J.* 333-353

Tuohy, C., "The Costs of Constraint and Prospects For Health Care Reform In Canada" (2002), 21(3) *Health Affairs* 32-46

Vogel, L., "Landmark tool assesses Canadian hospitals (2012), 184(8) *Canadian Medical Association Journal* 86

Warburton, R., "Improving patient safety: an economic perspective on the role of nurses" (2009), 17(2) *Journal of Nursing Management* 223-229

Wellington, H.W & Winter, R.K., "The Limits of Collective Bargaining in Public Employment" (1969), 78 *Yale L. J.* 1107

West, E. *et al*, "Nursing resources and patient outcomes in intensive care: a systematic review of the literature" (2009), 46(7) *International Journal of Nursing Studies* 993-1011

Wilkins, K. & Shields, M., "Correlates of medication error in hospitals" (2008), 19(2) *Health reports / Statistics Canada, Canadian Centre for Health Information* 7-18

Wilson S. *et al*, "The effect of nurse staffing on clinical outcomes of children in hospital: a systematic review" (2011), 9(2) *International Journal of Evidence Based Healthcare* 97-121

NEWS MEDIA

___, "Quebec makes medical errors public", CBC News, December 6, 2011, <http://www.cbc.ca/news/canada/montreal/quebec-makes-medical-errors-public-1.1124587>

___, "Registered nurses say proposed changes could hurt patients: LPNs accuse RNs of fear-mongering and hysteria", CBC News Regina, September 17, 2014, at <http://www.cbc.ca/news/canada/saskatchewan/registered-nurses-say-proposed-changes-could-hurt-patients-1.2769608>

___, "Medical errors and negligence cost Quebec \$62M: report", CTV News Montreal, July 14, 2014, <http://montreal.ctvnews.ca/medical-errors-and-negligence-cost-quebec-62m-report-1.1912699>

___, "Saskatchewan nurses say Lean program has little impact on patient care", *Globe and Mail*, March 19, 2014, <http://www.theglobeandmail.com/news/national/saskatchewan-nurses-say-lean-program-has-little-impact-on-patient-care/article17561357/>

Blackwell, T., "Inside Canada's secret world of medical error", *National Post*, January 16, 2015, at <http://news.nationalpost.com/2015/01/16/inside-canadas-secret-world-of-medical-errors-there-is-a-lot-of-lying-theres-a-lot-of-cover-up/>

Boyle, T., "Nurses say hospital 'dangerous,' but CEO denies charge" *Toronto Star*, February 28, 2014, at http://www.thestar.com/life/health_wellness/2014/02/28/humber_river_hospital_dangerous_says_nurse_association_ceo_denies_the_charge.htm;

Grant, K., "Supply of nurses falls in Canada for first time in almost 20 years: report", *Globe and Mail*, June 23, 2015

Hazelton, J., "Independent committees to aid nurses, improve patient care", *The Chronicle Herald (Halifax, NS)*, Opinion, January 25, 2014, E3

Kubinec, V., "Medication mix-up leaves cancer patient, wife shocked - Man given different patient's medications by mistake at Health Sciences Centre", CBC News, April 3, 2014, at <http://www.cbc.ca/news/canada/manitoba/medication-mix-up-leaves-cancer-patient-wife-shocked-1.2596397>

Mason, G., "Wildrose Leader Jean spurred by son's tragic medical experience", *Globe and Mail*, April 22, 2015, at <http://www.theglobeandmail.com/news/alberta/alberta-wildrose-leader-brian-jean-enters-critical-stretch-of-campaign/article24070378/>

Priest, L. & D'Aliesio, R., "Health-care efficiency seen as more critical than funds, survey finds", *Globe and Mail*, December 20, 2011, at <http://www.theglobeandmail.com/news/national/health-care-efficiency-seen-as-more-critical-than-funds-survey-finds/article4181627/>

NURSE UNION/ASSOCIATION PUBLICATIONS

British Columbia Nurses' Union, *Position Statement on Mandated Nurse-Patient Ratios, March 2015* (2015), at https://www.bcnu.org/AboutBcnu/Documents/PS_Mandated_Nurse_Patient_Ratios_2015-1.pdf

British Columbia Nurses' Union, *Position Statement on Nursing Workload and Patient Safety* (2015), at <https://www.bcnu.org/AboutBcnu/Documents/position-statement-patient-safety.pdf>

British Columbia Nurses' Union, "Safe Patient Care. It's in our contract. Use it!", at <https://www.bcnu.org/news-and-events/campaigns-and-initiatives/current-campaigns/safe-patient-care>

Canadian Federation of Nurses Unions (Berry, L., & Curry, P.), *Nursing Workload and Patient Care: Understanding the Value of Nurses, the Effects of Excessive Workload, and How Nurse-Patient Ratios Can Help* (Ottawa: Canadian Federation of Nurses Unions, 2012), at https://t.co/JxcQqZwVsUhttp://nursesunions.ca/sites/default/files/cfnu_workload_paper_pdf.pdf

Canadian Federation of Nurses' Unions, "Nursing Workforce Backgrounder" (2013), at http://nursesunions.ca/sites/default/files/2013.backgrounder.nursing_workforce.e.pdf

Canadian Federation of Nurses Unions (MacPhee, M.), *Valuing Patient Safety: Responsible Workforce Design* (2014), at <https://nursesunions.ca/news/valuing-patient-safety-responsible-workforce-design>

Canadian Federation of Nurses' Unions, "Overview of Key Nursing Contract Provisions" (October 2012), at https://nursesunions.ca/sites/default/files/contract_comparison_english.pdf

Canadian Nurses Association & University of Toronto Faculty of Nursing, *Nurses and Patient Safety: A Discussion Paper* (2004), https://www.cna-aiic.ca/~media/cna/page-content/pdf-fr/patient_safety_discussion_paper_e.pdf?la=en;

Canadian Nurses Association, *Code of Ethics for Registered Nurses (2008 Centennial Edition)* (2008), at <https://www.cna-aiic.ca/~media/cna/page-content/pdf-fr/code-of-ethics-for-registered-nurses.pdf?la=en>

Canadian Nurses' Association et al, *Nurse Fatigue and Patient Safety: Research Report* (2010), at https://www.cna-aiic.ca/~media/cna/page-content/pdf-fr/fatigue_safety_2010_report_e.pdf?la=en;

Canadian Nurses' Association, "Long Working Hours of Hospital RNs Associated With Increased Errors" (2010), at https://www.cna-aiic.ca/~media/cna/page-content/pdf-en/rs_long_working_hours_e.pdf?la=en

Nova Scotia Government and General Employees' Union, "Our Proposed Ratios" (2015), at <http://nsgeu.ca/nsgeu-nurses-put-patient-safety-first/>

Registered Nurses' Association of Ontario, "Position Statement: Patient Safety" (2004), at <http://rnao.ca/policy/position-statements/patient-safety>

Saskatchewan Union of Nurses, "SUN takes to social media with patient safety message" (2014), at http://www.makingthedifference.ca/sun_takes_to_social_media_with_patient_safety_message

Saskatchewan Union of Nurses, "Proposed Changes to SALPN Bylaws: Background Information" (2014), at http://sun-nurses.sk.ca/+pub/document/SRNA/Backgrounder_sept%2029.pdf

Saskatchewan Union of Nurses, *Registered Nurses Committed to Patient Safety* (2015), at <http://sun-nurses.sk.ca/government-relations/patient-safety>

GOVERNMENT AND PUBLIC SECTOR PUBLICATIONS

FEDERAL

Canada, Standing Committee on Health (Joy Smith, MP, Chair), "Promoting Innovative Solutions to Health Human Resources Challenges" (2010), at

<http://www.parl.gc.ca/HousePublications/Publication.aspx?DocId=4631326&Language=&Mode=1&Parl=40&Ses=3>

Canadian Health Services Research Foundation (Sanchez-McCutcheon, A. *et al*), "Evaluation of Patient Safety and Nurse Staffing" (Ottawa: Canadian Health Services Research Foundation, November 2005)

Canadian Institute for Health Information, *Healthcare in Canada, 2004 (Part A: Focus on Safe Care)*, at <https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC375&lang=fr&media=0c>

Canadian Institute for Health Information, *Findings from the 2005 Study of the Work and Health of Nurses* (2006), at <http://www.hc-sc.gc.ca/hcs-sss/pubs/nurs-infirm/2005-nurse-infirm/index-eng.php>

Canadian Institute for Health Information, "Analysis in Brief - Patient Safety in Canada: An Update" (2007), at https://secure.cihi.ca/free_products/Patient_Safety_AIB_EN_070814.pdf

Canadian Institute for Health Information, *HSMR: A New Approach for Measuring Hospital Mortality Trends in Canada* (2007), at https://secure.cihi.ca/free_products/HSMR_hospital_mortality_trends_in_canada.pdf

Canadian Institute for Health Information, *Distribution and Internal Migration of Canada's Registered Nurse Workforce, 2007*, at http://www.cihi.ca/CIHI-ext-portal/pdf/internet/2007_rn_en

Canadian Institute for Health Information, *Regulated Nurses: Canadian Trends, 2004 to 2008*, at <https://secure.cihi.ca/estore/productFamily.htm?pf=PFC1391&locale=en&lang=EN&mediatype=0>

Canadian Institute for Health Information, *Regulated Nurses: Canadian Trends, 2005 to 2009*, at <https://secure.cihi.ca/estore/productFamily.htm?pf=PFC1565&locale=en&lang=EN&mediatype=0>

Canadian Institute for Health Information, *Learning From the Best: Benchmarking Canada's Health System* (2011); at <https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC1676>

Canadian Institute for Health Information, *The National System for Incident Reporting: Program Overview* (2011), at http://www.cihi.ca/CIHI-ext-portal/pdf/internet/NSIR_PROGRAM_OVERVIEW_EN

Canadian Institute for Health Information, *Regulated Nurses: Canadian Trends, 2007 to 2011* (2012), at https://secure.cihi.ca/free_products/Regulated_Nurses_EN.pdf.

Canadian Institute for Health Information, *All-Cause Readmission to Acute Care and Return to the Emergency Department* (2012), "One in 12 patients readmitted to Canadian hospitals within 30 days", at http://www.cihi.ca/cihi-ext-portal/internet/en/document/health+system+performance/release_14june12

Canadian Institute for Health Information, *Regulated Nurses, 2012 – Summary Report* (2013), at https://secure.cihi.ca/free_products/RegulatedNurses2012Summary_EN.pdf

Canadian Institute for Health Information, *A Performance Measurement Framework for the Canadian Health System 2012*, at https://secure.cihi.ca/free_products/HSP-Framework-ENweb.pdf

Canadian Institute for Health Information, *Developing a Model for Measuring the Efficiency of the Health System in Canada* (2012), at https://secure.cihi.ca/free_products/HS_Efficiency_Tech_Report_EN-web.pdf

Canadian Institute for Health Information, *Regulated Nurses, 2013: Report* (July 2014), at https://secure.cihi.ca/free_products/Nursing-Workforce-2013_EN.pdf

Canadian Institute for Health Information, *Regulated Nurses, 2014*, at https://secure.cihi.ca/free_products/RegulatedNurses2014_Report_EN.pdf

Canadian Institute for Health Information, "International Comparisons: A Focus on Quality of Care" (2014), at https://secure.cihi.ca/free_products/OECD_AFocusOnQualityOfCareAiB_EN.pdf

Canadian Institute for Health Information, *Measuring the Level and Determinants of Health System Efficiency in Canada* (2014), at https://secure.cihi.ca/free_products/HSE_TechnicalReport_EN_web.pdf,

Canadian Institute for Health Information, *Health System Efficiency in Canada: Why Does Efficiency Vary Among Regions?* (2014), at http://www.cihi.ca/cihi-ext-portal/pdf/internet/hse_short_aib_10apr14_en

Health Canada, *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses* (2002), at <http://www.hc-sc.gc.ca/hcs-sss/pubs/nurs-infirm/2002-cnac-cccsi-final/cnac-cccsi3-eng.php>

Health Canada, *Health Human Resources: Balancing Supply and Demand* (2004, Health Canada Bulletin) at <http://dsp-psd.pwgsc.gc.ca/Collection/H12-36-08-2004E.pdf>

Health Canada, *2004 First Ministers' Meeting on the Future of Health Care*, at <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php>

Health Canada, *2004 Health Human Resource Strategy*, at <http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/index-eng.php>

Health Canada, *The 2003 Accord on Health Care Renewal: A Progress Report* (2004), at http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/fs-if_01-eng.php

Health Canada, Health Canada Nursing Sector Study (2006), *Building the Future: An integrated strategy for nursing human resources in Canada*, Phase II final report, at <http://www.cha.ca/documents/pa/NSSII.pdf>

Health Canada, Advisory Committee on Health Delivery and Human Resources, *Framework for Collaborative Pan Canadian Health Human Resource Planning* (2007), at http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/hhr/2007-frame-cadre/2007-frame-cadre-eng.pdf

ALBERTA

Alberta Health and Wellness, *Provincial Comprehensive Health Workforce Plan* (2003), at <http://www.health.alberta.ca/documents/Workforce-Plan-2003.pdf>

Alberta Health and Wellness, *Health Workforce Action Plan, 2007 to 2016*, at <http://www.health.alberta.ca/documents/Workforce-Action-Plan-2007.pdf>

Alberta Health, *Health System Outcomes and Measurement Framework 2013* (2014), at <http://www.health.alberta.ca/documents/PMIS-Outcomes-Measurement-Framework-2014.pdf>

Alberta Health, “Performance Measures: Better Quality, Better Outcomes, Better Value” (2014), at <http://www.albertahealthservices.ca/performance.asp>

Alberta Health Services, *2013-2014 Annual Performance Report* (2014), at <http://www.albertahealthservices.ca/assets/about/publications/ahs-pub-pr-2013-14-dashboard.pdf>

College & Association of Registered Nurses of Alberta, *Working Extra Hours: Guidelines for Regulated Members on Fitness to Practise and the Provision of Safe, Competent, Ethical Nursing Care* (2011), at http://www.nurses.ab.ca/content/dam/carna/pdfs/DocumentList/Guidelines/RN_ExtraHours_Sep2011.pdf

Nursing Advisory Council of Alberta, *Alberta’s Nursing Workforce Strategy* (2005), at <http://www.health.alberta.ca/documents/Workforce-Nurse-Strat-2005.pdf>

Nursing Advisory Council of Alberta, *Alberta’s Nursing Workforce Strategy Forum* (2006), at <http://www.health.alberta.ca/documents/Workforce-Nurse-Strat-2006.pdf>

BRITISH COLUMBIA

British Columbia Ministry of Health, “Setting Priorities for the B.C. Health System” (2014), at <http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf>

British Columbia Ministry of Health, *2015/16 – 2017/18 Service Plan* (2015), at <http://www.bcbudget.gov.bc.ca/2015/sp/pdf/ministry/hlth.pdf>

College of Registered Nurses of British Columbia, *Professional Standards for Registered Nurses and Nurse Practitioners* (2012), at <https://www.crnbc.ca/Standards/Lists/StandardResources/128ProfessionalStandards.pdf>

