

CHAPTER 8

WHAT ARBITRATORS REALLY NEED TO KNOW IN HEALTH CARE ARBITRATION

RALPH BERGER, MODERATOR*

I. INTRODUCTION

This panel discussion focuses on employment-related problems and issues in the health care industry. The two advocates define what they conceive to be the principal problems facing the industry. Many of these problems arise from the extreme financial concerns, but others come from such factors as patient expectations, communications issues, the pressure under which work is performed, the often laborious nature of that work, and the separation of the health care provider from the individuals or institutions who pay the bills. Janet Gaunt, the arbitrator, concentrates on defining the unique characteristics of the health care industry that arbitrators might consider when they render their decisions. The discussion that follows the presentations is built around a case over the discharge of a nurse from a subacute care unit. The case is presented in the appendix.

II. THE HEALTH CARE INDUSTRY: MANAGEMENT'S VIEW ON THE TOP TEN ISSUES

THOMAS HAYDEN LEE**

Health care in the southeastern states is provided largely in a nonunion environment. The business issues that pertain to health

*Member, National Academy of Arbitrators, Brooklyn, New York.

**Waller Lansden Dortch & Davis, Nashville, Tennessee.

care are the things that I will discuss with you. I represent primarily hospital chains and that's the experience and the background that I can give to you. It is helpful to know something about the business if you are to understand what gives rise to employee and employer conflicts in our industry and the context for those disputes. My colleagues and I decided to structure our presentation in the form of a list of list of the top 10 issues, with no apologies to anybody else who has done that before.

10. Many providers are having trouble providing. Hospitals are closing; they are not opening. There is contraction, not growth, in hospitals. A Robert Wood Johnson Foundation survey recently found that 27 percent of the urban hospitals that were operating in 1980 nationwide had closed by 1998. That's a dramatic shift. Rural providers are facing the same problems. Smaller communities that at one time could support a hospital under the old fee-for-service system can no longer support them because Medicare no longer provides that form of reimbursement. We see rural hospital closures around the country. We also see consolidations as companies attempt to roll up these small hospitals into proprietary organizations or to manage them by way of management contracts, which create a whole other layer of interesting legal issues and problems. In Waltham, just north of Boston, the board of trustees of that hospital recently announced they were closing, and more than 30 Massachusetts hospitals have closed since 1980. Hospitals are not an expansion business.
9. Subacute care is actually more care than acute care. The nursing home environment is more heavily regulated than the hospital environment.
8. Providers don't want bad outcomes. Not only are bad outcomes expensive, but they are bad for business. Providers actually want their patients to do better, but there is a complication in that from the business side. Patient expectations of the health care industry are not declining. In fact, that may have been at the core of many of the financial difficulties suffered by health maintenance organizations (HMOs). HMOs believed that if you gave people financial incentives to see their primary care providers first, they would do that, and it turns out they don't. People have not changed their way of seeking health care. HMOs have tried to force that and in many cases have failed because people

want high-quality service, and for many of us that means going immediately to the specialist. And when providers attempt to meet that level of expectation, they have to do a lot of things, such as increase investment in equipment, in technology, and in people. That's problematic and it's expensive.

7. The most powerful instrument in the hospital is the physician's pen. The doctor's pen decides what gets bought and paid for. If the doctor doesn't write it down on the chart, the hospital cannot bill for it. That is a powerful difference. The hospital, for reasons we'll talk about in a moment, is already disconnected from the consumer in a commercial transaction, but the hospital doesn't even get to decide which of its services are sold. The doctor decides which services are sold by writing down, or not writing down, what they've provided. A real problem for health care is the need to create accurate medical records. Part of the reason that the Office of the Inspector General has such a great time is not the actual fraud that occurs, but the simple misrecording of care because (1) the doctor didn't write it down or wrote it down the wrong way, and (2) a medical records transcriptionist created that as a record. Unfortunately, the people who are signing the record and swearing that it's true didn't create it and in most cases do not have a direct employer-employee relationship with the person who did.
6. Health care is manual labor. This shocks a lot of people who think that health care is a service industry. In 2001, no industry suffered more on-the-job injuries than health care. In part that's a function of the size of the economy because health care makes up roughly one-seventh of the economy. In 2001, 594,000 people reported on-the-job injuries in the health care industry, and 7.2 percent of all health care workers reported an on-the-job injury to the Occupational Safety and Health Administration that year. That's a higher injury rate than experienced by general contractors and the same as manufacturers of industrial machinery. The work is hard. We ask nurses to lug patients, move heavy equipment, and use sharp things. There are things that fall and things that cut. The health services industry loses 3 out of every 100 work days to on-the-job injuries and that increases costs.

