used to be on the property because we're using that process to resolve things, and there are not as many arbitrations anymore. For the employees, it's like, "What am I paying dues for?"

Parker: Well, my time keeper is telling me that it's about time to wrap things up. Thanks for being such a great audience.

VIII. HEALTH CARE

Moderator: Jay Nadelbach, NAA Member, New York, New York

Panelists: Bill Flannery, Partner, Post & Schell, P.C., Harrisburg, Pennsylvania
Barbara Hoey, Chair, Labor and Employment Practice Group, Kelley Drye & Warren LLP, New York, New York
Hope Pordy, Attorney, Spivak, Lipton, Watanbe Spivak Moss & Orfan LLP, New York, New York
Gwynne Wilcox, Partner, Levy Ratner, P.C., New York, New York

Nadelbach: I will briefly introduce everyone beginning with the person next to me and moving down the line. Gwynne Wilcox is a partner at Levy Ratner and represents unions before the National Labor Relations Board (NLRB) and other administrative agencies as well as in arbitrations and litigation. Barbara Hoey is chair of the labor and employment practice group for Kelley Drye & Warren, a national firm based in New York City that represents management in all types of labor and employment matters. Bill Flannery is based in Harrisburg, Pennsylvania, and represents management in labor and employment practice. Finally, Hope Pordy is associated with the law firm of Spivak Lipton in New York City.

This will be an interactive session and we will begin with the general reaction from each of our panelists to the presentation on arbitral discretion and the discharge penalty as it applies to the health care industry where each of our panelists practice. I invite the panelists to tell us if they have witnessed an evolution of the "just cause" standard and, if so, how?

Wilcox: I have not witnessed an evolution in arbitral discretion with regard to the discharge penalty. The Mittenthal/Vaughn paper did place in perspective the arbitration practice and just cause. Arbitrators make their decisions based upon what they

think the facts should be and looking at whether it is a reasonable standard or apply their sense of what the workplace standard is. We pick arbitrators who we believe have an understanding of the industry and understanding of the dynamics of the workplace and we use the same arbitrators who we are comfortable with and who look not only at management's decision but examine it from the union's and employee's standpoint and a sense of fairness. We never say to a grievant that an arbitrator is going to make a decision based upon fairness but based upon the facts and "just cause."

On the issue of the remedy and whether it should be reinstatement with back pay or without back pay, oftentimes the employers are making decisions where they know the person will be reinstated. They expect the arbitrator to make the decision but that shouldn't be the way to run a business. In health care there are vast resources consumed to train people and then the employee is terminated; that is disruptive to the workplace as well as the person's life so maybe discipline or termination wasn't the appropriate way to handle it.

There are limited resources in the industry and hospitals and nursing homes are challenged on a daily basis to meet their needs. To create a revolving door where employees are constantly overly disciplined is a cost to the industry. Reinstating without back pay is not a win/win situation. The union wants the employee back to work but he may have lost his apartment or house and I hope that arbitrators would consider that when issuing a remedy.

Nadelbach: Let's discuss the threshold issue of whether or not there's been an evolution in arbitral discretion and just cause in the health care industry.

Hoey: There has been an evolution in two ways. Number one the process has become much more legalistic and I'm a lawyer criticizing the legalisms. When I started about 20 years ago, most of the cases took about a day because there were no extensive requests for discovery from the union. We did not spend the first half-day of the hearing arguing whether or not we had complied with that request. People did not subpoena every witness who possibly could testify; people were more reasonable about who should be there.

Number two is this evolution into a criminal justice standard raised by one of the speakers in the Mittenthal/Vaughn presentation. This harms my clients because I'm not sending anyone to jail or placing anyone in the electric chair. Yes, they are losing their

job but life will go on. Many times unions and arbitrators hold the hospitals to a standard of criminal justice, meaning have you proven beyond a reasonable doubt that this person did it—did you have a sufficient identification of the person, did you do a lineup? If you show the patient a picture of the grievant and the patient states that's the person who did this to me, was that fair? I feel like I'm on *Law & Order*. Sometimes the hospital loses when they're held to that standard because, news flash, they're not district attorneys and they're not cops, they're human resources personnel running a hospital or hospital administrators and they're not trying to discharge someone based on a criminal justice standard. The heightened burden of proof means that management is sometimes quick to end the discharge cases, which is not fair because the system was not designed in that manner.