NOVA SCOTIA

College of Registered Nurses of Nova Scotia (and five other N.S. health profession Colleges), *Joint Position Statement on Patient Safety* (2015) at <http://crnns.ca/wp-content/uploads/2015/02/Patient-Safety-2007.pdf>

Nova Scotia Department of Health and Wellness, “How Often Do Patients Get Clostridium difficile Infection While In Hospital?”, at http://novascotia.ca/dhw/qps/c-diff_psi.asp

Nova Scotia Department of Health and Wellness, “How Often Are Healthcare Workers Cleaning Their Hands?”, at http://novascotia.ca/dhw/qps/public_reporting.asp

Nova Scotia Department of Health, *Health Human Resources Action Plan* (2005), at http://www.gov.ns.ca/health/reports/pubs/hhr_action_plan.pdf

Nova Scotia Department of Health, *Nova Scotia's Nursing Strategy: Summary Report, 2001-2006* (2006), at http://www.healthteamnovascotia.ca/files/Nursing_Strategy_Summary_2001_2006.pdf

Nova Scotia Department of Health, "Public Reporting of Patient Safety Indicators" (2012), at http://novascotia.ca/dhw/qps/public_reporting.asp

ONTARIO

College of Nurses of Ontario, *Practice Standard, Professional Standards*, at http://www.cno.org/Global/docs/prac/41006_ProfStds.pdf

College of Nurses of Ontario, *Practice Standard, Medication* (Revised 2015), at <http://www.cno.org/Global/docs/prac/41007%20Medication-Rev%202015%20watermark%20v3.pdf>

Ontario Hospital Association, "Quality and Patient Safety", at <http://www.oha.com/currentissues/keyinitiatives/patientsafety/pages/default.aspx>;

Ontario Hospital Association, *A Guidebook to Patient Safety Leading Practices* (2010), at <https://www.oha.com/KnowledgeCentre/Library/Documents/Final%20-%20Patient%20Safety%20Guidebook.pdf>

Ontario Hospital Association, *2010-2013 Quality and Patient Safety Plan (QPSP)*, at <http://www.oha.com/CurrentIssues/keyinitiatives/PatientSafety/QPSP/Pages/Default.aspx>;

Ontario Ministry of Health and Long-Term Care (1999), *Good Nursing, Good Health : An Investment for the 21st Century: Report of the Nursing Task Force*, at http://www.health.gov.on.ca/en/common/ministry/publications/reports/nurserep99/nurse_rep.aspx

Ontario Ministry of Health and Long-Term Care, "Guidelines for Critical Incident Reporting" (2010), at http://www.health.gov.on.ca/en/pro/programs/ecfa/docs/guidelines_cir.pdf

QUEBEC

Quebec, ministère de la Santé et des Services sociaux, *Rapport semestriel des incidents et accidents survenus lors de la prestation des soins et services de santé au Québec (Période du 1er octobre 2013 au 31 mars 2014)*, at <http://msssa4.msss.gouv.qc.ca/fr/document/publication.nsf/961885cb24e4e9fd85256b1e00641a29/c98781ce6012799785257d8100527734?OpenDocument>

SASKATCHEWAN

Saskatchewan Department of Health (2005), *Working Together: Saskatchewan's Health Workforce Action Plan*, at <http://www.gov.sk.ca/news-archive/2005/12/14-1138-attachment.pdf>

Saskatchewan Department of Health (2008), "Backgrounder: Recruitment and retention of Saskatchewan nurses", at <http://www.gov.sk.ca/adx.aspx/adxGetMedia.aspx?mediaId=507&PN=Shared>

COMMISSION OR INQUIRY REPORTS

Commission on the Future of Health Care in Canada (Roy J. Romanow, Chair), *Building on Values: The Future of Health Care in Canada – Final Report* (Ottawa: Commission on the Future of Health Care in Canada, November 2002), at <http://www.publications.gc.ca/site/eng/237274/publication.html>

Commission on the Reform of Ontario's Public Services (Don Drummond, Chair), *Public Services for Ontarians: A Path to Sustainability and Excellence* (Drummond Report, 2012), Ch. 15, "Labour Relations and Compensation"

Standing Senate Committee on Social Affairs, Science and Technology (Hon. Michael J.L. Kirby, Chair), *The Health of Canadians – The Federal Role: Final Report. Volume Six: Recommendations for Reform* (Ottawa: Senate of Canada, October 2002), at <http://www.parl.gc.ca/Content/SEN/Committee/372/soci/rep/repoct02vol6-e.pdf>

OTHER NON-GOVERNMENTAL ORGANIZATIONS

Canadian Patient Safety Institute, *Canadian Paediatric Adverse Events Study* (2013), online at http://www.patientsafetyinstitute.ca/English/research/commissionedResearch/PaediatricAdverseEvents/Documents/CPSI_Canadian_Paediatric_Adverse_Events_doc_March%205_2013_English_Final.pdf

Commonwealth Fund, **2005** *Commonwealth Fund International Health Policy Survey of Sicker Adults*, at http://www.commonwealthfund.org/~media/files/surveys/2005/2005-commonwealth-fund-international-health-policy-survey-of-sicker-adults/2005_chartpack_full_set-pdf.pdf

Commonwealth Fund, *International Profiles of Health Care Systems, 2014* (2015), at http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/jan/1802_mossialos_intl_profiles_2014_v7.pdf

Commonwealth Fund (Davis, K. *et al*), *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2014 Update*, at http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf

Environics Research Group, "Canadians Feel Improving the Health Care System Lies With Addressing Inefficient Management Over Expanding Funding", last updated December 21, 2011, at http://www.environics.ca/news-andinsights?news_id=110

Grant, M. & Foucher, R., *Unionism, Professionalism and Professionals: A Study in Perceptions* (Kingston, Ont.: IRC Press, 1992)

Institute for Safe Medication Practices Canada, "Ontario Hospital Critical Incidents Related to Medications or IV Fluids: Analysis Report, January to December 2013", online at https://www.ismp-canada.org/download/ocil/ON_Critical_Incidents_Analysis_Report_3JUL2014.pdf

Joanna Briggs Institute, "Critical appraisal tool for Systematic reviews", in *Joanna Briggs Institute Reviewers' Manual, 2011 Edition* (Adelaide, Australia: JBI, 2011), at <http://joannabriggs.org/assets/docs/sumari/reviewersmanual-2011.pdf>

Swan, K., *Professional Obligations, Employment Responsibilities and Collective Bargaining* (Kingston, Ont.: IRC Press, Queen's University, 1978)

World Health Organization, *Health Care in Canada Survey 2006: A national survey of health care providers, managers, and the public* (2006), at http://www.who.int/patientsafety/news/2006_hcic.pdf

COLLECTIVE AGREEMENTS

ALBERTA: *Collective Agreement Between Alberta Health Services, Covenant Health, Lamont Health Care Centre, The Bethany Group and United Nurses of Alberta*, April 1, 2013 – March 31, 2017, at https://www.una.ab.ca/files/447/Provincial_AHS_UNA_CA_2013-2017.pdf

BRITISH COLUMBIA: *2012-2014 Provincial Collective Agreement between Health Employers' Association of British Columbia and the Nurse Bargaining Association*, April 1, 2012 – March 31, 2014, at <https://www.bcnu.org/Contracts-Bargaining/Documents/NBA%202012-2014%20-%20FINAL%202015-01-30.pdf>

MANITOBA: Collective agreements in Manitoba between the Manitoba Nurses' Union and the various health regions and hospitals in that province (Prairie Mountain Health Region, Interlake Eastern Regional Health, Southern Health Authority, Northern Regional Health Authority, Churchill Regional Health Authority, Winnipeg Regional Health Authority, Concordia Hospital, St. Boniface Hospital, Grace Hospital, Health Sciences Centre, Misericordia Hospital, Riverview Hospital, Seven Oaks Hospital, Victoria Hospital), available at <https://manitobanurses.ca/resources/collective-agreements.html>

NOVA SCOTIA (NSNU): *Collective Agreement between the Nova Scotia Nurses' Union and South Shore District Health Authority, South West Nova District Health Authority, Annapolis Valley District Health Authority, Colchester East Hants Health Authority, Cumberland Health Authority, Pictou County Health Authority, Guysborough Antigonish Strait Health Authority, Cape Breton District Health Authority, Capital District Health Authority & Izaak Walton Killam Health Centre*, at <http://www.nsnu.ca/site/media/nsnu/NSNU%20Acute%20Care%20Collective%20Agreement%202012-2014.pdf>

NOVA SCOTIA (NSGEU): *Collective Agreement between the Capital District Health Authority and the Nova Scotia Government and General Employees' Union, Nursing Bargaining Unit*, November 1, 2012 – October 31, 2014, at <http://www.cdha.nshealth.ca/employees/labour-relations/nsgeu-local-97-nurses>

ONTARIO: *Collective Agreement between Participating Hospitals and the Ontario Nurses' Association*, Expiry March 31, 2016, at https://www.ona.org/documents/File/pdf/cas/hospitals/HospitalCentralAgreement-English_March312016.pdf; and 153 local collective agreements for each individual hospital available at https://www.ona.org/ona_members/hospital/collective_agreements.html

SASKATCHEWAN: *Collective Agreement Between the Saskatchewan Association of Health Organizations and Saskatchewan Union of Nurses*, April 1, 2012 – March 31, 2014, at http://sun-nurses.sk.ca/+pub/document/Labour/CBA/SUN-SAHO%20CBA%202012-2014_101612.pdf

STATUTES, REGULATIONS, COLLEGE BYLAWS

USA

National Labor Relations Act (1935), 49 Stat. 449, 29 U.S.C. § 151–169

Public Employment Relations Act, A. 336, 1947, as amended (Michigan)

FEDERAL

Canada Health Act, R.S.C. 1985, c. C-6

Canadian Charter of Rights and Freedoms, Part I of the *Constitution Act, 1982*, Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11

Constitution Act, 1867 (U.K.), 30 & 31 Victoria, c. 3

Wartime Labour Relations Regulation (Order in Council P.C. 1003)

ALBERTA

An Act to Implement a Supreme Court Ruling Governing Essential Services, S.A. 2016, c. 10 (Bill 4, 2016)

Labour Relations Code, R.S.A. 2000, c. L-1

Regional Health Authority Collective Bargaining Regulation, A. Reg. 80/2003

BRITISH COLUMBIA

Health and Social Services Delivery Improvement Act, S.B.C. 2002, c. 2

Health Authorities Act, R.S.B.C. 1996, c. 180

Health Care (Consent) and Care Facility (Admission) Act, R.S.B.C. 1996, c. 181

Health Care Services Continuation Act, S.B.C. 2001, c. 23

Health Care Services Collective Agreements Act, S.B.C. 2001, c. 26

Health Care Employers Regulation, B.C. Reg. 427/94

Health Professions Act, R.S.B.C. 1996, c. 183

Health Sector Labour Adjustment Regulation (Health and Social Services Delivery Improvement Act), B.C. Reg. 39/2002

Labour Relations Code, R.S.B.C. 1996, c. 244

Nurses (Registered) and Nurse Practitioners Regulation, B.C. Reg. 284/2008

Personal Information Protection Act, S.B.C. 2003, c. 63

Public Education Flexibility and Choice Act, S.B.C. 2002, c. 3

Public Sector Employers Act, R.S.B.C. 1996, c. 384

MANITOBA

Essential Services (Health Care) Act, C.C.S.M., c. E146

Health Care Directives Act, The, C.C.S.M., c. H27

Labour Relations Act, C.C.S.M., c. L10

Personal Health Information Act, C.C.S.M., c. P33.5

Regional Health Authorities Act, C.C.S.M., c. R34

Regional Health Authorities Establishment Regulation, Man. Reg. 207/97

Winnipeg Authority Amalgamation Regulation, Man. Reg. 165/99

NOVA SCOTIA

Essential Health and Community Services Act, S.N.S. 2014, c. 2 (Bill 37, 2014)

Healthcare Services Continuation (2001) Act, S.N.S. 2001, c. 27

Patient Safety Act, S.N.S. 2012, c. 13

Patient Safety Reporting Regulations, N.S. Reg. 55/2013

Personal Directives Act, S.N.S. 2008, c. 8

Personal Health Information Act, S.N.S. 2010, c. 41

Trade Union Act, R.S.N.S. 1989, c. 475

ONTARIO

Crown Employees Collective Bargaining Act, 1993, S.O. 1993, c. 38

Excellent Care for All Act, 2010, S.O. 2010, c. 14

Health Care Consent Act, 1996, S.O. 1996, c. 2

Hospital Labour Disputes Arbitration Act, R.S.O. 1990, c. H.14

Hospital Management Regulation, R.R.O. 1990, Reg. 965

Labour Relations Act, 1995, S.O. 1995, c. 1, Sch. A

Local Health System Integration Act, 2006, S.O. 2006, c. 4

Nursing Act, 1991, S.O. 1991, c. 32

Nursing Act, 1991 – Professional Misconduct Regulation, O. Reg. 799/93

Personal Health Information Protection Act, 2004, S.O. 2004, c. 3

Public Hospitals Act, R.S.O. 1990, c. P.40

Public Sector Dispute Resolution Act, 1997, S.O. 1997, c. 21, Sch. “A”

Regulated Health Professions Act, 1991, S.O. 1991, c. 18

Savings and Restructuring Act, 1996, S.O. 1996, c. 1, Sch. “Q”

Strong Action for Ontario Act (Budget Measures), 2012 (Bill 55), First Reading:

http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=2600&isCurrent=&BillStagePrintId=5142&btnSubmit=go, Sch. 30

Strong Action for Ontario Act (Budget Measures), 2012, S.O. 2012, c. 8

Substitute Decisions Act, 1992, S.O. 1992, c. 30

QUEBEC

An Act Respecting Health Services and Social Services, R.S.Q., c. S-4.2

An Act Respecting the Process of Negotiation of the Collective Agreements in the Public and Parapublic Sectors, CQLR c R-8.2

SASKATCHEWAN

Critical Incident Regulations, R.R.S. 2000, c. R-8.2

Health Labour Relations Reorganization Act, S.S. 1996, c. H-0.03

Health Labour Relations Reorganization (Commissioner) Regulations, R.R.S. c. H-0.03, Reg. 1

Public Service Essential Services Act, S.S. 2008, c. P-42.2

Regional Health Services Act, S.S. 2002, c. R-8.2

Registered Nurses Act, 1988, S.S. 1988-89, c. R-12.2

Saskatchewan Employment Act, S.S. 2013, c S-15.1

Trade Union Act, R.S.S. 1978, c. T-17

COURT DECISIONS

British Columbia (Public Service Employee Relations Commission) v. B.C.G.E.U., [1999] 3 S.C.R. 3, 176 D.L.R. (4th) 1

British Columbia Teachers' Federation (Chudnosky) v. British Columbia, 2011 BCSC 469

British Columbia Teachers' Federation v. British Columbia, 2015 BCCA 184

Canadian Union of Public Employees (CUPE) v. Ontario (Minister of Labour), 2003 SCC 29, [2003] 1 S.C.R. 539