5. Consumers believe that as between doctor (MD) and HMO, fewer letters are better. The Gallup poll reports that in 2002, almost two-thirds of all Americans say that when their doctor gives them medical advice they take it seriously, and 61 percent say they have a great deal of trust in their doctors. By contrast, 47 percent say they have little or no confidence in HMOs.
4. The customer is always right, but the patient is not the customer. You have to imagine a triangle—patient, provider, payer. When you negotiate a contract for someone to paint your house, you are both the consumer of the service and the payer; you're going to write the check. As such, you have some bargaining power. If you are contracting with a painter to paint Ralph's house, Ralph is the consumer but the contractor will listen to you, because you're writing the check. That's how health care works. There is a split of authority between the person who actually consumes and receives the services and the person who pays for it. As for the provider, who decides what costs what? If you go to the grocery store and the grocer sells apples at \$x a pound, that's what you pay. You may dicker but, by and large, the seller sets the price. But in health care, the buyer sets the price. You can charge whatever you want for a magnetic resonance imaging test, but you only get what Medicare says it's going to pay. That's why you see these crazy bills. When you go to the hospital or a doctor and see that the cost of service is \$10,000 negotiated down to \$59.99, that's no negotiated discount. That's just the buyer saying this is all it will pay. There's some negotiation back and forth, but for the most part the people who provide the care do not win.
3. Hospitals can do little to increase revenue. The Blues don't want to pay more and the hospital wants to charge more. This may seem to be simple stuff, easy to work out, except that the cost of doing business for the hospital is once again rising. We went through a period in the late 1990s and early 2000 where the increase in health care costs seemed to level off, but now they're back up. The April 2003 medical consumer price index shows that hospital care costs 6.2 percent more than it did just a year ago, and that is a large increase for one year. What are they doing on the other side? The centers for Medicare announced just a few weeks

ago that their increase in Medicare compensation or Medicare reimbursement for 2004 will be 3.3 percent. How do you make money in that business? How do you stay afloat? That's the reality of the business. The buyer sets the price, the consumer drives the expectations, and the providers have to change the way they do business. There's a lot of serious rethinking and retrenching.

2. Forty-one million. That's the number of people with no health insurance in the United States today. In 1993, Americans overwhelmingly identified access to health care as the most important issue facing the country. At that time there were 37 million uninsured people. The numbers of uninsured have gone up by 10 percent in a decade and very little has been done about the underlying problems. Market reforms haven't worked and nibbling around the edges hasn't worked. We have an enormous number of people without any health insurance, but they are not going without health care. Often they wait for care until the last minute, when their care needs are greater and more expensive. The bill doesn't go unpaid: charity care is one of the costs of doing business in this industry. One-quarter of the country tells Gallup this year that their greatest fear, their greatest anxiety for their family, is going broke because of medical expenses. Because they don't think they're sheltered in the event of inflation and without insurance.
1. Topping our list of 10 things you should know about health care is that the real arbiter is George W. Bush. He's the person who has the most important decisions to make about how the health care business is going to operate in this country. The President is the person who pays the bills for most of the health care that is given.

III. THE HEALTH CARE INDUSTRY:
A UNION PERSPECTIVE ON THE TOP TEN ISSUES

GWYNNE A. WILCOX*

I agree with many of the things that Tom said this morning. My client is the union, District 1199, based in New York City, and they are affiliated with the Service Employees International Union. We represent health care workers in nursing homes and hospitals and other health-related facilities in New York City and New York state, and I work in a very unionized setting. In our area, the union has partnered with hospitals and nursing homes and the health care industry in general to figure out how to deal with the issues that they constantly face and the changing environment they confront. We constantly see the problems associated with consolidations and closings, and I plan to address some issues that trickle down into the arbitration process.

10. Hospitals and nursing homes are different worlds. Hospitals provide many services to people who are in for short periods of time and they move at a very fast pace. The patients see health care workers on a much more limited basis than they do in the nursing home setting. The nursing home is more like someone's home, owned by administrators or smaller corporations, and the patients and the workers have a very close relationship. The certified nursing attendants (CNAs) and residential nurses see the residents day in and day out, and relationships are built that you do not see in hospitals. Because of this homelike atmosphere, you often have stories presented at arbitration that I can't put on tape. The homes are more like Peyton Places because they're replicating the home and the relationships between people. Often the stories are titillating, but they are different from the ones you find in hospital settings.
9. State administrative proceedings are independent of the arbitration process. In nursing homes, in particular if there are allegations of patient abuse, those allegations must, in New York, be reported to the New York State Department of Health. If there are allegations of criminal activity, the

*Levy, Ratner & Behroozi, New York, New York.