Flannery: Reading the Mittenthal/Vaughn paper and listening to the presentation today, I was immediately reminded of a story about a gentleman and his friend who decided to go sailing in a hot air balloon. A tremendous wind took them way up into the clouds and they were there for hours. When the wind abated they came down and were very close to the ground. They saw a beautiful country setting and there was a gentleman dressed in tweed walking along the road. They yelled "Sir, where are we?" and the gentleman replied "You're in a balloon." The wind took them away again and the one person turned to the other and said that the gentleman had to be a lawyer. "Why do you say that?" the other replied. His friend said, "Because what he told me was absolutely accurate but it doesn't help me whatsoever."

The Mittenthal/Vaughn paper was a nice description of the evolution of the "just cause" standard from the 1930s to the present, identifying the different phases or the different approaches––the traditional approach, the reasonableness approach. I spend 70 percent of my time representing health care institutions. Over the course of any given year, I will receive decisions that are based on the abuse of discretion standard, that are based on the reasonableness standard, that use the preponderance of the evidence test, that use the clear and convincing evidence test. It is very difficult to try to counsel the clients precisely what the definition of "just cause" is and what the standard's going to be in an arbitration of a discipline case. There are as many views of just cause as there are arbitrators in this room.

The only item that is somewhat health care–specific concerns health care cases involving clinical employees where the arbitra-

tor suggests that there may be a higher standard of care that the clinical employee should be held to when an employer makes a decision about discipline. The higher standard of care theory is not unusual to the law. Those of us who are lawyers know in torts, for example, that somebody who is a trained professional will be held to a higher standard of care in his or her field than a person who is not in that field. Pennsylvania unemployment law, for example, states that health care employees will be held to a higher and different standard of care in making decisions. Whether this theory is the musing of a few arbitrators who find it interesting and appropriate for health care or whether it has gained some life remains to be seen.

Pordy: I'm going to mimic some of Gwynne's comments. I don't know if I'm able to comment on the evolution of "just cause" over a significant period of time but I can at least comment on my observations in doing arbitrations in the health care industry and in non–health care industries.

When I first started doing arbitrations, my employer handed me a book with the seven tests of "just cause" and told me to learn it, love it, use it whenever possible. I dutifully copied the two or three pages listing the seven tests, took them to every arbitration hearing, and included them in every opening statement.

Arbitrators may have viewed that as too formulaic but it served a lot of beneficial purposes. One, it was a very good aid in preparing for arbitration because it provides a framework in which to analyze a case, to develop evidence, and to interview witnesses. I went into all my interviews with my witnesses with the similar outline, with the seven tests, and made sure that I discussed each test with my witness, so I had a good sense of the case and whether or not I could win on that "just cause" standard. Also, I thought the tests were very helpful in allowing the union employee, who I was representing, to grasp what we needed to prove or disprove in a hearing. As an advocate, I always am very conscious of making sure that whoever I represent understands the process and what we need to show to the arbitrator to win the case.

Having said that and noticing that when I compare discipline cases in health care and non–health care, in other industries the arbitrators are more willing to look at the seven tests of "just cause" and do a checklist. We should examine discipline within that context because it's straightforward. In health care cases—and I represent the New York State Nurses Association—I find that the seven tests disappear and the arbitrator is looking at the serious-

ness of the conduct. This occurs with nurses because it's life and death issues all the time.

There are certainly run-of-the-mill absenteeism cases, but even those implicate life and death issues because employers always complain that they cannot have a nurse not report for work on time because now the emergency room is understaffed. Some arbitrators are not necessarily looking for that checklist. I've had cases where a 30-year nurse has performed well, no prior discipline, but she didn't properly adjust a monitor and didn't respond to an alarm on a telemetry machine and the patient had a heart attack. Nobody responded and if there had been a timely response the patient would have survived. At that point nobody really cares about the seven tests of "just cause." All they care about is one situation where, unfortunately, that nurse was not on top of her job. Some of the other mitigating factors that surface with the seven test model are not as important in a health care situation.

Nadelbach: Would the other panelists agree that there's something unique about the health care field that this reasonableness test should be looked at from the employer's perspective more so than from the individual arbitrator's perspective?