Chaoulli v. Quebec (Attorney General), [2005] 1 S.C.R. 791, 2005 SCC 35

Health Services and Support -- Facilities Subsector Bargaining Assn. v. British Columbia, 2007 SCC 27, [2007] 2 S.C.R. 391

Hydro-Québec v. Syndicat des employées de techniques professionnelles et de bureau d'Hydro-Québec, section locale 2000 (SCFP-FTQ), [2008] 2 S.C.R. 561, 2008 SCC 43

Ontario (Attorney General) v. Fraser, 2011 SCC 20, [2011] 2 S.C.R. 3

P.S.A.C. v. Canada, [1987] 1 S.C.R. 424

Reference Re Public Service Employee Relations Act (Alta.), [1987] 1 S.C.R. 313

R.W.D.S.U. v. Saskatchewan, [1987] 1 S.C.R. 460

Saskatchewan Federation of Labour v. Saskatchewan, 2015 SCC 4, reversing 2013 SKCA 43, reversing 2012 SKQB 62

United Nurses of Alberta v. Alberta (Attorney General), [1992] 1 S.C.R. 901

GRIEVANCE ARBITRATION AWARDS and LABOUR BOARD DECISIONS

Building Service Employees, Local 204 and Welland County General Hospital (Re) (1965) 16 L.A.C. 1 (Arthurs, Wren, Cromarty)

Canadian Union of Operating Engineers, Local 101 and Grace Hospital, Toronto (Re) (1966), 17 L.A.C. 233 (Arthurs, Miller, Middleton)

Canadian Union of Public Employees, Local 576 and Trustees of Ottawa Civic Hospital (Re) (1969), 23 L.A.C. 145 (Schiff, Wright, Reid)

Compass Group Canada (Health Services) Ltd. [2009] B.C.L.R.B.D. No. 193, 171 C.L.R.B.R. (2d) 101

Health Employers' Assn. of British Columbia (Fraser Health Authority and Burnaby Hospital) [2002] B.C.L.R.B.D. No. 334, 87 C.L.R.B.R. (2d) 70

Health Employers Assn. of British Columbia [2001] B.C.L.R.B.D. No. 125, 70 C.L.R.B.R. (2d) 35

KVP Co. Ltd. (1965), 16 L.A.C. 73 (Robinson)

McMaster University and Faculty Ass'n (1990), 13 L.A.C. (4th) 199 (Shime)

Newfoundland (Treasury Board) and N.A.P.E. (1995), 52 L.A.C. (4th) 250 (Buffett)

Sault Area Hospital v. Ontario Hospital Assn. (Vaccinate or Mask Grievance) (2015), 262 L.A.C. (4th) 1, [2015] O.L.A.A. No. 339

INTEREST ARBITRATION AWARDS

Alexandra Marine and General Hospital v. Ontario Nurses' Assn. (Local Issues Grievance), [2012] O.L.A.A. No. 165 (Stephens (Chair), Hughes, Kuhne)

Campbellford Memorial Hospital v. Ontario Nurses' Assn. (Local Issues Grievance), [2012] O.L.A.A. No. 460 (Stephens (Chair), Hughes, Kuhne)

Centre for Addiction and Mental Health v. Ontario Nurses' Assn. (Local Issues Grievance), [2012] O.L.A.A. No. 168 (Stephens (Chair), Hughes, Kuhne)

Chatham-Kent Health Alliance v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2012] O.L.A.A. No. 362 (Stephens (Chair), Hughes, Kuhne)

Children's Hospital of Eastern Ontario v. Ontario Nurses' Assn. (Local Issues Grievance), [2012] O.L.A.A. No. 462 (Stephens (Chair), Hughes, Kuhne)

Collingwood General & Marine Hospital v. Ontario Nurses' Assn. (Local Issues Grievance), [2012] O.L.A.A. No. 463 (Stephens (Chair), Hughes, Kuhne)

Cornwall Community Hospital v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2009] O.L.A.A. No. 517 (Reilly (Chair), Hughes, Kuhne)

Grey Bruce Health Services v. Ontario Nurses' Assn. (Renewal Collective Agreement Grievance), [2012] O.L.A.A. No. 175 (Stephens (Chair), Hughes, Kuhne)

Grey Bruce Health Services v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2015] O.L.A.A. No. 173 (Stephens (Chair), Hughes, Kuhne)

Guelph General Hospital v. Ontario Nurses' Assn. (Renewal Collective Agreement Grievance), [2012] O.L.A.A. No. 176 (Stephens (Chair), Hughes, Kuhne)

Humber River Regional Hospital v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2009] O.L.A.A. No. 523 (Reilly (Chair), Hughes, Kuhne)

Lakeridge Health Corp. v. Ontario Nurses Assn. (Collective Agreement Grievance), [2006] O.L.A.A. No. 525, 86 C.L.A.S. 107 (Reilly (Chair), Hughes, Mayne)

Lakeridge Health Corp. v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2009] O.L.A.A. No. 524 (Reilly (Chair), Hughes, Kuhne)

Lakeridge Health Corp. v. Ontario Nurses' Assn. (Renewal Collective Agreement Grievance), [2011] O.L.A.A. No. 419 (Burkett (Chair), Kuhne, McIntyre)

Lakeridge Health Corp. v. Ontario Nurses' Assn. (Local Issues Grievance), [2012] O.L.A.A. No. 373 (Stephens (Chair), Hughes, Kuhne)

Lakeridge Health Corp. v. Ontario Nurses' Assn. (Grievance 201400337, Local Issues), [2015] O.L.A.A. No. 70 (Stephens (Chair), Hughes, Kuhne)

London Health Sciences v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2015] O.L.A.A. No. 179 (Stephens (Chair), Hughes, Kuhne)

Muskoka Algonquin Healthcare v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2009] O.L.A.A. No. 529 (Reilly (Chair), Hughes, Kuhne)

Muskoka Algonquin Healthcare (Participating Hospitals) v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2011] O.L.A.A. No. 34, 104 C.L.A.S. 305 (Reilly (Chair), Hughes, Kuhne)

Norfolk General Hospital v. Ontario Nurses' Assn. (Nursing Unit Grievance), [2012] O.L.A.A. No. 379 (Stephens (Chair), Hughes, Kuhne)

North York General Hospital v. Ontario Nurses' Assn. (Grievance 201308160, Local Issues), [2015] O.L.A.A. No. 67 (Stephens (Chair), Hughes, Kuhne)

Participating Hospitals v. Ontario Nurses' Assn. (Collective Agreement Grievance) (Keller, 2004)

Participating Hospitals v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2007] O.L.A.A. No. 101, 88 C.L.A.S. 301 (Albertyn (Chair), Filion, McIntyre)

Participating Hospitals and Ontario Nurses' Association (Devlin (Chair), Riddell, McIntyre), June 2, 2011, at http://www.ona.org/documents/File/onanews/Award_ParticipatingHospitals_ONA_20110602.pdf

Participating Hospitals v Ontario Nurses' Association, 2014 CanLII 20914 (ON LA) (Kaplan (Chair), Kay, McIntyre)

Pembroke Regional Hospital v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2009] O.L.A.A. No. 520, 99 C.L.A.S. 402 (Reilly (Chair), Hughes, Kuhne)

Peterborough Regional Health Centre v. Ontario Nurses' Assn. (Grievance 201400793, Local Issues), [2015] O.L.A.A. No. 68 (Stephens (Chair), Hughes, Kuhne)

Providence Healthcare v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2012] O.L.A.A. No. 382 (Stephens (Chair), Hughes, Kuhne)

Religious Hospitallers of Saint Joseph of the Hotel Dieu of Kingston v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2009] O.L.A.A. No. 522 (Reilly (Chair), Hughes, Kuhne)

Royal Victoria Hospital v. Ontario Nurses' Assn. (Collective Agreement), [2009] O.L.A.A. No. 532 (Reilly (Chair), Hughes, Kuhne)

Royal Victoria Hospital v. Ontario Nurses' Assn. (Local Issues Grievance), [2012] O.L.A.A. No. 187 (Stephens (Chair), Hughes, Kuhne)

Sault Area Hospitals v. Ontario Nurses' Assn. (Collective Agreement), [2009] O.L.A.A. No. 533 (Reilly (Chair), Hughes, Kuhne)

Sault Area Hospital v. Ontario Nurses' Assn. (Local Issues Grievance), [2012] O.L.A.A. No. 471 (Stephens (Chair), Hughes, Kuhne)

Shouldice Hospital v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2009] O.L.A.A. No. 301 (Albertyn (Chair), Winter, Robbins)

St. Mary's of the Lake Hospital v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2009] O.L.A.A. No. 540 (Reilly (Chair), Hughes, Kuhne)

Strathroy Middlesex General Hospital v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2012] O.L.A.A. No. 47 (Goodfellow (Chair), Girvan, Klug)

Strathroy Middlesex General Hospital (Collective Agreement Grievance), [2013] O.L.A.A. No. 98 (Goodfellow (Chair), Girvan, Klug)

St. Thomas-Elgin General Hospital v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2015] O.L.A.A. No. 166 (Stephens (Chair), Hughes, Kuhne)

Toronto East General Hospital v. Ontario Nurses' Assn. (Grievance 201310133, Local Issues), [2015] O.L.A.A. No. 71 (Stephens (Chair), Hughes, Kuhne)

William Osler Health System v. Ontario Nurses' Assn. (Grievance 201400023, Local Issues), [2015] O.L.A.A. No. 69 (Stephens (Chair), Hughes, Kuhne)

Windsor General Hospital v. Ontario Nurses' Assn. (Local Issues Grievance), [2012] O.L.A.A. No. 291
(Stephens (Chair), Hughes, Kuhne)

York Central Hospital v. Ontario Nurses Assn. (Collective Agreement Grievance), [2007] O.L.A.A. No. 305
(Kaplan (Chair), Filion, McIntyre)

OTHER

Ontario, ONA-OHA Independent Assessment Committee reports, online at
http://www.ona.org/professional_practice/IACreports.html

Cambie Surgeries Corporation v. British Columbia (Medical Services Commission) Vancouver Registry No. S090663; most court documents have been made available unofficially online by the B.C. Health Coalition: see <http://www.bchealthcoalition.ca/what-you-can-do/save-medicare/court-documents>

Affidavit of Gregory Marchildon filed in *Cambie Surgeries Corporation v. British Columbia (Medical Services Commission)* Vancouver Registry No. S090663

APPENDIX: NURSE COLLECTIVE BARGAINING ROUNDS

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ONTARIO

1999 ONTARIO ROUND (PS-RELATED)

BRIEF SUMMARY

Wages were the dominant issue, along with workload and scheduling. A settlement was reached without arbitration.

PATIENT SAFETY-RELATED ISSUES?

Yes: scheduling, workload issues

ISSUES

Wages, Scheduling, Workload

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

None

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

A 6.7% wage increase over 3 years; also, some specific nursing groups whose wages had been capped under previous legislation got as much as 31%.

Improvements to benefits, professional development and scheduling initiatives.

An initiative for a 30-hour weekend shift that paid a full week salary.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

___, "Nurses angry at union for keeping deal secret", *The Toronto Star*, January 31, 2000, A4

___, "Ontario nurses reaching for the top: Deal would make them highest paid", *The Toronto Star*, February 1, 2000

Picard, A., "Ontario hospital nurses ratify pact", *Globe and Mail*, February 5, 2000, A10

___, "Nurses ratify deal", *Niagara Falls Review*, February 5, 2000, D8

2001 ONTARIO ROUND

BRIEF SUMMARY

ONA demands wage increases, new hires benefit improvements, premium increases, leave provisions and "protection of nursing work" language. Settled for wage and premium increases.

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages, new hires, benefit improvements, premium increases, protection of nursing work

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

None

ALTERNATIVE PRESSURE TACTICS?

A brief overtime ban

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

11% wage increase over three years, premium increases, and minor changes to layoff language.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

___, "Deal would see Ontario nurses become highest paid", *National Post*, December 20, 2001, A11

2004 ONTARIO ROUND

BRIEF SUMMARY

The ONA sought wage increases, premium increases, and benefit enhancements.

The OHA again sought an accelerated hiring process and relaxation of bumping rights language.

Interest arbitrator Brian Keller awarded a 6% wage increase over three years, some premium increases, improved benefits and more vacation time for senior nurses.

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages, benefits, premium increases, benefit enhancements

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

No

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

Interest arbitrator Brian Keller awarded a 6% wage increase over three years, some premium increases, improved benefits and more vacation time for senior nurses.

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

A. Lindgren, "Unions warn of all-out 'war' with Ontario" *Ottawa Citizen*, February 12, 2004, A3

B. Currie, "Bad faith, bias nixed VON" *Niagara Falls Review* August 31, 2004, A1

D. Williamson, "Hospitals seek limit on wage increases" *Windsor Star*, September 28, 2004, A2

___, "Talks between nurses and hospital employers break down", *Canada News Wire*, February 20, 2005

___, "Nurses receive pay hike", *Windsor Star*, September 12, 2005, A2

___, "Nurses finally get contract but nursing shortage remains a serious concern", *Canada News Wire*, September 12, 2005

2007 ONTARIO ROUND (PS-RELATED)

BRIEF SUMMARY

Wages and some non-monetary issues were negotiated. Settlement on most issues, but interest arbitrator Chris Albertyn awarded a 6% wage increase over two years, as well as some other matters.

PATIENT SAFETY-RELATED ISSUES?

Yes: workload, scheduling (premiums)

ISSUES

Wage increase: union wanted 8% over two years, the OHA offered 5.25%

ONA "workload measurement tools" proposal

ONA demand to double hourly rate for nurses called in on an unscheduled day that is also a paid holiday

ONA asked for premium payment increases

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT

No

STRIKE VOTE?

No

STRIKE ACTION

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

None reported.

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

No

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

Interest arbitrator Chris Albertyn decided several matters, including:

A 6% wage increase over two years;

Adding a memorandum establishing the ONA's proposed "workload measurement tools"

Awarding the ONA's demand for double the hourly rate for unscheduled call-ins on holidays; and

Awarding the ONA's increases to premium rates.

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

G. Livingston, "Nurses, hospitals at impasse with talks; accuse each other of walking out", *The Thunder Bay Chronicle-Journal*, May 31, 2006, A4

_____, "Arbitration Award Falls Short of Front-Line Nurses' Expectations, says Ontario Nurses' Association", *Canada News Wire*, March 5, 2007

Participating Hospitals v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2007] O.L.A.A. No. 101 (Albertyn, Fillion, McIntyre, March 5, 2007)

2008 ONTARIO ROUND

BRIEF SUMMARY

Wages were key issue; the ONA settled for a wage increase of 8.25% over three years.

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Wage increase of 8.25% over three years (3.25%, 3% and 3%)

Vacation, benefit and premium improvements;

Contract language relating to the improvement of workplace safety stemming from the late Justice Archie Campbell's final SARS report);

Commitments to address violence in the workplace, including disruptive physician behavior;

Dental benefits for early retirees (aged 60 to 65).