Attorney General's Office must be informed. When we present a case to an arbitrator, we want you to understand that those proceedings should be considered independent. Often those investigations are of long duration and sometimes you would assume that, because of state involvement, those matters are extremely serious. We have found that, while there's an obligation to report allegations of patient abuse and/or criminal activity, it may be done to protect the interests of the institution, to appease an unhappy family member, or because of the belief in the Attorney General's Office that the Department of Health is not doing its job properly. Such cases often leave the union trapped uncomfortably in the middle. We ask arbitrators not to be heavily influenced by the fact that there is a pending investigation in another arena.

8. Remedial training is a rarity. We often find that management is hasty to discipline employees without considering remedial training. Remedial training may better serve the patient and the institution and, of course, the employee. I have a situation right now where a CNA was terminated after many years of service and great evaluations. There was a prior patient abuse allegation that had been grieved and resulted in a suspension. Now, 2 or 3 years later, she is terminated because of one incident with one patient. Management acknowledged the fact that this was totally out of character and that it was a matter of neglect rather than abuse. As a union, we do not condone either patient abuse or patient neglect, but wouldn't remedial training have been better? That good employee would still be working there, and all the patients with whom she had been working would have been better served. Instead, the organization has to hire and train a new person.
7. Restructuring jobs causes uncertainty among workers. As the previous speaker talked about the challenges that face the health care industry, hospitals have had to come up with ways to handle their financial problems. One of the approaches they have taken has been to restructure jobs, to consolidate well-established positions into different jobs. You may have a CNA now doing additional tests or clerical employees handling billing on top of patient admissions. These reconfigured jobs often come out of different departments and health care workers often are not clear about their new

responsibilities. There's a lot of uncertainty among workers as to how they are actually going to do their jobs and sometimes, because of job restructuring, they even have questions about what their tasks are. The union I represent, District 1199, does not stand in the way of job restructuring. However, we have negotiated language in contracts that provides for job security in these times of financial uncertainties.

6. One of Tom's points was that health care is manual labor. Health care workers are the front-line soldiers in our industry. We certainly recognize that we are manual workers, but we are very unhappy when management comes into an arbitration and acts as if they are the only ones who really are concerned with health care. Our members provide the bedside manner and care to the patients as well as having that day-to-day contact with their families.
5. Reinstatement of a disciplined worker with full back pay will not destroy the entire health care industry. We hear that claim in every arbitration.
4. Health care workers care about patient care. We are the ones doing the jobs, constantly multitasking, required to handle hands-on work. Our people can see the human connections and identify the needs of the patient on a constant basis. We are the faces of the institution. We are really concerned about the patients rather than the bottom line.
3. Underfunding places greater demand on health care workers. We experience lack of supplies, lack of equipment, cost-saving rules, and reductions, but at the same time there is a requirement for increased productivity. While employees are trying to provide excellent performance under these difficult conditions, patients are much sicker and need more intense care. This places increased stress on the worker and makes their jobs much more difficult.
2. Short-staffing causes everyone to be short on patience and short on services. As we said in item 3, when there's not enough staff, employees are expected to do a miraculous job. We see more disciplinary arbitrations as a result of the problems generated by short-staffing.
1. Good labor relations reduces arbitrations. I've seen two models. Under one model, the hospitals come to the union and to the employees when they have a problem. They come in advance to identify the problem and try to solve it so that

everyone's on board and trying to reach a solution to the problem. Under this model, we have meaningful communication and a reduction of potential grievances and disputes, whether disciplinary or contractual. Under the second model, management does not come to the union first. They solve the problem in the way they want, even though they may have violated our collective bargaining agreement. This does not encourage labor-management cooperation. And because the employer is violating our collective bargaining agreement, we go into a defensive mode and file a grievance. At that point, if we try to work out a resolution, the employees will think that we are sleeping with management. The underlying problem here is a lack of trust, and that's the scenario that leads to filing more arbitrations.