Hoey: What about "just cause" for the hospitals? What about "just cause" for the employer? Two things unions don't understand. My clients go through a wrenching process before they decide to fire someone. We are not firing people willy-nilly, particularly when we're dealing with nurses because there is a nursing shortage. We have a technician shortage. We have a radiology technician shortage. We have multiple shortages in a lot of the specialty areas. They are not going to fire one of those people unless they feel that they have a very real and serious reason to do it. It goes often to the highest levels, a CEO in most hospitals will review the discharge of a nurse or the Vice President of Nursing. That's number one.

Number two is the fact that hospitals are most concerned with their constituency—the patients and the patients' families—who have either seen what happened or witnessed what happened or are extremely upset about what might be a very bad outcome.

Also I think there are two kinds of situations and my clients recognize the difference. There is the clinical employee who makes an honest mistake. The nurse misread the chart and she gave the wrong medication. The technician miscalibrated the machine but tried to do it correctly and honestly made that mistake. Those are the kinds of errors that are reviewed from a quality assurance

standpoint and the hospital will try to remediate with process. Can we improve the process? Can we improve the chart? Can we make it clearer? Will progressive discipline help that person because they probably will learn from that error?

The other category is people who do something intentionally bad. They intentionally neglect a patient. They don't want to change her—she's incontinent for the sixth time—they're tired, they don't feel like dealing with it. They intentionally walk past the room when the patient is calling for them. This happens in nursing homes because the patient is a pain. I see abuse cases but they are of more minor bad things that harm patients. Those things don't deserve to be remediated by progressive discipline. Hospital administrators will tell you there are people who simply do not belong in the profession. They should not be a Nurse's Aide. They shouldn't be working in a hospital with patients. This is not a place for progressive discipline because this person just shouldn't be in this profession.

Joel Rosenboom: We represent the less-skilled employees; there is not a shortage of personnel for these positions. They are able to get other jobs when they're discharged. When they are accused of neglect or abuse and the union argues they did not do it, I have a problem with arbitrators who have sleepless nights about reinstating that person even if the arbitrators think that they didn't do it but they might do it again.

I counsel my grievants that if you have another job or if you have any other prospects for another job, waive reinstatement, go for your back pay, and clear your record. When I lose cases I like to think that the arbitrator had sleepless nights making the decision, but I don't want the arbitrator to lose any sleep or hesitate to reinstate that person unless that's critical to my grievant. I try to make it a victory where the person gets all of his or her back pay but goes on to another job. I'd like your reaction to that.

Wilcox: The cases that we're talking about are the cases that the parties were not able to resolve so they are headed to arbitration, which is a small percentage of all cases. When one side believes they may win or lose, they'll try to resolve it. In those situations the unions do not see it as intentional conduct because they've done an investigation, they've spoken to co-workers, they know what the person's reputation is on the unit, and they've tried to make some assessments as to whether this happened. I am not familiar with the situation out West but in New York City there are people looking for these jobs because of the benefits and decent salaries.

Oftentimes a lot of the risk is placed on the worker. I don't see the situations where people are intentionally engaging in misconduct with regard to patients but that happens. Is it due to short staff? Is it because supervision is not as good as it could be? Are there other things happening on the floor that may cause a particular problem? The issues are different.

Rosenboom: By the way, it's always up to the grievant whether that person is willing to waive reinstatement.

Pordy: As far as New York, I agree with Gwynne in that I've never seen a grievant waive reinstatement.

Audience Member: Even if the employee has another job, that person will go through the process saying "I want to come back."

Panel Member: A lot of times it's advisable for the individual employee adversely affected by an employment decision to always represent to the court or the arbitrator that he or she wants the job back. One, it can be a bargaining chip if you get into settlement discussions because the first thing the employer wants the employee to give up is the demand for reinstatement and all of a sudden money falls on the table. In our practice we represent that reinstatement is always an option.

Audience Member: I'd like to hear the reason why—in an off-the-record discussion—the union advises the employer that the individual grievant is not interested in reinstatement. I'd like to get a reason why that case doesn't settle out.

Panel Member: I was going to say it is how much money is on the table and then they'll leave. I've had cases where the union attorney states that the employee is not returning to work but will not make that statement on the record.