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

___, "Ontario Nurses' Association and Ontario Hospital Association Reach Tentative Contract Agreement", *Canada News Wire*, February 7, 2008

___, "Ontario Nurses' Association releases details of tentative settlement for 50,000 hospital registered nurses", *Canada News Wire*, February 22, 2008

J. Smith, "Tentative deal for nurses, Ontario hospitals: Vote scheduled on contract endorsed by union offering safer work environment, pay raises", *Toronto Star*, February 23, 2008, A2

___, "ONA Hospital Nurses Vote Overwhelmingly in Favour of New Contract", *Canada News Wire*, March 20, 2008

2011 ONTARIO ROUND

BRIEF SUMMARY

Interest arbitrator Jane Devlin awarded a three-year collective agreement providing lump sum payments for nurses in the first two years (between \$565 and \$1306), and a 2.75% wage increase for the third year. Arbitrator Devlin also awarded increases to various benefits.

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages and benefits

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

No

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

Interest arbitrator awarded lump sum payments and a 2.75% increase.

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

Participating Hospitals v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2011] O.L.A.A. No. 101 (Devlin, Riddell, McIntyre, June 2, 2011)

ONA, "Arbitration Award Released for Ontario Registered Nurses" (news release), June 3, 2011, at http://www.ona.org/news_details/arbitration_award_20110603.html

2014 ONTARIO ROUND (PS-RELATED)

BRIEF SUMMARY

The ONA sought a wage increase, improvements to the "professional responsibility" workload complaint process and other non-monetary improvements.

PATIENT SAFETY-RELATED ISSUES?

Yes

ISSUES

Wages, benefits, other non-monetary issues, workload

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

No

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

Wage increase of 2.8% over two years, various non monetary awards, revisions to workload complaint process

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

ONA, "Ontario Nurses' Association says no to concessions that would harm patients", March 14, 2014, at

http://www.ona.org/news_details/ONA_no_concessions_20140314.html

ONA, "Ontario Nurses' Association President to address regressive contract proposals with members", March 17, 2014, at

http://www.ona.org/news_details/ONA_Pres_address_members_20140317.html

Participating Hospitals v. Ontario Nurses' Assn. (Collective Agreement Grievance), [2014] O.L.A.A. No. 101 (Kaplan, Kay, McIntyre, April 30, 2014), at

http://www.ona.org/documents/File/bargaining/ONA_HospitalCentralCollectiveAgreement_KaplanAward20140430.pdf

K. Grant, "Arbitrator sides with nurses on raises", *The Globe and Mail*, May 2, 2014, A7

_____, "Ontario's Hospitals to Face Increased Financial Pressures Due to Arbitration Award", *Canada News Wire*, May 2, 2014

ONA, “Highlights of the Kaplan Award Between ONA and Participating Hospitals”, May 2, 2014, at http://www.ona.org/documents/File/bargaining/ONA_HospitalCentralCollectiveAgreement_HighlightsOfArbitratorAward20140502.pdf

Ontario Nurses’ Association, “Ontario Registered Nurses Receive Hospital-Sector Arbitration Award” (media release) May 2, 2014, at http://www.ona.org/news_details/ontario_registered_nurses_receive_hospital_sector_arbitration_award.html

ALBERTA

1999 ALBERTA ROUND (PS-RELATED)

BRIEF SUMMARY

The UNA asked for a 20% wage increase over two years and that the government commit to hiring 2,000 new nurses.

The government counter-offered 4.5% over two years and demanded various “flexibility” based changes to the collective agreement.

The UNA set a date for a strike vote, but the government obtained an injunction on the vote from the Alberta Labour Relations Board. The UNA began to collect a strike fund.

Surgeries were cancelled and services reduced at hospitals in Calgary and Edmonton.

A mediator recommended a settlement of a 9.7% wage increase over three years plus a promise of 500 new nursing hires.

The settlement was accepted by the UNA and ratified by an 82% vote of the members.

PATIENT SAFETY-RELATED ISSUES?

Yes

ISSUES

Wage increases

New nursing hires

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

Yes, but stopped by order of Alberta Labour Relations Board

STRIKE VOTE?

No

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

Cancelled surgeries, hospital bed closures, service reductions

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Wage increase of 9.7% over two years; 500 new nursing hires

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

___, "Nurses demand 10-per-cent pay raise", *Edmonton Journal*, January 26, 1999, A3

___, "Alberta adds \$935 million to heal health care system Province hiring 1,000 health professionals over next three years", *Toronto Star*, March 10, 1999, A8

G. Kent, "Strike policy advises union decertification and unlimited fines: Public empathy for nurses a concern" *Edmonton Journal*, June 2, 1999, A5

___, "Shortage of RNs reported well before contract talks stalled over issue: study, *Edmonton Journal*, June 3, 1999, A6

___, "Labour board delays *Charter* challenge" *Calgary Herald*, June 9, 1999, A1

___, "Alberta nurses' union bitterly endorses new contract: Province wouldn't commit to hiring 2,000 more nurses." *National Post*, June 18, 1999, A4

E. Kenny, "Nurses' dispute fraught with accusations, frustrations" *Calgary Herald*, June 20, 1999, A16

C. Derworiz, "Nurses expected to OK contract today" *Calgary Herald*, June 28, 1999, B1

J. Aldred & R. Pedersen, "Nurses, health authorities ratify pact: 82 per cent vote for contract offering 9.7-per-cent pay increase" *Edmonton Journal*, June 29, 1999, A6

2001 ALBERTA ROUND (PS-RELATED)

BRIEF SUMMARY

Bargaining lasted only four months, from January to March, 2001, and was conducted almost entirely in secret.

Bargaining coincided with a provincial election in March, 2001.

Wages were the key issue, with the UNA asking for a 30% pay hike over two years.

The resulting settlement awarded increases of between 17 and 22% over two years. The deal also included increased education allowances and pay rates for casual nurses, increases to on-call premiums, vacation bonuses for nurses with 25 or more years' experience, a vision care program, a supplemental pension and three paid professional development days.

In exchange, the employers obtained some "flexibility" changes: multi-site positions with the union's consent, and increased scheduling flexibility for individual nurses.

PATIENT SAFETY-RELATED ISSUES?

Yes

ISSUES

Wages, scheduling flexibility

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Wage increases of between 17% and 22% over two years, various raises to allowances and premiums and other benefits. For employers, allowances for more individualized scheduling arrangements.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

S. Ohler, Nurses, boards mum on talks: Initial bargaining secrecy a change from past years, *Edmonton Journal*, January 11, 2001, A7

R. Walker, "Nurses seek mediator's assistance: 'An upset' for Klein if talks break down" *Calgary Herald*, February 14, 2001, A6

D. Henton, "Alberta nurses ratify rich deal that makes them the best paid in Canada" *Canadian Press News Wire*, March 9, 2001

___, "Bosses OK rich nurses' contract: New deals make Alberta nurses best paid in country" *Edmonton Journal*, March 19, 2001, B3

___, "Alberta nurses' contract model for nation" *Edmonton Journal*, March 22, 2001, A14

S. Foster, "More practical nurses urged to solve shortage", *Edmonton Journal*, June 15, 2001, B5

2003 ALBERTA ROUND (PS-RELATED)

BRIEF SUMMARY

Government sought changes to overtime, scheduling and hours of work provisions to give it more flexibility and operational efficiency, and offered a wage increase of 7% over three years.

Specifically, government wanted changes to provisions governing overtime rates, designated days of rest, multi site positions, and allowances for permanent night shift patterns.

The UNA strongly opposed the government's demands.

A mediator adopted most of the government's proposals in his recommended settlement.

The UNA warned of possible strike action but did not hold a strike vote, and the government warned the union of penalties for an illegal strike.

Agreement reached, giving a 9.5% wage increase over three years, but containing none of the government's "flexibility"-based proposals.

PATIENT SAFETY-RELATED ISSUES?

Yes

ISSUES

Scheduling, overtime, hours of work, wages

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

Threat of strike vote

STRIKE VOTE?

No

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

No

GOVERNMENT WARNED LEGISLATIVE END?

Yes

SETTLEMENT?

Agreement reached, giving a 9.5% wage increase over three years, but containing none of the government's "flexibility"-based proposals.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

S. Ruttan, "Proposed contract angers Alberta nurses", *Edmonton Journal*, January 14, 2003, A6

___, "Alta health authorities want mediator for contract talks with nurses", *Canadian Press News Wire*, March 31, 2003

K. Cryderman, "Unions upset over Bill 27 regulations: 'Going to have chaos within health care'", *Calgary Herald*, April 2, 2003, A12

___, "Nurses' union accuses province of breaking law", *Edmonton Journal*, September 16, 2003, A7

D. Heyman, "Strike vote an option for nurses: Talks with province have collapsed", *Calgary Herald*, September 30, 2003, A5

S. Ruttan, "Nurses' union ready for possible strike: Rollbacks won't be accepted, says union president", *Edmonton Journal*, October 8, 2003, A8

___, "Alta. nurses, health authorities to resume talks after labour board ruling", *Canadian Press News Wire*, October 29, 2003

S. Ruttan, "Nurses union doubts settlement can be reached", *Edmonton Journal*, November 27, 2003, B10

S. Ruttan & D. Howell, "Klein threatens jail if nurses walk out", *Calgary Herald*, December 22, 2003, A1

M. Canton & T. Hurman, "Nurses to vote on deal: 9.5% wage hike offered, relocation item scrapped", *Calgary Herald*, June 1, 2004, B1

___, "Nurses to vote on new contract", *Edmonton Journal*, June 3, 2004, B9

___, "Alberta nurses win 9.5% raise" *Regina Leader Post*, June 10, 2004, C9

J. Elves, "Nurses vote on deal", *The Taber Times*, June 16, 2004, Front

2005 ALBERTA ROUND (PS-RELATED)

BRIEF SUMMARY

Wages were the only issue, and the parties agreed to a 3% wage increase over two years. It was ratified by a 95% margin.

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

No

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Wage increase of 3% over two years

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

S. O'Brien, "Nurses accept one-year contract extension", *The Lethbridge Herald*, May 6, 2005, A3
____, "Nurses negotiate pay hike", *Edmonton Journal*, May 7, 2005, A6

2007 ALBERTA ROUND (PS-RELATED)

BRIEF SUMMARY

Wages, scheduling for part-time nurses and overtime restrictions were the key issues.

UNA rejected the government's opening offer, and warned of illegal strike if government offered no wage increases.

Mediator recommended settlement: 15% wage increase over three years, increased premiums for evening, night and weekend shifts, more flexible part-time schedules, seasonal part-time positions, and further restrictions on mandatory overtime.

UNA accepted recommendation, and membership ratified the agreement by a vote of 82% in favour.

PATIENT SAFETY-RELATED ISSUES?

Yes

ISSUES

Wages, scheduling for part-time nurses and overtime restrictions were the key issues.

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

Yes

STRIKE VOTE?

No

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Mediator recommended settlement: 15% wage increase over three years, increased premiums for evening, night and weekend shifts, more flexible part-time schedules, seasonal part-time positions, and further restrictions on mandatory overtime.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

K. Hohensinn, "Alta. nurses ink highest wage deal in Canada", *Medicine Hat News*, June 13, 2007, A1

J. Sinnema, "Nurses ponder 'competitive' contract offer; Three-year deal would make senior Alberta nurses best-paid in Canada", *Edmonton Journal*, June 20, 2007, B4

S. Gallant, "Nurses to vote July 11 on mediator's recommendations for new contract", *The Lethbridge Herald*, June 21, 2007, A2

J. Komarnicki, "Nurses say yes to deal, early results show; Union warns staff being lost to cost of living", *Calgary Herald*, July 12, 2007, A5

P. Beauchamp, "Nurses get pay raise of up to 9% with new deal", *Calgary Herald*, July 13, 2007, C2

2010 ALBERTA ROUND (PS-RELATED)

BRIEF SUMMARY

UNA sought 4% wage increase over 2 years, 700 new nursing hires, and scheduling protections.

UNA also proposed that a nurse be given the authority to call in staff or stop the admission of new patients to a unit or program when they believe it's unsafe to do so.

The employers/government proposed a reduction in the required rest time between shifts from 15.5 hours to 10 hours.

After a brief dispute, a mediator recommended a wage increase of 6% over four years (a freeze in year one, 2% in year two, and 4% in year three), and a commitment by the government to hire 70% of the province's nursing graduates, or 700 new RNs, in the first year of the contract and as many as 1,300 new hires in each subsequent year.

UNA accepted the mediator's recommendation, which was ratified by the membership.

PATIENT SAFETY-RELATED ISSUES?

Yes

ISSUES

Wages, workload (new hires), scheduling

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

A 6% wage increase over four years, and a commitment by the government to hire 70% of the province's nursing graduates, or 700 new RNs, in the first year of the contract.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

___, "Alberta nurses say employer wants cuts in salaries, benefits in next contract", *The Canadian Press*, March 9, 2010

___, "New contract has 'rollbacks,' Alberta nurses say", *CBC Calgary (web site)*, March 9, 2010

___, "Alberta nurses meet to ponder mediator's contract recommendations", *The Canadian Press*, Western News, June 14, 2010

___, "Mediator suggests pay freeze for nurses", *Red Deer Advocate*, June 16, 2010, A3

___, "No wage freeze for Alberta nurses: health board", *CBC Calgary (web site)*, June 30, 2010

___, "24,000 Alberta registered nurses approve three-year contract", *The Canadian Press*, Western News, July 1, 2010

___, "Nurses hope deal tackles staffing", *CBC Calgary (web site)*, Friday, July 2, 2010

___, "Alberta registered nurses approve three-year contract", *Daily Herald (Prince Albert)*, July 2, 2010, p. 3

R. Sanchez, "Alta. nurses strike a deal", *Prairie Post*, July 9, 2010, A15

2014 ALBERTA ROUND (PS-RELATED)

BRIEF SUMMARY

Bargaining lasted 14 months.

Union sought workload-related minimum staffing levels, but mediator did not recommend.

The UNA said the mediator also called for "designated days of rest" to be maintained for part-time employees.

PATIENT SAFETY-RELATED ISSUES?

Yes

ISSUES

Wages, workload (staffing levels, professional responsibility process)

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Mediator recommended settlement, which was ratified by the membership. It included:

A \$2,000 lump sum payment for 2013-14;

A two-per-cent salary hike in 2014-15, plus a \$1,000 lump sum payment;

A 2.25-per-cent salary hike in 2015-16, plus a \$1,000 lump sum payment; and

A three-per-cent salary hike in 2016-17.

The UNA did not achieve its goal of establishing minimum staffing level targets for all nursing units, but the mediator persuaded the parties to agree to create a forum to talk about the concern.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

___, "Alberta nurses, government closer to collective agreement - Nurses union, Alberta Health Services and Covenant Health negotiators accept recommendations", *CBC Edmonton (web site)*, July 8, 2014

K. Gerein, "AHS, nurses reach tentative deal", *Edmonton Journal*, July 9, 2014, A7

___, "Nurses union contract vote set for Aug. 6", *Edmonton Journal*, July 16, 2014, A7

F. Buchanan, "Nurses ratify four-year contract", *Calgary Herald*, August 8, 2014, A11

F. Buchanan, "Nurses ratify new contract with Alberta Health Services; Union VP says four-year deal got 98% support", *Edmonton Journal*, August 8, 2014, A12

SASKATCHEWAN

1999 SASKATCHEWAN ROUND (PS-RELATED)

BRIEF SUMMARY

Bargaining lasted seven months in total, and coincided with a provincial election and with bargaining by other public sector unions.