IV. AN ARBITRATOR'S PERSPECTIVE ON HEALTH CARE ISSUES

JANET L. GAUNT*

Arbitrators are used to applying well-established principles to resolve either contract disputes or challenges to discipline. However, the manner in which those principles are applied and which principles are emphasized often can be affected by the setting in which a particular case arises. I'm going to use a few minutes to highlight situations that we feel will potentially affect an arbitrator's decision in health care cases.

One theme in the remarks of both Tom and Gwynne is the financial squeeze that exists today in the health care industry. A restructuring of jobs and reduced staffing levels are characteristic of many health care facilities. Fluctuating patient population is another practical reality. These realities sometimes can affect an arbitrator's interpretation of disputed contract language. For example, if one plausible interpretation would provide more flexibility when making work or shift assignments, that might seem more reasonable to an arbitrator hearing a health care dispute than it would when hearing the same dispute in another industry.

*Member, National Academy of Arbitrators, Seattle, Washington.

Tom referenced legal liability concerns that are acute in health care and the vast array of regulatory requirements that are imposed on health care employers. It is important to keep in mind that there are also regulatory requirements that apply directly to certain kinds of health care employees. The point can be reached where, because of reductions in staffing, licensed nursing personnel might come to believe they are at risk of violating the professional standards they have a responsibility to maintain. It is certainly not in the best interests of either a union or its bargaining unit members to have a health care institution's sources of revenue jeopardized, but neither can members of a bargaining unit take job requirements lightly that they feel put them at risk of violating professional standards. At what point does it become reasonable for a nurse to insist that he or she cannot provide appropriate care to the number of patients assigned? What are the appropriate methods of pressing that argument? These are issues arbitrators might be asked to resolve in a health care case.

Discipline decisions frequently are affected by the setting in which they arise. For an acute care facility, an overriding consideration has to be assuring the continuity of 24-hour, uninterrupted patient care in situations that are potentially life-threatening. In this work environment, an employee's failure to obey orders, excessive absenteeism, or the theft of supplies of rather negligible value all will take on heightened seriousness because of the impact on the lives of vulnerable patients. It is one thing for a production worker to leave a plant early or take an extended lunch break without authorization. It is quite different for a nurse to do the same thing at an acute care facility where the consequences can be a lot more tragic.

Events that upset patients emotionally are known to potentially affect their physical recovery. Certain kinds of behavior will thus become more serious in a health care setting because others are impacted, not just co-workers. Coarse language that might be dismissed by arbitrators as "shop talk" in many work environments becomes far less acceptable when it can be overheard by patients in a fragile condition. Even without obscenities, verbal or physical conflict between co-workers is reasonably regarded much more seriously if it occurs when patients are near. A health care employer will be less likely to tolerate such behavior, and arbitrators need to be sensitive to the reasons why.

Frequently, grievances arise from changes to job duties. Whether an affected employee has been given a reasonable opportunity to

adjust to the changing expectations is a judgment call that should take into consideration the realities of the industry. New assignments may demand technical skills that once existed but have declined from lack of use. Hospitals sometimes have to close units and then transfer staff to patient care areas they have not worked in for years. Even when transfers do not occur, the technical demands for working in a particular unit may increase beyond a particular employee's capability because of changing technology. How much time and training should an existing employee be given before his or her job is endangered? These can be difficult judgment calls.

In her remarks, Gwynne expressed the view that remedial training is not used often enough to address performance issues. When health care facilities are caught in an economic squeeze, administrators often feel that they do not have the luxury of remedial training. Instead, they resort to a purely disciplinary approach, implementing progressive steps of discipline when a health care worker is not able to handle the demands of a new or changing assignment. I agree with Gwynne that this is often a penny-wise and pound-foolish approach. When one considers the cost of litigation or appeals that can result from a termination, it may in fact be cost efficient to first provide remedial training. I have seen a number of grievances settled on just that basis. Even if termination is ultimately resorted to, an employer's case can be strengthened if it shows it first tried to address a performance issue through remedial training.

The length of that training can reasonably be affected by the requirements of this industry. Negligence and carelessness are concerns in any industry, but especially in health care. The more risk of harm there is to others, the shorter the period of time an arbitrator is likely to allow an employee to correct performance deficiencies. If housekeeping tasks are not done properly, it is not just a matter of appearance. A lack of cleanliness can lead to the spread of contagious diseases and infections. The Severe Acute Respiratory Syndrome outbreak has tragically demonstrated the fact that inattention or carelessness regarding infection control practices—even though not deliberate—can jeopardize not just patients in an institution but also the lives of colleagues. In the field of education, a teacher is sometimes given notice of serious deficiencies and then placed on an Improvement Plan for perhaps as long as the next school year. Depending on the kind of health care worker, a year or even 6 months is an unfeasible period of time

because of the risk of harm to others. That reality and the potential liability created for the employing institution are things we arbitrators must be sensitive to when making our judgments.