Nadelbach: The question was posed that the statement was made on the record.

Audience Member: I've said it in my opening statement.

Audience Member: And that doesn't settle?

Audience Member: It won't settle if it is a money issue. We'll pay you the nuisance value but we're not going to give you a significant amount of back pay.

Audience Member: What if you appear before an arbitrator and the employee states that he does not want reinstatement but the arbitrator's not inclined to issue a back pay remedy because he sees termination wasn't appropriate but a nine-month suspension was appropriate? What remedy is left? If reinstatement is on the table at least there's something to fall back on.

Audience Member: You push for settlement.

Audience Member: Even if you hear it for the first time in an opening statement, why doesn't the arbitrator pull the attorneys out into the hall and figure out what's going on?

Panel Member: It depends in large part about the reason for the termination. When we use the term "health care" we tend to think about the clinical side but health care institutions are big and complex businesses. A health care institution is a hotel in which health care services are provided. We provide the whole range of hotel services and we provide clinical services. When dealing with cases that involve the support service employees, I do not think anybody is suggesting that the dietary employee should be held to a higher standard of care in food preparation or that a housekeeping employee or maintenance employee should be held to a higher standard of care in what he or she may do. Even when you're talking about the professional employee's absenteeism and parking in the wrong parking place, nobody's suggesting a higher standard of care in those cases.

When talking about the narrow category of professional clinical employees and the performance of their duties toward patients, we are in that narrow category of circumstances that something different should be applied.

Dan Brent: I am arbitrator in Princeton, New Jersey. One of the manifestations of "just cause" in health care occurs, for example, when either the patient or the family member is not present to testify. The arbitrator is presented with hearsay about what a patient told a supervisor and there is no patient or family member to testify.

Panel Member: Yes, that is very hard for the hospital. I've had a couple of cases where the patient testifies that he made the complaint and he believed it happened. I had one case where the gentleman was very elderly and had a tracheotomy so he could barely speak. To bring him in would have been bizarre—who was going to put him through that? When there is no patient to testify that can be held against the hospital.

Panel Member: Many contracts will have a clause that says something to the effect that the arbitrator will not hold it against the hospital that the patient is not required to testify. As an arbitrator bound by the terms of the contract where you cannot add to or subtract from its terms, you must respect that clause. What do you do in that case where the contract doesn't say that and there is an

allegation of patient abuse? My clients would never put a patient through an arbitration hearing. They will walk away and deal with the consequences that may flow from that before they would ever put a patient on the stand.

Audience Member: There is a different concept of "just cause" in terms of the right to confront the witness and use of hearsay. If I had a credible supervisor or charge nurse present on the scene and that person described what the patient alleges credibly as being hit or grabbed, why would a charge nurse fabricate that story?

Audience Member: If you have somebody who observed the event then that testimony is not hearsay.

Panel Member: Correct. Again, unless there is bizarre motivation to make up this entire allegation why would the charge nurse or patient make it up? There are difficult patients and I've had cases where the union will prove that this person was a complainer and complained about everyone. Those are difficult cases. Again, I think this gets back to the case I had with the patient with a tracheotomy and the nursing home believed that the nurse had done things like this in the past. They were never able to prove it because the nurse had always chosen people who were vulnerable, could not speak, or did not know how to report her. We settled because the client felt more strongly about having the nurse removed and making sure she would be gone than the amount of money they had to pay, which was very distasteful to them.

Edward A. Pereles: Given the possibility of a malpractice claim or allegation, how does that affect your thinking whether to discipline or the whole issue about a possible civil action?

Panel Member: I've had cases where there was a serious patient incident and the employer brought in a court reporter to capture all the testimony in case there were any further proceedings. There does seem to be more formality to the process in the anticipation there may be a civil action. I don't think the union was permitted to object during the transcription but we were entitled to view the transcript. My understanding is that we cannot prevent a party from having a transcript made at arbitration. You have to look at the case in a much different way because you need to study very closely your witnesses' credibility, consider if there is any other litigation, and coordinate with other attorneys who may be representing the individual employee to make sure that you're all on the same page with the same theory and the same factual

evidence. Different attorneys have different perspectives on the facts and the issues as reported in a transcript.