The SUN sought wage increases of 22% over two years, workload-regulation measures, and caps on consecutive nursing shifts.

The SUN took a strike vote before bargaining began, and received a strike mandate of 74%.

After 40 days of bargaining, the union commenced a lawful strike.

In anticipation of a strike, surgeries were cancelled, hospital beds closed, and the Saskatchewan Association of Health Organizations (SAHO) estimated that 45 patients had been flown to Alberta, Manitoba and North Dakota. A typical flight cost \$7,000. Hospitals were accepting only emergency cases and discharging all but the most seriously ill.

The government passed legislation ordering the nurses back to work and imposing a final contract, which included a wage increase of 6% over three years.

Despite the legislation, the SUN continued an illegal strike for 10 days, resulting in injunctions and contempt of court proceedings against the union. During this time, however, bargaining continued. The government increased its wage offer to 13.7% over three years, and agreed to the SUN's demands on workload and hours of work.

Nurses voted 76.6% to ratify the settlement.

PATIENT SAFETY-RELATED ISSUES?

Yes (workload, hours of work)

ISSUES

Wages, workload, hours of work, scheduling

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

Lawful and unlawful strike

STRIKE VOTE?

Yes

STRIKE ACTION?

Yes

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

Yes: elective surgeries cancelled, beds closed, patients transferred out of province.

GOVERNMENT WARNED LEGISLATIVE END?

Yes

SETTLEMENT?

Yes. Terms included:

Wage increase of 13.7% over three years;

Caps on the number of consecutive shifts;

Allowances for individual nurses to adopt flexible scheduling and field hours; and

An Employer duty to "...provide a work environment consistent with nursing practice." This includes having policies and procedures that meet nursing professional guidelines, and being open to audit by a nursing professional association.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

Yes, back-to-work legislation passed imposing terms, but further strike action by SUN resulted in an enhanced final settlement for SUN despite the law and subsequent contempt proceedings against the union. In July 1999, Mr. Justice Zarzeczny of the Saskatchewan Court of Queen's Bench fined the SUN \$120,000 for defying the law, and ordered the funds paid to Saskatchewan hospitals. The judge held that the union had caused "...irreparable harm and a threat to the health and safety of Saskatchewan citizens". It was clear, he said, that "...many essential services were not being provided by nurses to Saskatchewan citizens who needed those services, and that the situation constituted a real and present danger to their health and well being." (*Saskatchewan Health-Care Association v. Saskatchewan Union of Nurses* [1999] S.J. No. 480 (Sask. Q.B., paras. __))

REFERENCES

___, "Nurses give union strike mandate", *Canadian Press News Wire*, December 9, 1998

M. O'Hanlon, "Saskatchewan nurses defy back-to-work legislation", *Canadian Press News Wire*, April 8, 1999

M. O'Hanlon, "Saskatchewan nurses say they will defy any court ruling", *Globe and Mail*, April 10, 1999, A4

M. O'Hanlon, "Judge grants injunction in Saskatchewan nurses strike", *Canadian Press News Wire*, April 11, 1999

___, "Nurses propose deal to end illegal strike", *Canadian Press News Wire*, April 15, 1999

____, “Saskatchewan nurses reject government offer, stay on strike”, *Canadian Press News Wire*, April 16, 1999

M. O’Hanlon, “Saskatchewan nurses end illegal strike”, *Canadian Press News Wire*, April 18, 1999

M. O’Hanlon, “Saskatchewan nurses walk away from talks”, *Canadian Press News Wire*, May 19, 1999

____, “Saskatchewan nurses finally reach deal”, *Calgary Herald*, July 3, 1999, A6

____, “Judge fines Saskatchewan nurses for illegal strike: directs them to donate the sum to local hospitals”, *Toronto Star*, July 9, 1999, A20

Saskatchewan Health-Care Association v. Saskatchewan Union of Nurses [1999] S.J. No. 480 (Sask. Q.B.)

2002 SASKATCHEWAN ROUND

BRIEF SUMMARY

Bargaining lasted four months.

SUN opened with a demand for a 30% wage increase over three years.

The government counter-offered 9% over three years, which was its offer to all public sector unions in that round of bargaining.

After initial positions, both sides made concessions: SUN lowered its wage demand to 20%, and the employers raised their offer to 11%

The SUN set a date for a strike vote, but it was never held.

Soon after strike vote threat, government conceded to the SUN and attained a 20% wage over two years. The settlement was ratified by nurses by a 91% margin.

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

Strike vote threat

STRIKE VOTE?

No

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Wage increase of 20% over two years

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

J. Warick, "30% wage hike sought", *Regina Leader Post*, January 7, 2002, A1

___, "Saskatchewan nurses seek Alberta parity", *Calgary Herald*, January 7, 2002, A4

___, "Talks going well", *Regina Leader Post*, January 26, 2002, A10

N. Scott, "Nurses spending \$100,000 on image", *Regina Leader Post*, February 6, 2002, A1

N. Scott, "Nurses' union calls for 'whistleblower' law", *Regina Leader Post*, February 26, 2002, A1

N. Scott, "Nurses say they will still go after raises", *Regina Leader Post*, February 26, 2002, A4

A. Kyle, "Essential services legislation requested", *Regina Leader Post*, March 21, 2002, B2

N. Scott, "Nurses reject 11% raise: 'Insulted,' now talking strike" *Regina Leader Post*, March 21, 2002, A1

N. Scott, "Insulted nurses to vote on strike mandate", *Regina Leader Post*, March 23, 2002

N. Scott, "Talks resume, pay raises key" *Regina Leader Post*, April 3, 2002

N. Scott, "Nurses set to launch public relations blitz", *Regina Leader Post*, April 6, 2002, B2

___, "Sask. nurses reach deal on lucrative contract", *Edmonton Journal*, April 11, 2002, A10

N. Scott, "Nurses OK deal", *Regina Leader Post*, April 24, 2002, B2

2005 SASKATCHEWAN ROUND (PS-RELATED)

BRIEF SUMMARY

Bargaining lasted seven months.

The SAHO and government began by insisting on the near-total wage restraint (no increase in year one, and a one percent increase in each of years two and three) that it had imposed on other parts of the public sector.

The SAHO also sought changes to clauses on scheduling, overtime, and other non-monetary issues.

However, the SUN held firm in resisting the SAHO's imperatives, and achieved a 7.5% wage increase over three years, as well as a commitment to "research" the possibility of using nurse-patient ratios as a workload regulation tool, and other non-monetary items.

PATIENT SAFETY-RELATED ISSUES?

Yes

ISSUES

Wages, workload, scheduling, overtime, other non-monetary issues

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

A 7.5% wage increase over three years, a commitment to "research" the possibility of using nurse-patient ratios as a workload regulation tool, and other non-monetary items.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

V. Rhodes, “Nurses set to begin contract negotiations”, *Regina Leader Post*, March 17, 2005, A7

N. Scott, “Sask. nurses’ union blasts ‘rollbacks’” *Regina Leader Post*, April 14, 2005, B3

___, “SUN head predicts tough talks ahead”, *Saskatoon Star-Phoenix*, April 16, 2005, A

___, “Nurses’ contract talks progress”, *Saskatoon Star-Phoenix*, October 28, 2005, A13

N. Scott, “Nurses reach tentative deal: Agreement provides nurses with 7.5% raise” *Saskatoon Star-Phoenix*, October 29, 2005, A3

N. Scott, “Nurses ratify contract”, *Regina Leader Post*, November 30, 2005, B2

2008 SASKATCHEWAN ROUND (PS-RELATED)

BRIEF SUMMARY

Bargaining coincided with a provincial election and with the passage of legislation intended to move Saskatchewan to a “limited strike” model of dispute resolution in health care with restrictions and preconditions to be met before a lawful strike can occur.

Shortly after the election, the SUN and government reached a “framework agreement” to address nursing workload, in which the government committed to 800 new nursing hires and to regulate elective patient admissions in step with nurse staffing levels on a given shift.

In collective bargaining, the SUN asked for a wage increase of 27% over three years; the SAHO offered 10% and also demanded more freedom to assign mandatory overtime, a proposal the SUN strongly opposed.

The SUN held a strike vote, with 77% voting in favour of strike action.

Shortly afterward, the SAHO increased its offer to a 35% wage increase over four years and dropped its mandatory overtime demands.

The SUN agreed, and the membership voted 78% to ratify the agreement.

PATIENT SAFETY-RELATED ISSUES?

ISSUES

Wages, workload (new hires), hours of work

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

Yes

STRIKE VOTE?

Yes

STRIKE ACTION?

No

ALTERNATIVE PRESSURE TACTICS?

No

ESSENTIAL SERVICE EFFECTS?

No

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

A 35% wage increase over four years, no changes to mandatory overtime restrictions in agreement.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

REFERENCES

J. Wood, "Gov't, SUN at impasse over nurse retention strategy", *Saskatoon Star-Phoenix*, September 29, 2007, A6

A. Kyle, "Talks with nurses stall", *Regina Leader Post*, September 29, 2007, A1

V. Rhodes, "SUN asks for emergency plan: Partnership agreement 'unacceptable': SAHO", *Saskatoon Star-Phoenix*, February 13, 2008, A3

J. Wood, "SUN negotiations a big test for government", *Regina Leader Post*, February 26, 2008, A4

A. Kyle, "Annual targets set for hiring nurses", *Regina Leader Post*, February 29, 2008, A1

A. Kyle, "Nurses, SAHO differ on contract strategy", *Regina Leader Post*, March 7, 2008, A1

A. Kyle, "Talks on new nurses' contract stalled", *Regina Leader Post*, March 8, 2008, A1

A. Hall, "Critic says agreement has created 'quite a mess'", *Regina Leader Post*, March 14, 2008, A3

___, "Nurses receive new wage offer" *Saskatoon Star-Phoenix*, April 3, 2008, A3

B. Pacholik, "SAHO modifies contract offer", *Saskatoon Star-Phoenix*, April 23, 2008, A6

A. Kyle, "SAHO head 'mystified' by tough talk from SUN; Nurses union plans strike vote; only 10 minutes of talks since proposals exchanged", *Saskatoon Star-Phoenix*, April 25, 2008, A11

R. Burton, "SUN set to fast track bargaining", *Saskatoon Star-Phoenix*, April 26, 2008, A2

Tara Campbell, "Nurses' union prepares for strike vote", *Daily Herald (Prince Albert)*, April 26, 2008, p. 3

Mandryk, Murray, "SUN at odds with SAHO over 'takeaways'", *Daily Herald (Prince Albert)*, May 2, 2008, p. 4

M. Mandryk, "SUN claims of 'take-aways' shaky", *Saskatoon Star-Phoenix*, May 2, 2008, A10

___, "More than 7,200 Saskatchewan nurses hold strike vote to back contract demands", *The Canadian Press*, May 7, 2008

___, "Sask. nurses vote to strike", *CBC News*, May 8, 2008

___, "More than 7,200 Saskatchewan nurses hold strike vote", *Daily Herald (Prince Albert)*, May 8, 2008, p. 2

___, "Nurses vote for strike", *Victoria Times-Colonist*, May 9, 2008, A11

___, "Saskatchewan nurses offered 27% wage hike", *CBC Saskatchewan*, May 12, 2008

A. Kyle, "New offer for nurses: SAHO proposal would boost wages five per cent annually during four-year deal", *Saskatoon Star-Phoenix*, May 13, 2008, A1

A. Kyle, "SAHO revises proposal", *Saskatoon Star-Phoenix*, May 13, 2008, A3

___, "Strike would be first test of new bill: Norris", *Saskatoon Star-Phoenix*, May 13, 2008, A7

A. Kyle, "SUN trying to gain respect", *Regina Leader Post*, May 16, 2008, A3

___, "Saskatchewan nurses offered 35% wage hike", *CBC Saskatchewan*, May 26, 2008

___, "SUN nixes contract offer: But nurses asked to rethink position", *Saskatoon Star-Phoenix*, May 27, 2008, A3

___, "Saskatchewan nurses union rejects latest offer", *CBC Saskatchewan*, May 27, 2008

V. Rhodes, A. Hall, "Union gives SAHO a new proposal", *Regina Leader Post*, May 28, 2008, A3

V. Rhodes, "SUN, SAHO trade proposals", *Saskatoon Star-Phoenix*, May 30, 2008, A7

V. Rhodes, "Talks with nurses at a critical point", *Saskatoon Star-Phoenix*, May 30, 2008, A7

P. Cowan, "'Final offer' tabled; SAHO asks nurses union to take proposal to members", *Regina Leader Post*, May 31, 2008, A1

R. Burton, "SAHO draws line in the sand", *Saskatoon Star-Phoenix*, May 31, 2008, A2

___, "Nurses reach tentative four-year agreement with health employers", *Daily Herald (Prince Albert)*, May 31, 2008, p. 2

___, “7,200 registered nurses will vote June 23 on a new contract”, *The Canadian Press*, June 1, 2008

___, “Sask. nurses to vote on contract offer in 3 weeks”, *CBC Saskatchewan*, June 2, 2008

___, “Nurses to vote on 'final' SAHO offer”, *Times-Herald (Moose Jaw)*, June 3, 2008, A2

J. Warick, “Nurses torn; Many say contract flawed, but they will vote for it anyway”, *Saskatoon Star-Phoenix*, June 7, 2008, A1

J. French, “Nurses back final offer; Vote not a sign four-year contract ideal: SUN president”, *Saskatoon Star-Phoenix*, June 24, 2008, A3

___, “Local health authority votes in favour of deal”, *Regina Leader Post*, June 27, 2008, A8

___, “Health regions vote on nurses’ contract”, *Saskatoon Star-Phoenix*, July 4, 2008, B8

A. Kyle, “SUN, SAHO deal is done”, *Regina Leader Post*, July 9, 2008, A7

___, “Nurses union, SAHO to sign collective agreement today”, *Times-Herald (Moose Jaw)*, July 9, 2008, A2

A. Kyle, “Act ‘unconstitutional’: SUN”, *Regina Leader Post*, September 16, 2008, A3

2012 SASKATCHEWAN ROUND (PS-RELATED)

BRIEF SUMMARY

The parties settled on a lump sum payment in the first year, and a two per cent wage increase for the second year.

The parties also agreed to extend the previous round’s “framework agreement” on workload, and the employers agreed to maintain their nurse staffing complements, at a minimum, at 2007 levels.

PATIENT SAFETY-RELATED ISSUES?