In the first plenary session of today's conference, speaker Goldsmith pointed out how serious patient abuse allegations are for health care providers. In my prior life as an advocate, I represented health care institutions. I fully appreciate the fact that it is essential to protect individuals who, because of their physical or mental condition, are particularly vulnerable to mistreatment, sexual abuse, or theft. But a different prior job sensitized me to another side of the issue. My first job out of college was working as a social work assistant in a hospital. There, I had the experience of seeing what dealing with patients and their families is like from the perspective of the health care employee. What I learned from that experience is the risk of misperception or overreaction. I had a chance to see firsthand how the stress and anxiety being experienced by patients and their families affects their reaction to what might otherwise have been unobjectionable behavior.

One of the consequences of reduced reimbursement levels and short staffing is delayed response times to calls for care. Long delays sometimes result in heightened stress and frustration that is taken out on the nearest health care worker. Picture someone sitting in a hospital emergency or waiting room waiting hours for a diagnostic test, worrying the whole time about the seriousness of their condition. When someone's emotional state is on edge, they may more readily perceive a health care worker's behavior as "rude." Problems also arise from the fact that family members are not always present and may get only a piecemeal version of events. Anxious about a loved one's condition, they sometimes jump to conclusions or misconstrue actions by a caregiver. There can be a fine line between necessary restraint when dealing with a violent, resistant patient and excessive force that legitimately constitutes abuse. I am not making apologies for every instance of rude or inappropriate behavior. I just caution you to be aware of the very real possibility that a patient or family member has mischaracterized or overreacted to reasonable actions by a health care worker.

When making credibility judgments, it is also important to remember you are sometimes dealing with patients who are suffering from an illness or injury that potentially affects their ability to accurately perceive, recall or describe events. Patients may have diminished sensory or mental capacities because of their age or medications they are taking. While a social work assistant, I often

sat in on meetings where doctors or other health care specialists would explain diagnoses, test results, recommended treatment, etc., to a patient and perhaps family members. I saw how frequently the patient and/or family retained only part of what was said because of their anxiety level and how much they were having to absorb. When misunderstandings later arose, it was often not the doctor or specialists but rather the front-line health care worker who bore the brunt of the patients' or family's frustration.

I've been mentioning conditions that affect patients and family members who may lodge the complaints that generate disciplinary action. It is also important to keep in mind the impact of stress and their working environment on health care workers themselves. Under the right circumstances, Mother Teresa could become irritable. So too, even the most professional employee can at times become more abrupt than was intended. When demeanor is alleged to be an employee's problem, I am therefore more interested in an employee's pattern of behavior than I am in an isolated incident. I will want to note, for example, whether complaints are coming from one particular patient and/or family, or whether the behavior being complained about has been noted and perceived the same way by a variety of different individuals. With these considerations in mind, our panel would like to discuss a hypothetical fact pattern.

V. DISCUSSION OF THE MISS JONES CASE

Ralph Berger: To summarize the case we've distributed to the audience: When she was a registered nurse, our hypothetical Miss Jones had good grades in some areas but poor grades in dealing with patients and co-workers. She has since been promoted to charge nurse and is employed in an understaffed subacute unit. She recently received a written reprimand for being rude to a patient's family member, and, 5 months later, in her annual performance evaluation, she was told about her unsatisfactory relationships with co-workers. Two months after that, she was diagnosed with ovarian cancer and was on leave for 6 weeks for chemotherapy. Over the next month or so, while undergoing chemotherapy, she received several written reprimands, one of which informed her that she was subject to termination for any further rude treatment of patients, staff, or family members. That

same month she was terminated for speaking in an unprofessional and demeaning manner to a patient's family members. I ask all of you to become the arbitrators. Let's start by asking Janet for her thoughts on what issues and arguments you would expect from the advocates.

Janet Gaunt: I'm going to throw the question to Tom. Miss Jones is a 15-year employee at the time of termination. She had four prior written reprimands when she was a supervisor but no disciplinary action more serious than that. Did your client just ignore your advice or do you really think you can sell this discharge to an arbitrator?