Panel Member: Risk management will be involved if it's a serious case. The risk manager is worried about the malpractice lawsuit. That manager will be at your meetings, reviewing the decision, thinking about how they're going to handle it. That may be a reason to settle.

Audience Member: Have you had a risk manager sit in at the arbitration hearing?

Panel Member: No but he is present for internal deliberations. I've also had the problem with differing standards applied to nurses compared with those in other positions. The nurse and physician are involved; the nurse is fired and the physician—it's a complicated situation.

Panel Member: You raised a very good question about this undercurrent that health care management has to deal with doing the right thing in terms of going forward with discipline where you believe discipline is appropriate versus setting yourself up for liability in a malpractice court later on. Those discussions do take place. I have never had a client state at the end of the day that the avoidance of a malpractice case is the reason that prevents him or her from doing what he or she thought was appropriate.

Dick Adelman: I am an arbitrator in New York City. There are two aspects as I see it. One is the burden of persuasion and the other is the heightened requirement for people in professional status with licenses and a higher duty or standard of care. My question is, do you think that because nurses and those kinds of practitioners have a higher duty or standard of care, you have a right to expect a lesser burden of persuasion? For example, when you have hearsay evidence and no other proof, do you think you should prevail in a case like that?

Panel Member: It depends on the type of hearsay. There is the example where a charge nurse gets a direct report from a patient who says this other nurse did X to me. The patient is credible and the patient writes a statement. The patient is discharged from the hospital and is no longer available so the charge nurse testifies at the hearing. To me, the charge nurse testimony is worth the same weight as if the patient is there.

Panel Member: From the union perspective about patient complaints, we find that evidence is very suspect. I had a case where there was a nurse in the neonatal intensive care unit with many

years of experience and no patient complaints in her file. A mother with a premature baby complained vigorously about this nurse. She was terminated with 20-plus years on the job and it was on the weight of that complaint from that mother. The hospital wouldn't budge because they felt that they could rely on that patient complaint. Patient complaints must be examined within the context of the situation. For example, the neonatal intensive care unit is an emotional, sensitive situation. Everybody there is at a heightened emotional state. In that case, the mother complained that the nurse didn't respond quickly enough but all the medical records show that there was an issue with another baby in the unit and she was administering appropriate medical treatment to the baby who needed the attention. This other mother thought it was her baby who needed attention based on what she saw on the monitors. The nurse did not get her job back. In other situations we have a very difficult time obtaining the medical records. Not many arbitrators will compel the hospital to bring in a patient but I've always taken the position that the union should at least see the medical records to determine whether or not they support the nurse's version of what happened. The patient, sick and uncomfortable, doesn't always know necessarily about the treatment so the patient believes that his finger was stuck too roughly by the nurse when drawing blood but the nurse did her job and the procedure is simply uncomfortable.

Audience Member: I found the comment interesting that if you admit that something wrong happened and issue discipline, then you may be liable in another forum. Based on my experience with sexual harassment and violence in the workplace, employers are quick to discipline because they're afraid of liability if they don't discipline and something worse happens later. Is that necessarily unique in health care?

Panel Member: That is a totally different standard and it is not unique to health care, however, you would be prone to discipline for a minor allegation of negligence or abuse lodged by a patient to prevent something more serious from happening that might make you liable.

Flannery: We have been overemphasizing the patient complaint because a clinical worker, normally, is not terminated for a "patient complaint." I can think of one nurse fired because a patient admitted to the intensive care unit from the emergency room was clearly at risk for a stroke and the doctor told the nurse

to monitor the patient's vitals every 15 minutes because the woman was descending rapidly. At the change of shift, the nurse had not recorded any vital signs for four-and-a-half hours and she left for the day. The next day somebody comes in and finds that the nurse recorded vital signs after the fact. Luckily, somebody photocopied the medical record the night before.

The nurse claims that she recorded the vital signs on another slip of paper and didn't put it in the medical record. Talk to nurses—if it's not documented, it's not done. The union invokes arbitration claiming the nurse was busy, had other patients, her action was unintentional, she did the vitals but didn't write them down. When a nurse doesn't record that she gave the diabetic patient insulin, then the nurse on the next shift medicates and the person ends up in insulin shock because they've had too much. The first nurse did give the insulin but she didn't write it down. Some of these nurses were subject to progressive discipline and some were not.