Yes (workload/staffing freeze)

ISSUES

Wages, workload

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

No

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Lump sum wage increase in first year, and two per cent in the second. Also extended 2008 framework agreement and employers committed to minimum staffing levels.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

Angela Hall, "Nurses expect to hammer out agreement in January", *Daily Herald (Prince Albert)*, December 31, 2011, A2

___, "SUN ramps up contract campaign", *Daily Herald (Prince Albert)*, January 31, 2012, A2

___, "Saskatchewan nurses release ads to push message of care ahead of contract talks", *Times-Herald (Moose Jaw)*, January 31, 2012, A2

___, "Tentative deal for Saskatchewan nurses, but no details revealed", *The Canadian Press*, April 26, 2012

___, "Saskatchewan nurses vote on two-year contract offer that includes wage increase", *The Canadian Press*, May 28, 2012

___, "SAHO/SUN come to an agreement", *Prairie Post (web site)*, May 29, 2012

BRITISH COLUMBIA

2001 BRITISH COLUMBIA ROUND (PS-RELATED)

BRIEF SUMMARY

The BCNU opened bargaining with a demand for a 60% wage increase over three years, but later conceded and reduced its demand to 43% and later 32% over three years.

The HEABC's opening wage offer was 11% over three years, but later was raised to 22%, and finally 23.5% over three years.

HEABC also sought more "flexibility" from various patient safety-related provisions on overtime and removal of "designated days of rest" which triggered overtime rates.

Bargaining coincided with a provincial election in which the incumbent NDP government was defeated and replaced by the Liberal party led by Gordon Campbell. The BCNU held a strike vote before the election, resulting in a 95% vote in favour.

BCNU also began overtime bans as a pressure tactic.

The prospect of a nurses' strike led to 600 cancelled surgeries province-wide

The outgoing NDP government made a final pre-election wage offer of a 22% increase over three years, but also insisted on its "flexibility" demands.

The BCNU postponed the nurses' ratification vote on the NDP government's final offer until after the election.

After the Campbell government took office, the vote was held and nurses rejected the NDP's last offer by a 96% margin.

The Liberal government then passed Bill 2, banning the BCNU from strike action and the overtime bans.

The government then enacted Bill 15, imposing the former NDP government's final offer that the BCNU had rejected.

The following year, 2002, the government went on to pass Bill 29, which eliminated collective bargaining altogether on contracting out, work assignments, job security and layoffs. The legislation also prohibited any future bargaining between health care unions and the government on those matters.

In 2007, the Supreme Court of Canada struck down Bill 29 as infringing the health care unions' freedom of association under section 2(d) of the *Charter*. In deciding, the Court held that section 2(d) guarantees all trade unions the right to a "meaningful process" of collective bargaining.

PATIENT SAFETY-RELATED ISSUES?

Yes (hours of work – overtime)

ISSUES

Wages

Hours of work: overtime, designated days of rest

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

Strike vote

STRIKE VOTE?

Yes

STRIKE ACTION?

No (rendered illegal by Bill 2)

ESSENTIAL SERVICE EFFECTS?

Yes: 600 cancelled surgeries

GOVERNMENT WARNED LEGISLATIVE END?

Yes

SETTLEMENT?

No

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

Yes: wage increase of 23.5% over three years, changes to overtime and hours of work terms.

ALTERNATIVE PRESSURE TACTICS?

Yes: Overtime ban, mass resignation attempt

REFERENCES

___, "More than 600 surgeries cancelled across B.C. due to nurses ban on overtime" *Canadian Press News Wire*, April 27, 2001

___, "B.C. nurses lower wage demands from initial 60% over three years" *Canadian Press Newswire*, April 30, 2001

___, "B.C. hospital officials ask nurses to end overtime ban and put patients first" *Canadian Press News Wire*, May 14, 2001

C. Bains, "B.C. nurses overwhelmingly reject contract offer from health employers" *Canadian Press Newswire*, June 6, 2001

C. Bains, "BC nurses say most people on their side in labour dispute with government" *Canadian Press Newswire*, June 25, 2001

___, "B.C. nurses say they have new proposal to settle protracted contract dispute" *Canadian Press Newswire*, June 28, 2001

I. Bailey, "B.C. Premier dictates end to health dispute: Legislation of contract" *National Post*, August 8, 2001, A8

C. Bains, "Labour board orders B.C. nurses not to picket as tension with Liberals mounts" *Canadian Press Newswire*, August 9, 2001.

Health Care Services Continuation Act, S.B.C. 2001, c. 23 [Bill 2, 2001]

Health Care Services Collective Agreements Act, S.B.C. 2001, c. 26 [Bill 15, 2001]

Health and Social Services Delivery Improvement Act, S.B.C. 2002, c. 2 [Bill 29, 2002]; *Health Sector Labour Adjustment Regulation (Health and Social Services Delivery Improvement Act)*, B.C. Reg. 39/2002

Health Services and Support -- Facilities Subsector Bargaining Assn. v. British Columbia, 2007 SCC 27, [2007] 2 S.C.R. 391, [2007] S.C.J. No. 27

2004 BRITISH COLUMBIA ROUND (PS-RELATED)

BRIEF SUMMARY

Bargaining coincided with large and bitter labour dispute between the government and the other unions in health care.

Nurses' union sought extensive data from health employers on a wide range of patient safety-related issues including workload, staffing, and overtime, and obtained an order from the B.C. Labour Relations Board to obtain this information.

Bargaining was shrouded in secrecy. The parties settled for a wage freeze for two years and no other changes to the collective agreement.

However, the parties entered into a two year "framework agreement".

The framework agreement defines four basic "nursing policy" areas for "joint problem solving": phased retirement plans to promote retention, more full time positions, shift scheduling and hours of work (flexibility).

Over the two-year period, the parties are to engage with high level Health Ministry officials and other stakeholders to define a "short list" of bargaining ("problem-solving") topics to be bargained in 2006.

PATIENT SAFETY-RELATED ISSUES?

Yes: hours of work and scheduling

ISSUES

Retirement, hours of work, scheduling

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

None reported.

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Wage freeze for two years, and “framework agreement” process

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

___, “B.C. nurses, employer agree on boundaries for contract talks”, *Canadian Press News Wire*, May 26, 2004

___, “Nurses’ union agrees to no wage increase to keep labour peace” *Canadian Press News Wire*, May 27, 2004

J. Rud, “Truce called in nurses’ talks” *Victoria Times-Colonist*, May 27, 2004, A1

H. Mick, “Nurses should be under same umbrella in contract talks: nurses’ union” *Canadian Press Newswire*, July 14, 2004

2006 BRITISH COLUMBIA ROUND (PS-RELATED)

BRIEF SUMMARY

In 2005 and 2006, one of the goals for the British Columbia government was to ensure that the next rounds of public sector bargaining would not interfere with the February 2010 Winter Olympics. Therefore, it reached four year (2006-2010) collective agreements with all of its major public sector unions, including the nurses’ union. All agreements were set to expire March 31, 2010, well after the Olympics.

To accomplish this, in March the government offered “signing bonuses” of more than \$3,000 per nurse as an incentive for the union to settle by midnight March 31. This offer was made to all public sector unions, and all took it by April 1, 2006. Besides the signing bonuses, the new agreement included:

- Wage increases of 17% over 4 years, increased night and weekend premiums, and signing bonuses.
- Bonuses for nurses who commit to work in departments with the worst nurse shortages
- Development of a workload measurement system

A “commitment” of the government to consult and develop solutions on workload, the organization of work, and workplace safety

In May, the BCNU held a ratification vote on the settlement, which was passed by 97%

PATIENT SAFETY-RELATED ISSUES?

Yes: workload measurement, workload, work organization

ISSUES

Wages, workload measurement, workload, work organization

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

None reported.

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Wage increases of 17% over 4 years, increased night and weekend premiums, and signing bonuses.

Bonuses for nurses who commit to work in departments with the worst nurse shortages

Development of a workload measurement system

A “commitment” of the government to consult and develop solutions on workload, the organization of work, and workplace safety

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

D. Harrison, "Many nurses irked by deal, nurse claims: 15.1% wage hike over four years not enough", *The Province*, March 27, 2006, A13

J. Rud & L. Kines, "Negotiators burn midnight oil", *Victoria Times-Colonist*, April 1, 2006, A2

J. Rud & L. Kines, "Nurses sign deal at 11th hour", *Victoria Times-Colonist*, April 1, 2006, A1

___, "B.C. Nurses Union reaches tentative contract on eve of bonus deadline", *Canadian Press News Wire*, April 1, 2006

___, "BC nurses get 14.2% increase plus signing bonus", *Community Action*, 21:8, April 24, 2006

Mertl, Steve, "B.C. nurses embark on honeymoon with government after signing new contract", *Canadian Press News Wire*, May 8, 2006

A. Ivens, "Nurses happy with healthy raises: Four-year deal provides for 17% pay and benefit hike", *The Province*, May 9, 2006, A11

S. Mertl, "Nurses union head lauds contract", *The Globe and Mail*, May 9, 2006, S3

P. Fayerman, "Nurses in B.C. are now Canada's best compensated", *Victoria Times-Colonist*, May 9, 2006, A5

2009 BRITISH COLUMBIA ROUND (PS-RELATED)

BRIEF SUMMARY

In March 2009, the BCNU, HEABC and the government agreed to extend their agreement two years, from March 2010 to March 2012.

In each of these two years, nurses will receive a 3% "labour market adjustment" increase.

In addition, the extension agreement created a new Joint Quality Worklife Committee. This committee consists of representatives from all parties, and has a mandate to address and propose solutions to a wide range of nursing "quality of working life" issues. These issues include: workload, violence prevention, health and safety, use of agency nurses, staffing processes and work organization. In theory, the committee would make recommendations on these issues to one or both parties to collective bargaining on these matters.

PATIENT SAFETY-RELATED ISSUES?

Workload, staffing processes

ISSUES

Nursing “quality of working life” issues: workload, violence prevention, health and safety, use of agency nurses, staffing processes and work organization

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

No

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

A 3% “labour market adjustment” increase for each of two years, and a new Joint Quality Worklife Committee as described above.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

_____, “B.C. nurses get 6 per cent pay boost in 2-year contract extension”, *The Canadian Press*, March 17, 2009

2012 BRITISH COLUMBIA ROUND (PS-RELATED)

BRIEF SUMMARY

The parties settled for a two-year agreement, which includes an hourly wage increase of three per cent across the board, beginning April 1, 2013.

An agreement from health employers to control workload by (i) staffing fill-in nurses for others away on leave, and (ii) stipulating that when there is “hallway care” and other overcapacity problems, employers are required to call in more nurses to meet patient needs and maintain workloads to safe levels.

PATIENT SAFETY-RELATED ISSUES?

Yes: workload

ISSUES

Wages, workload control

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

None reported.

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

The parties settled for a two-year agreement, which includes an hourly wage increase of three per cent across the board, beginning April 1, 2013.

An agreement from health employers to control workload by (i) staffing fill-in nurses for others away on leave, and (ii) stipulating that when there is “hallway care” and other overcapacity problems, employers are required to call in more nurses to meet patient needs and maintain workloads to safe levels.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

Burgmann, Tamsyn, "B.C. nurses demand up to 2,000 more staff in new contract to relieve workloads", *The Canadian Press*, March 12, 2012

___, "BC nurses contract includes 3 per cent wage hike; adds 2,100 more nurses", *The Canadian Press*, October 2, 2012

___, "B.C. nurses' union vote near 85 per cent to ratify two-year agreement", *The Canadian Press*, October 19, 2012

MANITOBA

1999 MANITOBA ROUND

BRIEF SUMMARY

Bargaining preceded a provincial election

MNU sought 26% over two years, government offered 6%; MNU cited need to be competitive with other provinces

Strike vote was discussed but never held

Mediator became involved, recommended 11% over three years, MNU recommended deal

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

Strike vote threatened

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

11% wage increase over three years

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

___, "Manitoba nurses seek hefty raises, better conditions", *Victoria Times-Colonist*, March 13, 1999, A8

___, "Manitoba nurses reach 11th-hour deal to avert strike", *Calgary Herald*, April 27, 1999, A9

2002 MANITOBA ROUND (PS-RELATED)

BRIEF SUMMARY

MNU asked for wage increase of 31% over two years, government offered 15% over three.

MNU later dropped its demand to 29% over two years, government held to 15% over three

MNU held strike vote, 88% in favour of strike, also threatened an OT ban

Strike date set, union rejected appointment of mediator

Despite essential services law, beds were closed, most elective surgeries cancelled pre-emptively after strike vote, hospital services reduced by about 30%

Health authorities threatened fines to nurses refusing OT

Strike threat resulted in MNU winning 20% over 2 and a half years, plus shift premiums

PATIENT SAFETY-RELATED ISSUES?

Yes: hours of work-premiums

ISSUES

Wages, shift premiums

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

Strike vote held

STRIKE VOTE?

Yes: 88% in favour

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

Yes: Hospital beds were closed, most elective surgeries cancelled pre-emptively after strike vote, hospital services reduced by about 30

GOVERNMENT WARNED LEGISLATIVE END?

No, but warned of fines if nurses refused overtime

SETTLEMENT?

Yes: Strike threat resulted in MNU winning 20% over 2 and a half years, plus shift premiums

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

Threat of OT bans

REFERENCES

___, "Nurses want 31% wage hike; government wants rollbacks" *Regina Leader Post*, September 22, 2001, A6

___, "Manitoba nurses seek 31-per-cent hike", *Victoria Times-Colonist*, September 22, 2001, F7

___, "Man. Nurses' Union calls latest contract offer by the province an insult", *Canadian Press News Wire*, February 21, 2002

___, "Manitoba and its nurses battling", *Prince George Citizen*, February 22, 2002, p. 7

___, "Man. nurses bring wage demands down, but two sides still far apart", *Canadian Press News Wire*, February 23, 2002

___, "Manitoba nurses up ante in contract talks by setting strike vote for March 18", *Canadian Press News Wire*, March 4, 2002

___, "Union expecting positive results when Manitoba nurses hold strike vote Monday", *Canadian Press News Wire*, March 16, 2002

___, "Man. nurses vote to strike; seek parity with Alta. counterparts" *Whitehorse Star*, March 19, 2002, p. 10

Mia Rabson, "Nurses vote to strike: 11,000 could walk out April 1 if contract isn't settled" *The Winnipeg Free Press*, March 19, 2002, A1

___, "Manitoba hospitals prepare for possible nurses' strike as talks continue", *Canadian Press News Wire*, March 19, 2002

Mia Rabson, "Surgeries cut as nurses' strike looms", *The Winnipeg Free Press*, March 20, 2002, A1

___, "Manitoba hospitals brace for walkout by 11,000 nurses", *Montreal Gazette*, March 20, 2002, A13

Mia Rabson, "Province gearing for strike by nurses: Private clinics to be used, nursing-home service cut", *The Winnipeg Free Press*, March 23, 2002, A13

___, "Manitoba nurses may refuse overtime after criticizing province's latest offer", *Canadian Press News Wire*, March 25, 2002

Mia Rabson, "New offer on the table to prevent nurses' strike: Union rejected province's last offer of 15 per cent over three years", *The Winnipeg Free Press*, March 26, 2002, A10

___, "Manitoba nurses who refuse overtime may be fined: health authority", *The Canadian Press*, March 28, 2002

Mia Rabson "Hospital services stripped to basics: Beds closed, surgeries cut as nurses' strike looms", *The Winnipeg Free Press*, March 28, 2002, p. A1

___, "Manitoba nurses union prepare to challenge job action fines in court", *Canadian Press News Wire*, March 30, 2002

Mia Rabson, "Work shifts or face fines, nurses told: Union calls tactic 'bullying,' but health authority says it's the law", *The Winnipeg Free Press*, March 30, 2002, A3

Paul McKie, "Hospitals face havoc on eve of strike: Nurses, province have until midnight to forge contract", *The Winnipeg Free Press*, March 31, 2002, A3

___, "Manitoba nurses continue negotiations with province past deadline", *Canadian Press News Wire*, April 1, 2002

___, "Nurses 'very happy' after striking deal in Manitoba" *Montreal Gazette*, April 2, 2002, A10

___, "Manitoba nurses win 20% pay increase", *Calgary Herald*, April 2, 2003, A4

___, "Manitoba nurses avoid strike, accept 20 per cent pay raise", *Edmonton Journal*, April 2, 2002, E10

___, "Manitoba nurses, gov't agree on tentative deal", *Regina Leader Post*, April 2, 2002, A4

___, "Manitoba nurses win 20% pay increase", *Calgary Herald*, April 2, 2002, A4.

___, "Manitoba Tories wonder where money will come from for nurses' pay hike", *The Canadian Press*, April 2, 2002

Mia Rabson, "Services revived from bare minimum after deal with nurses: Hospitals return to normal", *The Winnipeg Free Press*, April 3, 2002, A5

2004 MANITOBA ROUND

BRIEF SUMMARY

Key bargaining issues were pensions, although wages were also negotiated.