Thomas Lee: I would not be surprised if my client did not ask me in advance what I wanted to do about this. There are some very real issues. Patient dignity is a primary concern. When a patient is in a nursing home or a subacute care unit, that is their home, that's what the federal law determines it to be, and it is a different environment for that reason. The Medicaid regulations spell it out pretty clearly. You cannot treat patients and their family members the same way you might in other settings for that reason. Furthermore, I think that the incidents that are reported in the evaluations should be considered disciplinary actions even though they do not rise to the level of an adverse employment action. On behalf of the employer, I argue that the grievant not only has notice of the problem that led to her termination, but she's received specific instruction about what's going to happen if she doesn't fix it and she's received specific feedback as to why it matters.

Janet Gaunt: Well, you do have that series of prior written reprimands but there's no mention in the facts that they were grieved at the time of issuance. Gwynne, let's assume for the moment that they weren't grieved. Are you going to try to litigate the merits of that prior disciplinary action and, if so, how frequently are you successful with arbitrators?

Gwynne Wilcox: While I think that it would be hard to make an issue over the earlier disciplines, I would argue the issue of adequate notice. Under our collective bargaining agreement there should be progressive discipline, and there was no progressive discipline in this case. Because all of the discipline was at the same level, was she given adequate notice? I would argue that because they continued to give the same kind of written reprimand, she was not given progressive discipline. Because all of these reprimands occurred over a short period of time, I would try to have more information in the record with regard to what caused the reprimands.

mands. Furthermore, because she was under a doctor's care, she may have been disabled. Although the fact pattern suggests that there is no evidence that her leave of absence was under the Family and Medical Leave Act (FMLA), but if she had taken an FMLA leave, we would want to argue that retaliation occurred.

Janet Gaunt: Gwynne mentioned the FMLA. Tom, are you going to be concerned about an Americans with Disabilities Act (ADA) claim here?

Thomas Lee: Of course, but there's an interesting wrinkle. In order to have a claim under the ADA, the grievant has to be disabled. She's got to have an impairment that substantially limits life activities. But she got better! Although cancer is undoubtedly a disability on its face, there is only one condition I'm aware of as a matter of law that is a disability and that is HIV positive status. Cancer is as close as it gets. She gets better. She comes back to work and works every day. It's difficult to argue that you are substantially limited in that major life activity if you come back to work.

Janet Gaunt: In our panel discussion, you said that she toughed her way out of any ADA claim.

Thomas Lee: Miss Jones did tough it out, to her credit. It's exactly what you would want as an employer and exactly what you would admire in a person. However, when she does that, she has worked her way out of the ADA claim at least by the time of the termination.

Janet Gaunt: Isn't that going to win her some sympathy from the arbitrator? For all her alleged deficiencies, she appears to have been somebody who was very conscientious. There's a short-staffing situation and it appears that she may have come back, despite the ongoing need for chemotherapy, in part to alleviate that short-staffing. We're talking about termination for basically a demeanor problem. How are you going to address the likely sympathy an arbitrator is going to feel toward a person who would act this way? How are you going to address that concern, especially since one of the incidents appears to have occurred while she was still receiving chemotherapy?

Thomas Lee: I have to go back to the prior incidents. And there it depends on what the collective bargaining agreement allows me to do. If it's an agreement that wouldn't allow me bring up an incident prior to a certain date, then I may not be able to do that. I want to be able to talk about the entire disciplinary record and the entire employment history. If I can't go back past 9 months to talk about prior discipline, then I have a problem on the sympathy factor because I'd like to be able to say that this is not new, it's not

caused by the cancer, it really goes back, but I might be limited with what I can do with that.

Janet Gaunt: You might have another problem. Even if you don't have a contractual time limit that governs the cases predating her promotion to charge nurse, I suspect that Gwynne might argue that, if the deficiencies were so great, why move her into a position where communication skills are even more needed?

From the Floor: Miss Jones is in charge of three registered nurses and sometimes a CNA. Given the short-staffing and her recent medical condition, she might not be able to continue in that role. She's supposed to be a role model for the other nurses and CNAs, and she is charged with rudeness and so forth. It may be possible to look at her additional responsibilities as the in-charge person as something that could be adjusted and she could be brought back as an employee with lesser supervisor-type responsibilities.

Ralph Berger: And lesser pay?

From the Floor: Given her behavior, particularly vis-à-vis her co-workers, that might be an area of compromise.

From the Floor: It seems to me the first thing that should be done is take the advocates outside the hearing room and say that this case involves two things: (1) Does the punishment fit the crime? and (2) Was this individual correctly assigned both initially and subsequent to her health problem? Because her whole history shows her having trouble with interpersonal dealings, perhaps she needs a different assignment.