Panel Member: What my clients will tell you—and Bill will tell you the same—90 percent of our employees and most clients never meet. I meet 5 percent or 10 percent of them. Ninety percent of these people are doing a good job, are doing the best they can, are not causing problems, are not making errors. There are some who don't belong in the job in the first place or have grown to the point where they need to move onto something else.

Panel Member: It's the exception to the rule. Most of the issues for the nurses I represent are run-of-the-mill issues where there are disputes on the job with co-workers or attendance problems. Certainly with nonprofessional employees you don't have these other issues, but more run-of-the-mill issues.

One of the things that we always want to say to arbitrators is that we are health care workers. Not only are managers concerned about health care but we are concerned about it as well. Nurses and other health care professionals or other nonprofessional employees working in health care have connections with the patients but we are not insensitive or always wrong. There are mitigating circumstances beyond our control or sometimes within our control but maybe it was a bad circumstance and we want to argue that before the arbitrator.

Panel Member: Most of us in the room are lawyers, human resource professionals, or people from that background. When we hear the term "patient abuse," I'm sure that among us we have an

almost immediate consensus of what we think that is. Our definition is different from the definition of patient abuse in the Medicare or Medicaid standards, which the long-term care industry deals with where that standard is very broad and very sensitive.

I can't tell you how many times I've had cases—mostly in the long-term care industry—where the client will describe the patient abuse and my first reaction is "That's it?" The nurses are horrified that I have reacted that way because I'm not sensitive to this standard in these regulations on patient abuse. There is always an active debate within arbitration whether arbitrators should go beyond the four corners of the contract, whether you should be looking at other arbitration decisions for information. In this particular area there are times where you need to be looking beyond the contract and looking at some of these regulations and decisions issued by the various administrative bodies within the federal and state agencies to understand what the employer's perspective is with regard to this concept of just cause and discipline.

Panel Member: The nursing home industry in New York is more heavily regulated than the hospital industry. You would not expect that the Department of Health would come in and put a nursing home on a watch over some of the incidents. I have also had vice presidents of nursing asking me if I understand that every nurse who practices in that institution is practicing under the nursing home's license. The vice presidents believe they are responsible for the care that's being rendered to every single patient because those nurses and nurses' aides in that department are practicing under their license. That is how seriously they take it and that's why they get very passionate and make decisions that they don't feel should be challenged.

Kim Wolfe: I'm from the New York State Nurses Association. Those same facilities have one nurse in the whole building all night because that's what the regulations allow.

Panel Member: To your credit, the New York State Nurses Association is very, very expensive. An entry-level nurse's salary is now 60-something and that is without benefits, and then you add in multiple vacation days and multiple sick days. When you do the multiplier and how many people you can hire, one nurse is not actually working a full year.

Wolfe: Can I ask, is that different from an entry-level attorney?

Panel Member: The difference is that a law firm is a service business. We can raise our rates to some degree and get the clients

to pay for whatever it is we want to pay our associates, but hospitals and the nursing homes cannot do that because they are regulated and their reimbursement rates are capped by entities that they don't control. They can't charge managed care providers more because they have to raise the salaries of the nurses. Nursing homes and hospitals are really squeezed. The nursing vice president would love to hire more nurses but (a) there is a shortage and (b) the hospital can't afford it. Unfortunately the busy nurse defense is not a valid defense that the employer can use to defend itself in a patient abuse case.

Audience Member: I understand but we're talking about disciplining nurses because of medication errors and the busy nurse defense is raised because of the shortage of staff. In some cases it may be legitimate but the question I want to ask is how many arbitrators take a look at the staffing ratios and things like that when they're deciding those cases? Are those factored into the decisions? I'm asking the arbitrators in the room or the panel.

Panel Member: The reality is that patients in hospitals today are sicker, most of them are critically ill or you wouldn't be there because once you're not critically ill, you're out. I know that nurses are working with less staffing than they did before but that doesn't mean that the patients and the patients' families expect the hospital to give them any lesser standard of care. That's the problem.

Audience Member: I am not arguing that point but the lesser standard of care results not only from the nurse but also the lack of staff at the hospital.