Settlement reached on pension issues, as well as a wage increase of 7.5% over three years.

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages, benefits, pensions

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

No

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Settlement reached on pension issues, as well as a wage increase of 7.5% over three years.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

L. Janzen, "Nurses' contract battle predicted", *The Winnipeg Free Press*, April 27, 2004, A5
_____, "Manitoba nurses' union balks at rollback of pension benefits", *The Canadian Press*, October 19, 2004
M. Rabson, "Province clears pension hurdle, nurses agree to three-year deal", *Winnipeg Free Press*, December 18, 2004, A5

2008 MANITOBA ROUND

BRIEF SUMMARY

Wages were the key issue in dispute: province had offered a 9.6% wage increase over two years.
The MNU began an overtime ban, and set a strike vote date
Hospital beds were closed and services were reduced because of job action.
Province offered to arbitrate dispute
Last-minute agreement before strike vote provided a wage increase of 10% over two years, agreement ratified by 94.5%.

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

Threat of strike vote

STRIKE VOTE?

No

STRIKE ACTION?

No, but overtime ban

ESSENTIAL SERVICE EFFECTS?

Yes

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Yes: wage increase of 10% over two years

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

Overtime ban

REFERENCES

A. Santin, "Bargaining with nurses' union bogs down", *Winnipeg Free Press*, January 4, 2008, B2

___, "Talks break down between nurses' union, province", *CBC Manitoba*, February 26, 2008

Jen Skerritt, "Nurses to refuse extra shifts: Strike for set for March 10", *The Winnipeg Free Press*, February 26, 2008, A3

___, "Health authorities in Manitoba prepare for possible nurses' strike", *The Canadian Press*, March 6, 2008

___, "Manitoba health officials warn of service reductions", *CBC Manitoba*, March 6, 2008

___, "Possible nurses' strike puts surgeries on hold", *Winnipeg Free Press*, March 7, 2008, A8

___, "Strike by 11,000 Manitoba nurses averted with tentative deal", *The Canadian Press*, March 9, 2008

___, "Manitoba nurses reach tentative deal", *Edmonton Journal*, March 10, 2008, A5

___, "Tentative deal averts nurses' strike vote", *Calgary Herald*, March 10, 2008, A4

Jen Skerritt, "Staffing shortage unsolved: nurses; New contract won't address long hours, heavy workload", *The Winnipeg Free Press*, March 11, 2008, A1

Catherine Mitchell, "Nurses win, government wins, patients...", *The Winnipeg Free Press*, March 14, 2008, A13

___, "Nurses vote 94.5% to accept new contract", *The Winnipeg Free Press*, March 29, 2008, A7

___, "Manitoba nurses thank Sask. colleagues for expected pay hike", *CBC Manitoba*, May 29, 2008

___, "Nurses get 5 per cent raise", *Winnipeg Free Press*, October 16, 2008, W1

___, "Manitoba nurses' pay hike makes them the fourth-highest-paid in Canada", *The Canadian Press*, Oct 17, 2008

2010 MANITOBA ROUND

BRIEF SUMMARY

Wages were focus of brief dispute: government sought a two year freeze on wages.

Settled for lump sum payments to nurses but no wage increase.

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Lump sum payments but no wage increases

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

____, "Manitoba's NDP government asks public-sector workers for two-year wage freeze", *Daily Herald (Prince Albert)*, February 17, 2010, p. 2

Bruce Owen, "Wage-freeze plan sparks court threat", *Winnipeg Free Press*, February 19, 2010, A9
____, "Nurses, province suspend bargaining", *CBC Manitoba*, April 14, 2010
____, "Manitoba government says deal with nurses will help in difficult times", *The Canadian Press*, May 28, 2010
____, "Manitoba nurses get lump-sum payment but no raise in 1st 2 years of new contract", *The Canadian Press*, June 17, 2010

2014 MANITOBA ROUND

BRIEF SUMMARY

Wages were only issue in brief negotiation.

Settlement provided 10% wage increase over four years

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

A 10% wage increase over four years.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

___, "Nurses' union to vote on new deal", *Winnipeg Free Press* (web site), April 9, 2014

Kevin Rollason, "Nurses to see 10 per cent wage increase over four years", *Winnipeg Free Press* (web site), May 1, 2014

___, "Higher wages, reduced workload, part of Manitoba nurses' four-year contract", *The Canadian Press*, May 1, 2014

NOVA SCOTIA

2001 NOVA SCOTIA ROUND

BRIEF SUMMARY

Wages were the key issue in dispute.

NSNU and NSGEU demanded 25% and 22.5% over three years, and the government started with 6% over three.

Government later raised offer to 8.5% over three to NSGEU, and 10.5% over three to NSNU.

NSGEU urged rejection of the offer, NSNU accepted it and recommended ratification.

Both unions' members voted down the agreement, NSNU members by 75%.

Both unions took strike votes with overwhelming support for strike action.

Surgeries were cancelled, beds closed, services reduced.

Government introduced Bill 68 before strike action, removing right to strike and imposing terms in its first reading form; also contained injunction rights and penalties for illegal strike.

Polls showed disapproval of the first reading version, and unions threatened illegal strikes in response.

In its final version, Bill 68 did not impose terms and only applied to non nurse NSGEU members in CDHA.

Lawful strikes by nurses remained a possibility, and further services reduced as a result.

NSGEU threatened mass resignation campaign but ultimately did not succeed.

Government conceded on Bill 68 and remitted dispute to a 'final offer selection' arbitration.

The final demand from NSGEU was 27.5%, from NSNU was 22.5%, dropped to 17% each by the arbitration.

Government final offer was 12%, up from 10.5% over three.

Arbitrator selected the final offer of the unions: a 17% wage increase over two years

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

Yes

STRIKE VOTE?

Yes

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

Surgeries were cancelled, beds closed, services reduced.

GOVERNMENT WARNED LEGISLATIVE END?

Yes

SETTLEMENT?

No

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

Yes: final offer selection, union prevailed

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

S. MacKinlay, "Nova Scotians side with nurses: poll", *Halifax Daily News*, June 27, 2001, p. 4

S. MacKinlay, “Any backup plan inadequate in face of exodus – authority”, *Halifax Daily News*, July 4, 2001, p. 4

S. MacKinlay, “Nurses, health workers breathe sigh of relief”, *Halifax Daily News*, July 6, 2001, p. 4

P. Connolly, “Tories reached too far: We would have accepted Bill 68 if it had allowed arbitration”, *Halifax Daily News*, July 7, 2001, p. 2

B. Flinn, “Province can't find arbitrator: Few Nova Scotians seem interested in lucrative job settling health-care dispute”, *Halifax Daily News*, July 12, 2001, p. 4

P. Connolly, “Tories reached too far: We would have accepted Bill 68 if it had allowed arbitration”, *Halifax Daily News*, July 7, 2001, p. 2

D. Rodenhiser, “Hamm on the Bill 68 fiasco: It was worth it”, *Halifax Daily News*, July 8, 2001, p. 17

2004 NOVA SCOTIA ROUND (NSGEU)

BRIEF SUMMARY

The NSNU and NSGEU were bargaining separately.

From both unions, the government and health employers sought relaxation of various overtime and scheduling provisions.

The NSGEU sought a wage increase of 10% over two years, plus a one-time 23% “catch-up” increase to take effect immediately.

In November 2003, the NSGEU agreed to the employers’ “flexibility” driven demands, and agreed to have its wage dispute with the province decided by an interest arbitrator.

In August 2004, that interest arbitrator awarded NSGEU a 6.3% increase spread over three years, and an additional 2.9% per year as a “catch-up” wage increase, for a total of a 15% wage increase over three years.

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

No

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

Yes – NSGEU agreed to have wage issue decided by interest arbitration.

In August 2004, that interest arbitrator awarded NSGEU a 6.3% increase spread over three years, and an additional 2.9% per year as a “catch-up” wage increase, for a total of a 15% wage increase over three years.

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

H. Sullivan, “Nurses relieved province won’t evoke Bill 68: Purves tells union controversial legislation is ‘dead now’”, *Daily News [Truro]*, May 29, 2003, A1

S. MacKinlay, “Nurses unions have tough time getting past ‘mistrust’”, *Halifax Daily News*, June 5, 2003, p. 6

___, “N.S. Tories to accept binding arbitration in health union talks: Purves”, *Evening News [New Glasgow]*, July 28, 2003, A2

Capital District Health Authority v. Nova Scotia Government and General Employees Union (Compensation grievance), [2004] N.S.L.A.A. No. 16 (Kaplan, Plowman, Hayes)

2004 NOVA SCOTIA ROUND (NSNU) (PS-RELATED)

BRIEF SUMMARY

The NSNU and NSGEU were bargaining separately.

From both unions, the government and health employers sought relaxation of various overtime and scheduling provisions.

The NSNU asked for a 15% increase over 3 years, as well as an increase in the overtime factor (from 2 to 2.5 times the hourly rate), and opposed all the employers' "flexibility" demands.

The NSNU settled for a wage increase of 8.7% over three years and the overtime factor increase. The employers did not achieve any of their "flexibility" demands.

PATIENT SAFETY-RELATED ISSUES?

Yes: overtime and scheduling issues

ISSUES

Wages, overtime, scheduling

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Yes: The NSNU settled for a wage increase of 8.7% over three years and the overtime factor increase. The employers did not achieve any of their "flexibility" demands.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

H. Sullivan, “Nurses relieved province won’t evoke Bill 68: Purves tells union controversial legislation is ‘dead now’”, *Daily News [Truro]*, May 29, 2003, A1

S. MacKinlay, “Nurses unions have tough time getting past ‘mistrust’”, *Halifax Daily News*, June 5, 2003, p. 6

___, “N.S. Tories to accept binding arbitration in health union talks: Purves”, *Evening News [New Glasgow]*, July 28, 2003, A2

___, “Nurse head wants one agreement for N.S. nurses”, *Evening News [New Glasgow]*, October 9, 2003, A7

P. McLaughlin, “Secret no-strike deal out in the open”, *Halifax Daily News*, October 25, 2003, p. 6

B. Johnston-Ross, “Nurses want conciliator to settle stalled talks: Union seeks 15 per cent raise over three years” *Halifax Daily News*, January 9, 2004, p. 5

___, “NSNU recommending agreement to nurses”, *Evening News [New Glasgow]*, January 22, 2004, A3

H. Sullivan, “Nurses agree to new three-year contract”, *Daily News [Truro]*, January 29, 2004, A1

R. Boomer, “Contract makes NSNU nurses highest-paid in Maritimes”, *Halifax Daily News*, January 29, 2004, p. 4

2008 NOVA SCOTIA ROUND (NSNU)

BRIEF SUMMARY

The NSNU and NSGEU were bargaining separately. Wages and benefits were the sole issues.

Bargaining occurred simultaneously with introduction of legislation curtailing the right to strike in health care and introducing interest arbitration on the Ontario model.

Ultimately, the NSNU settled for a wage increase of 2.9% per year for three years.

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages and benefits

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

8.7% wage increase over three years

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

___, "N.S. moves to ban strikes in health care: Report advised against using Alberta model", *Edmonton Journal*, October 19, 2007, A7

___, "Nurses' contract talks not stopping anti-strike bill: premier", *CBC Nova Scotia*, January 7, 2008

___, "Nurses ratify contract", *The Daily News (Halifax)*, February 8, 2008, p. 2

J. Gillis, "New contract reflects 'needs of our nurses,' union president says", *The ChronicleHerald*, February 9, 2008, B2

___, "Nova Scotia nurses ratify new deals", *CBC Nova Scotia*, February 29, 2008

___, "Nova Scotia nurses accept new contract", *Globe and Mail*, March 1, 2008, A14

2008 NOVA SCOTIA ROUND (NSGEU)

BRIEF SUMMARY

The NSNU and NSGEU were bargaining separately.

The NSGEU and Capital Healt kept the details of the issues in dispute private.

Bargaining occurred simultaneously with introduction of legislation curtailing the right to strike in health care and introducing interest arbitration on the Ontario model.

The NSGEU and government had already agreed that if an impasse is reached the union must present its members a vote between two options: striking or accepting binding interest arbitration. However, after talks broke down, the union refused to hold that vote.

The parties settled in January 2008.

The settlement included an 8.7% wage increase over three years, as well as a new 3.5 per cent raise for nurses with 25 years of service and an annual retention bonus for those who agree to work beyond their retirement eligibility.

The membership ratified the agreement by a 60 per cent margin of the 1,490 nurses affected.

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages and benefits

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

The settlement included an 8.7% wage increase over three years, as well as a new 3.5 per cent raise for nurses with 25 years of service and an annual retention bonus for those who agree to work beyond their retirement eligibility.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

___, "N.S. moves to ban strikes in health care: Report advised against using Alberta model", *Edmonton Journal*, October 19, 2007, A7

P. McLeod, "Contract talks between NSGEU and Capital Health hit impasse", *The Daily News (Halifax)*, November 3, 2007, p. 9

___, "Nurses' contract talks not stopping anti-strike bill: premier", *CBC Nova Scotia*, January 7, 2008

J. Gillis, "Nurses reach tentative deal; NSGEU agreement includes retention bonus for nurses who agree to work beyond retirement", *The Chronicle-Herald*, January 19, 2008, A1

___, "Nurses, Capital Health reach tentative agreement", *The Hants Journal (Windsor, NS)*, January 31, 2008, p. 5

___, "Nurses ratify contract", *The Daily News (Halifax)*, February 8, 2008, p. 2

___, "Nova Scotia nurses ratify new deals", *CBC Nova Scotia*, February 29, 2008

___, "Nova Scotia nurses accept new contract", *Globe and Mail*, March 1, 2008, A14

2011 NOVA SCOTIA ROUND (NSGEU)

BRIEF SUMMARY

The NSNU and NSGEU were bargaining separately.