From the Floor: We're arbitrating this case; we're not mediating it. This is a case of did she get the message or does her long service warrant a better message. We're being asked if there is cause for this discharge and we've had no suspension, yet we've had very little progression. It's not a case about our finding a creative way to place her somewhere else. That's not our job—to me it's very clear-cut.

Ralph Berger: What if the issue was framed, "Was there just cause for the termination and, if not, what should be the remedy?" Do you think an arbitrator has authority to transfer her from this unit?

From the Floor: Assuming that 99½ percent of the arbitrators in this room would reinstate this woman, I'm interested in the issue that Gwynne raised when she said that she hears all the time that reinstating somebody with full back pay is going to bring down the industry. Is there anything about the health care setting that makes reinstating somebody with full back pay especially difficult?

Thomas Lee: I think the seriousness of the care concerns and the seriousness of the attitude concerns do matter. I reference Janet's

remarks earlier. This is not the woodshop. This is not only a health care setting, but this is somebody's house and if someone comes into your home and is rude to you in your home, you have the opportunity to say that I really don't want you in my home anymore.

From the Floor: That gets to the question as to whether or not the person should be reinstated. But if the arbitrator has decided that reinstatement is appropriate, is there anything about your industry as to why a full reinstatement would not be appropriate?

Thomas Lee: No.

From the Floor: It seems to me that that argument rings hollow in this case. This was a woman who had a long-term problem with communication and interpersonal relationships and she was promoted. How can you tell me that you're so concerned with what's going on in these patients' rooms, when you promoted somebody who clearly had performance issues in exactly the thing that you are now telling me makes it horrible to reinstate her.

Janet Gaunt: It also conveys a mixed message to the employee. You were making the point earlier that you want the arbitrator to treat the performance evaluation as equivalent to a type of disciplinary action. The problem is that in an evaluation, you usually get both positive and negative comments. Employees don't always realize that the negative ones are viewed as being so serious that their jobs could be in jeopardy. It's that latter concern that has to be communicated to the employee. If that's not conveyed, they're thinking that their performance in a particular area is OK when in fact it needs improvement. Before they know it, they're out the door! This employee got a negative evaluation earlier in her career and then got the promotion. Doesn't this reinforce the likely belief that her performance issues were not so serious that they could cost her her job?

Ralph Berger: Would any of the arbitrators in the audience order something akin to sensitivity training as part of the remedy?

From the Floor: When I read the scenario, I thought it was the employer's opening statement. I'm troubled by the fact that she was promoted. The facts as I saw them here are that there was not only some problem in terms of her interaction with fellow employees, but there was a consistent history of her being accused of being abusive or rude to patients and families. I would like to ask Gwynne and Janet, because both of them commented on this, where was the remedial training? And why no suspensions? Is that an issue in health care? Do they not do suspensions?

Gwynne Wilcox: They do. That's precisely what the problem was here. There wasn't any progressive discipline. Employees can get suspended and often get suspended more than once before there's a termination. What's troubling here is the fact that they did everything in such a short period of time. Between the time of her reinstatement from her leave of absence to going out the door, there's 1 month. What's really going on here? They obviously did see a lot of good things about her earlier because they put her in charge, despite anything that was going on with her on a personal level. Ralph asked a question about whether an arbitrator could award sensitivity training. I would be interested in hearing what the arbitrators in the audience would have to say about that. I think there should have been some type of sensitivity training in this case because maybe she needs a better understanding of how to deal with situations in a stressful environment.

Thomas Lee: Two quick points to follow. One, the suspension is a problem or the availability of a suspension is a problem. If you are only able to put two or three registered nurses on the unit and you've got to have a registered nurse on duty all the time, you can't send her home for 2 weeks. She's got to be there. The hospital's hands are tied. Two, to follow up on the promotion issue: they promoted her and the question for management is that it's pretty clear from the evaluations that you made a mistake and now what do you do? If you must keep her in that job, how do you ever address the mistake? Short of termination, the only management solution was getting her out of the unit altogether.

From the Floor: The hypothetical represents my general experience in the health care industry. I see a lot of the "good-hearted supervisor fact patterns" in health industry cases in which you've got four written reprimands followed by a discharge. One wonders whether there is a disincentive to take more substantial disciplinary steps because of the fear of legal liability when you have more immediate issues of patient care. I was particularly charmed by the management representative's recognition that sometimes it's a staffing problem. I suspect that means that most of us wouldn't get these problems and say, "I didn't write this progressive discipline stuff into the contract and gee I'm sorry about your staffing problem."