Panel Member: The question is who bears the risk for the short staffing and the nurse/patient ratios when they are not met. Unions and employees don't want to bear the responsibility for that dissatisfaction and that is where the hospitals often ignore those factors in making decisions.

Audience Member: For the arbitrator the issue is not whether the hospital is short staffed but whether the nurse engaged in the conduct for which he or she is charged. Was he or she too busy doing something of a higher priority or ordered by a supervisor to do something or given a workload in which it was impossible to do all of the things for the three people that were under his or her care? Arbitration is a very fact-specific endeavor.

Pereles: If the argument about data or staffing is not presented, the arbitrator does not know about it. It someone introduces the Medicare staffing rules, the other party objects because that

was not a bargained item and has nothing to do with whether the grievant did or did not perform work as ordered. These are the hard cases when a party tries to put in front of the arbitrator those facts and rules that allow the arbitrator to make what one party thinks is an appropriate decision. If you don't put it in front of me, I can't look at it.

Bill Nugent: I'm with the United Steel Workers of America. When extrinsic law or regulation is presented in a case, will an arbitrator accept it, consider it as invalid references, or simply take them for what they were, which means I can give you a Chinese menu and you'd take it.

Panel Member: There are all kinds of reasons to take it in and there are all kinds of reasons to leave it out. And as somebody said, this is case specific and you have to make your argument as to why the extrinsic evidence should not be admitted. If it has some application to what the parties are doing, maybe it's quite appropriate that it be considered.

Panel Member: If staffing is below the regulatory requirement, does that not mean that staffing had something to do with the misconduct? What was it worth? The answer is I'm not sure what it's going to be worth. If an employee did not document what he or she was supposed to document because he or she forgot or due to an emergency, I think it is important to know what was not documented and why. Did he or she forget to take a temperature? I can live with that. The nurse should know what is important and what's not important. You'd better document medications because that can cause severe problems.

Ed O'Connell: Those comments bring me back to what Bill Flannery talked about with the Medicare and Medicaid regulations. How much weight should we extend to that regulatory definition of patient abuse?

Panel Member: It's the issue of the different constituencies for the hospital. They deal with patients, patients' families, the government. The hospital's reputation in a community is important because hospitals compete for patients. It is one of the most heavily regulated industries in the nation. In New York there is the Joint Commission that regulates them as well as the State Department of Health. Hospitals look to all those masters and I know that the administration looks at all these different issues very closely when they decide whether to discipline somebody. I tell the client that it must explain through testimony what it considered to be patient

abuse. Why did you consider that to be so egregious? It must be articulated to the arbitrator because he doesn't understand it.

Audience Member: The problem is, of course, that arbitrators look at only the "just cause" standard. You have to look at was it reasonable to fire this person under these circumstances and the circumstances may mitigate the conduct depending on the regulations. The circumstances may be the person was overworked, the place was understaffed, there was an emergency. The arbitrator must consider all those factors when considering just cause and not only whether the conduct violated the regulations.

Panel Member: Contrary to belief, the hospital administration takes that into account when it decides whether the person should be fired.

Hoey: We have framed one of the most difficult and fundamental conflicts that exist, at least for health care employers, in making these judgments. You have a collective bargaining agreement with a management rights clause that allows the employer to issue rules and regulations that are not inconsistent with the terms of the contract. The rest of the contract is silent on discipline other than to state that employees shall not be disciplined except for "just cause." The contract contains the zipper clause that has all of the necessary incantations about waivers. The employer looks at these regulations that state it will be a cardinal sin punishable by termination to engage in patient abuse. Under the regulatory body in which the employer functions, that regulation must be examined to define patient abuse because that's the environment in which it operates. For an arbitrator to step in and rely on the "just cause" standard or some personal definition of "just cause" or even some well-grounded principle of reasonableness that exists under employment law as a basis to reverse the employer, that's very troubling to health care.

Nadelbach: What if that point is reduced to a work rule?

Hoey: It usually is. Most health care institutions would have a comprehensive code of conduct or standards of behavior where they identify—in some cases—nearly every conceivable violation that could occur and to categorize them. The following are minor reprimands, the following are semi-major and get suspensions, but here are the cardinal sins. Patient abuse is first on the list.

Audience Member: How do you define patient abuse? Is patient abuse when you slap a patient?

Panel Member: That's a common sense definition.