The government had insisted on a hard cap of a 1% per year wage increase across all of the provincial public service.

The NSGEU, which represents all provincial government employees, also represents the approximately 2,500 nurses in the Capital Health health region. On their behalf, it insisted on a 12% wage increase over three years.

NSGEU held a strike vote: 1,717 members voted, or 71% of the total membership. Of these, 94% voted in favour of strike action.

The NSGEU demanded a new offer from the government, and said it was preparing for a walkout and was talking with the health district about providing emergency services.

The resulting three-year contract provides wage increases of one per cent in each of the past two years. That increase is in line with other public-sector contracts because of provincial cost-cutting.

But the nurses also won an average wage hike of 3.5 per cent effective Tuesday and an across-the-board increase of 1.6 per cent on May 1.

The cumulative increase of roughly 7.1 per cent will make Capital Health nurses the highest paid in the Maritimes, said union president Joan Jessome.

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages: Government insisted on 1% per year, NSGEU insisted on more

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

Yes, strike vote held, 89% in favour

STRIKE VOTE?

89% in favour

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

No

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

Yes (but agreed to): 7.1% wage increase over three years

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

A. Dezsi, "Capital Health nurses pass strike vote as conciliation nears", *The Chronicle-Herald*, April 28, 2011, A8

___, "Talks break off between nurses and Capital Health", *CBC Nova Scotia (web site)*, May 3, 2011

___, "Capital Health RNs vote to strike", *CBC News (web site)*, May 25, 2011

M. Patten, "Nova Scotia nurses' union says no more talk till government ponies up more money", *The Canadian Press*, May 26, 2011

P. Lee, “Nurses, N.S. at odds on talks; Health minister pushes for bargaining, union wants better offer first”, *The Chronicle-Herald*, May 27, 2011, A8

___, “N.S. nurses union talks tough as possible strike looms on horizon”, *The Guardian (Charlottetown)*, May 27, 2011, A8

M. Patten, “No more negotiations until Nova Scotia ponies up more money, nurses union says”, *Cape Breton Post*, May 27, 2011, A5

___, “Capital Health nurses back to bargaining table”, *CBC News (web site)*, June 2, 2011

C. Mellor, “Nurses talks to resume today; 'Money is the issue' as union, Capital Health try again for deal”, *The Chronicle-Herald*, June 3, 2011, A6

___, “ACROSS NOVA SCOTIA”, *The Chronicle-Herald*, June 4, 2011, A3

___, “Nurses' strike in Nova Scotia may be averted”, *CBC Nova Scotia (web site)*, June 4, 2011

Capital District Health Authority v. Nova Scotia Government and General Employees Union (Wage Grievance), [2011] N.S.L.A.A. No. 9 (Burkett, Johnston, Power)

J. Mcphee & D. Jackson, “7.1% increase: Nurses win wage fight; Union: Arbitrated 3-year deal makes Capital Health's local highest paid in Maritimes”, *The Chronicle-Herald*, November 2, 2011, A1

2011 NOVA SCOTIA ROUND (NSNU) (PS-RELATED)

BRIEF SUMMARY

The NSNU and NSGEU were bargaining separately.

Unlike the NSGEU, the NSNU accepted the government's standard 1% per year raise in pay.

Union president Janet Hazelton said the government's pattern of one per cent raises for public sector workers was entrenched, so the union looked for other improvements to the contract.

The NSNU won the elimination of mandatory overtime.

PATIENT SAFETY-RELATED ISSUES?

Yes: hours of work – mandatory overtime

ISSUES

Wages, hours of work - mandatory overtime

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

None reported

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Yes: 1% wage increase per year, elimination of mandatory overtime

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

D. Jackson, "N.S. Nurses' Union to vote on tentative deal; 4,800 begin casting ballots Monday", *The Chronicle-Herald*, April 16, 2011, A6

M. Patten, "Nova Scotia nurses' union says no more talk till government ponies up more money", *The Canadian Press*, May 26, 2011

2012 NOVA SCOTIA ROUND (NSNU)

BRIEF SUMMARY

After the NSGEU obtained its wage increase in the 2011 round, the NSNU demanded an identical wage increase.

The NSNU warned of a strike vote but never held one.

Ultimately the government conceded and gave the NSNU a 3.9% wage increase over two years. The membership ratified the settlement.

PATIENT SAFETY-RELATED ISSUES?

No

ISSUES

Wages

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

Strike vote threatened

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

No

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Yes: 3.9% wage increase over two years

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

____, "N.S. nurse union threatens strike", *CBC Nova Scotia (web site)*, May 15, 2012

M. Gorman & D. Jackson, "N.S. nurses want Capital pay level; Union: Members ready to strike if June talks don't yield similar raise", *The Chronicle-Herald*, May 16, 2012, A1

____, "Nova Scotia acute and long-term care nurses reach tentative agreement", *The Canadian Press*, June 22, 2012

S. Ross, "Nurses union: Deal levels playing field; Latest contract gives members 'same rate' as in Capital Health", *The Chronicle-Herald*, June 23, 2012, A5

____, "Nurses union reaches tentative agreements", *The Reporter* (Port Hawkesbury, NS), June 27, 2012, p. 25

2013 NOVA SCOTIA ROUND (NSNU) (PS-RELATED)

BRIEF SUMMARY

The NSNU and government settled for a wage increase of 5.5% over two years, as well as the addition of a workload-measurement and complaint process to the collective agreement.

PATIENT SAFETY-RELATED ISSUES?

Yes: workload

ISSUES

Wages, workload

DISPUTE?

No

STRIKE OR STRIKE VOTE THREAT?

No

STRIKE VOTE?

No

STRIKE ACTION?

No

ESSENTIAL SERVICE EFFECTS?

No

GOVERNMENT WARNED LEGISLATIVE END?

No

SETTLEMENT?

Yes: 5.5% over two years, and the workload process described above.

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

No

REFERENCES

J. Mcphee, “Nova Scotia Nurses Union, province reach tentative deal”, *The Chronicle Herald* (Halifax, NS) (web site), October 4, 2013

J. Mcphee, “Nova Scotia Nurses Union, province reach tentative deal”, *The Chronicle-Herald*, October 5, 2013, A3

___, “N.S. nurses ratify deal that offers wage hikes, addresses workload”, *The Chronicle Herald* (Halifax, NS) (web site), November 14, 2013

2014 NOVA SCOTIA ROUND (NSGEU) (PS-RELATED)

BRIEF SUMMARY

NSGEU negotiated on behalf of the 2,600 nurses employed by Capital Health.

The central issue in dispute was workload, and specifically the proposal of the NSGEU for fixed nurse—patient ratios in the collective agreement. The union wanted one nurse to two patients in emergency room units and one nurse to four patients in the medical-surgical, psychiatric and rehabilitation units.

Other issues were scheduling, sick-call replacements and vacations.

After a mediator was unable to facilitate a settlement, the NSGEU took a strike vote in favour of strike action in support of the union’s nurse-patient ratio proposal.

The provincial government began drafting legislation that would, like similar models in other provinces, prohibit strikes in health care until the union and employer have made an agreement to provide essential services during any strike.

In response, the union took a further “mass resignation” vote by which the membership resolved to resign en masse if the government enacted the “essential services” legislation.

The government and employer warned nurses they could face legal action including professional discipline if they were to resign en masse.

Capital Health began reducing services such as scheduled surgeries and tests, as management believed that a work stoppage of any kind by the nurses would harm patients.

The government introduced the “essential services” legislation (Bill 37) which prompted a brief illegal strike and some protest actions by NSGEU members. About 90 operations were postponed.

The Nova Scotia Labour Relations Board issued an injunction under Bill 37 against any strike action, and the nurses returned to work.

PATIENT SAFETY-RELATED ISSUES?

Yes: workload – nurse-patient ratios; scheduling

ISSUES

Workload: nurse-patient ratios

DISPUTE?

Yes

STRIKE OR STRIKE VOTE THREAT?

Brief wildcat (illegal) strike

STRIKE VOTE?

Yes

STRIKE ACTION?

Yes

ESSENTIAL SERVICE EFFECTS?

Yes

GOVERNMENT WARNED LEGISLATIVE END?

Yes

SETTLEMENT?

No

LEGISLATIVE END TO STRIKE WITH INTEREST ARBITRATION?

No

LEGISLATIVE END TO STRIKE WITH UNILATERAL TERMS?

No

ALTERNATIVE PRESSURE TACTICS?

Mass resignation threat

REFERENCES

M. Gorman, "Union pushes for better nurse-to-patient ratios", *The Chronicle-Herald*, January 14, 2014, A5

___, "Nurses union: Contract talks at impasse", *The Chronicle Herald (Halifax, NS) (web site)*, January 31, 2014

___, "Nurses union contract talks break off with Capital Health Union says main sticking point is nurse to patient ratios", *CBC Nova Scotia (web site)*, March 18, 2014

Opinion, "Better way to resolve ratios issue; Nurse contract impasse", *The Chronicle-Herald*, March 19, 2014, A10

M. Gorman, "Mediator to seek deal in dispute with nurses", *Chronicle – Herald*, March 20, 2014, A4

___, "Capital Health threatens legal action if nurses resign", *CBC Nova Scotia (web site)*, March 20, 2014

___, "N.S. Premier chides nurses threatening strike action", *The Globe and Mail*, March 21, 2014, A5

C. Mellor, "Resignation threat sparks warnings; Capital Health warns of legal action if nurses quit over back-to-work", *Chronicle – Herald*, March 21, 2014, A3

D. Jeffery, "Mediation between nurses, Capital Health at 'impasse'", *The Chronicle Herald* (Halifax, NS) (web site), March 22, 2014

D. Denney, "Mass nurse resignations a serious concern", *Chronicle – Herald*, March 22, 2014, E4

M. Macdonald, "Capital Health considers postponing medical procedures", *Chronicle – Herald*, March 22, 2014, A11

M. Lightstone, "Labour leader urges Liberals to stay out of nurse negotiations", *Chronicle – Herald*, March 22, 2014, A11

C. Mellor, "RN talks nursing and numbers; Nurse-patient ratios remain major obstacle to Capital Health, NSGEU agreement", *Chronicle – Herald*, March 22, 2014, A11

D. Jeffery, "Nurses' talks stop; Sides could be in strike/lockout position on April 3", *Chronicle – Herald*, March 24, 2014, A1

D. Jeffery, "Mediation talks reach impasse; Nurses announce breakdown; sides could be in strike/lockout position as of April 3", *Chronicle – Herald*, March 24, 2014, A3

D. Leger, "The wacky world of labour talks", *Chronicle – Herald*, March 24, 2014, A11

S. Ross, "Nurses say they'd defy N.S.; Wildcat strike would result if province enacted back-to-work legislation, union", *Chronicle – Herald*, March 25, 2014, A1

___, "THE POSITIONS; Nurses and the employer speak about the sticking point in their negotiations: mandatory nurse-patient ratios", *Chronicle – Herald*, March 25, 2014, A7

___, "Do it soon; AVERTING A NURSE STRIKE", *Chronicle – Herald*, March 25, 2014, A11

M. Gorman, "Health boards merger could result in union power play", *Chronicle – Herald*, March 26, 2014, A1

L. Fraser, "N.S. to hold off on back-to-work bill if contract talks progress; Premier softens legislative threat as rhetoric", *Chronicle – Herald*, March 26, 2014, A6

S. McCulloch, "Nurses tell board of concerns about new care model", *Victoria Times – Colonist*", March 27, 2014, A3

M. Gorman, "Changes inevitable in staffing", *Chronicle – Herald*, March 28, 2014, A1

M. Gorman, "Heated exchange; Grits hammered on nurses strike", *Chronicle – Herald*, March 28, 2014, A9

M. Lightstone, "Nurse dispute; Strike staffing plan in works; But union's numbers worry Capital Health", *Chronicle-Herald*, March 28, 2014, A1

B. Outhouse, "Talks to resume in nurses' labour dispute", *The Ottawa Citizen*, March 29, 2014, A3

___, "Talks with nurses to resume", *Chronicle - Herald*, March 29, 2014, A12

L. Fraser, "Nurses face hefty fines in wildcat strike; Once new essential-services legislation passes, workers could be hit with \$1,000 penalty", *Chronicle - Herald*, April 1, 2014, A3

J. Taber, "Wildcat strike delays dozens of operations", *The Globe and Mail*, April 2, 2014, A5

I. Fairclough, "Some surgery called off at QEII", *Chronicle – Herald*, April 2, 2014, A6

K. Shiers, "Union asks nurses to return to work; NSGEU still plans protests, strike to fight essential services bill", *Chronicle – Herald*, April 2, 2014, A6

M. Gorman, "Labour faceoff in the House; Unions protest strike bill", *Chronicle – Herald*, April 2, 2014, A1

K. Shiers, "Union asks nurses to return to work; NSGEU still plans protests, strike to fight essential services bill", *Chronicle – Herald*, April 2, 2014, A6

J. Taber, "Wildcat strike delays dozens of operations", *The Globe and Mail*, April 2, 2014, A5

M. Gorman, "Labour faceoff in the House; Unions protest strike bill", *Chronicle – Herald*, April 2, 2014, A1

MacDonald, M., "Nova Scotia braces for nurses' strike", *Saint John Telegraph-Journal*, April 3, 2014, A8

M. Gorman, "McNeil says bill balances patient needs, workers' rights", *Chronicle – Herald*, April 3, 2014, A1

M. Gorman, "Essential services; MLAs debate, nurses to walk; Budget also on today's agenda", *Chronicle – Herald*, April 3, 2014, A1

M. Lightstone, "Capital Health, nurses at odds on emergency staffing levels", *Chronicle – Herald*, April 3, 2014, A3

___, "Capital Health nurse strike: what you need to know 2,400 registered nurses to start strike at 7 a.m. Thursday", *CBC Nova Scotia (web site)*, April 3, 2014

___, "Late-night debate held on strike bill", *Chronicle – Herald*, April 4, 2014, A10

___, "Surgeries put off, beds closed as Halifax nurses swap scrubs for pickets", *Saint John Telegraph-Journal*, April 4, 2014, A4

___, "Late-night debate held on strike bill", *Chronicle – Herald*, April 4, 2014, A10

S. Ross, "Strike law seen as 'great news'; Nova Scotia had been only province without essential services legislation – CEO", *Chronicle – Herald*, April 5, 2014, A4

M. Gorman, "Bill 37 passes amid noisy protest; Legislation sending NSGEU nurses back to work affects nearly 40,000", *Chronicle – Herald*, April 5, 2014, A4

K. Shiers, "Nurses back on job but vow new strategy", *Chronicle – Herald*, April 5, 2014, A4

G. Lethbridge, "Adversarial system fails us miserably", *Chronicle – Herald*, April 5, 2014, E1

D. Jobb, "Nova Scotia struggles to pay nurses", *Winnipeg Free Press*, April 8, 2014

Essential Health and Community Services Act, S.N.S. 2014, C. 2