Audience Member: If patient abuse is defined as not clipping fingernails every two days but doing it every three or four days, then you must convince the arbitrator that the consequences for that are serious, not trivial. Just because somebody calls it patient abuse, that doesn't mean you can fire that person.

Panel Member: The question is how the arbitrator should be looking at the employer's decision to discipline and whether or not that decision was reasonable. Medical standards and extrinsic law can be used as benchmarks to determine reasonableness. The arbitrator does not define what is or is not patient abuse. Look at the code of conduct, other work rules of the collective bargaining agreement, established medical standards. When the hospital shows that the employee violated these items, it's reasonable for the hospital to discipline that employee and the hospital probably has succeeded in establishing "just cause." The arbitrator should be using these benchmarks to determine what is reasonable and not necessarily using his or her own opinion of whether or not failing to cut someone's fingernails once or twice a week can be detrimental.

Vickie Heedan: Two questions. If the Medicare regulations state that failure to clip fingernails is patient abuse and your contract says patient abuse is grounds for discharge, how does the one get incorporated into the other? Is it something that the hospital might argue is patient abuse but the arbitrator may find it could be but I'm not going to be bound by that.

Panel Member: Absolutely! I had a case where a busy nurse told a patient in a long-term care setting that he needed to sit down and be quiet today and the Commonwealth of Pennsylvania found that to be patient abuse. The ombudsman cited the facility and depending on the level of citation, it directly reflects its ability to continue to receive Medicare or Medicaid funding. Ultimately a facility can be shut down. The hospital would be justified in disciplining the employee based on that citation.

Audience Member: I have a different scenario with a complaint against the hospital because of a patient incident and the cause of that incident was a staffing shortage. The patient was not able to receive the necessary and appropriate medical treatment. We obtained these documents from the state to introduce at the hearing and the hospital responds with, "We don't see it that way."

Chuck Nicholson: If a hospital can be cited by Medicare, that's a level of discipline from Medicare. The arbitrator can also con-

sider severity of the offense. We wouldn't fire someone for that on the first offense compared with slapping a patient. To me, violating Medicare's standard can be by degree, just as any other discipline.

Panel Member: I would argue that the arbitrator substituted personal judgment for the regulatory definition of patient abuse. Medicare tells us the standard.

Audience Member: So many cases don't rise to the level where the nursing home or a hospital is in jeopardy of losing money as result of the conduct. In New York state, nursing home employees can be reported to the State Department of Health, which does an investigation. We have cases where someone is found innocent by the Department of Health, but we still have arbitration over whether this person should be terminated. If the state concludes that you are not guilty of patient abuse and the employer states that under its standards there was patient abuse, then the arbitrator has to make a decision whether there was patient abuse by looking at all the factors. As a union, the state's decision is offered into the record and the arbitrator looks at it based upon what weight he or she should give to that decision.

Dick Adelman: If the industry requirement is that when someone engages in X-level of an offense, and discharge is the usual result, then I sustain the discharge. I doubt that the nursing home or a hospital discharges a person for rule violation on nail clipping. There is a concept of disparate treatment so you have to evaluate what it is that you actually do. If you tell me a level of conduct, which I would never conceive of as being a dischargeable offense, is a dischargeable offense in this industry or in this context, then I'm going to sustain the discharge because that's what the parties contemplated in their relationship with each other. "It depends" is the answer to most of these questions.

Panel Member: I agree in that I tell my clients, whether I am talking to the witness, the Vice President of Nursing, or the supervisor, to explain to the arbitrator why this person was fired. If she violated a particular nursing standard, if he violated a particular standard of taking X-rays, articulate that to the arbitrator. I generally find that we will prevail when the decisionmaker articulates why the nurse was discharged.

Audience Member: You are getting into issues of liability and damages because you can determine, based on the medical regulation, that the finger clipping incident is a violation of an es-

tablished medical standard. Therefore, the employee engaged in misconduct, but the second issue in the arbitration is the remedy. The arbitrator has more leeway to conclude that it was not patient abuse to justify discharge for a single incident, but require a written warning or a one-day suspension. The subjectivity comes into play with the remedial portion of the award.

Nadelbach: We probably could continue this discussion at least another hour but at this point I want to thank our panelists and the audience.