From the Floor: You say that the progressive discipline provision is in the contract, but what does it spell out: an oral warning, written

warning, a 1-day, a 3-day, a 5-day suspension, etc.? If it does, then that answers the question. If they didn't go through all the steps, then the arbitrator can only do one thing.

Ralph Berger: What if you have the argument that this is tantamount to verbal abuse and that's a dischargeable offense, just like physical abuse in a nursing home setting?

From the Floor: If it's a practice and not spelled out in the contract, you ask about how progressive discipline has been administered in the past and what are employees' reasonable expectations. If the contract just says just cause, it's an entirely different matter. Progressive discipline may mean nothing more than giving notice to the employee that what she is doing is wrong, giving her an opportunity to improve, and telling her that the second time it happens, she can be discharged for it. The question then concerns what the individual did that was wrong, whether she was on notice of what it was, and whether it is insufficient in and of itself to warrant discipline. To answer Ralph Berger's point, if it's a dischargeable event in and of itself, you don't have to inquire about progressive discipline. Shooting your supervisor usually is considered something that is not allowed and you don't have to warn people in advance about it.

Ralph Berger: Yes. But that makes it too easy.

Janet Gaunt: In other words, the lack of a prior suspension might not have been as troublesome if she had hauled off and slapped a patient in the last incident.

From the Floor: Most of my experience is that progressive discipline language is not incorporated in the contract but it's the application of arbitral principles of progressive discipline.

From the Floor: This is about remedial training. I agree with Gwynne that it's a rarity, but the hospitals I worked in did do that. I feel that we reduced turnover, especially among registered nurses. Everybody in health care knows that there's a nationwide recruiting problem in the industry. Some employers send representatives overseas and to Puerto Rico to recruit nurses and I think that the absence of remedial training is a failure of human resources (HR).

Thomas Lee: I think hospitals are typically thin on HR professional staff. This will vary with the size of the hospital. A 1,000-bed unit is absolutely going to have top-quality HR people, but a lot of hospitals with a couple of hundred beds may not have someone with HR training working in the facility.

From the Floor: Do your hospitals not have employee assistance programs?

Thomas Lee: Employee assistance programs are almost routine.

Ralph Berger: HR units are historically among the first to go in times of budget crunches, and if we followed the approach that your hospitals correctly did with remedial training, it wouldn't have been as good a hypothetical. If there are no more questions, I would like to thank you for coming.

APPENDIX
THE DISCHARGE OF PATRICIA JONES, RN

Patricia Jones, a registered nurse, has been employed by Get Well Hospital, a private institution, since January 1982. She has been a member of Local 123, Health Care Workers Union throughout her employment and is covered by the current collective bargaining agreement between Local 123 and Get Well Hospital. During her employment at the hospital, however, she received mixed reviews. While supervisors praised her punctuality and willingness to work, she received midlevel grades for her technical skills and consistently unsatisfactory grades for her ability to communicate and work well with colleagues and patients.

In 1996, the hospital transferred Jones from a day shift medical unit position to a day shift position with charge duty assignments in the hospital's new subacute unit, and Jones accepted it willingly. In this new assignment, Jones was still in a bargaining unit position, but received an "in charge" differential for this additional responsibility.

The hospital expected that the 50-bed subacute unit would have five registered nurses on the day shift. However, the unit was often short-staffed and there usually were only two to three registered nurses on duty. The unit also was serviced by certified nurses aides and licensed practical nurses who are also in the Local 123 bargaining unit.

The subacute care unit is different from the rest of hospital. It typically treats older patients transitioning from acute care to home care. The environment is more like that of a long-term care facility, such as a nursing home, than an acute-care hospital setting. Consequently, standard nursing practices in a hospital subacute care unit are governed by the same nursing practices as those in nursing homes. The federal regulations governing subacute care units place respect for the individual patient's dignity at the center of all nursing practices and require that nurses conduct themselves as though they work in the patient's home, not a business location.

On October 8, 1996, Jones received and signed a written reprimand from the hospital for reportedly being "very rude" to a family member who had tried to telephone a relative who was then a patient in the subacute care unit. Five months later, on March 19, 1997, Jones received and signed a written evaluation of her performance that stated: "At times, Pat's working relationship with co-workers is unsatisfactory and too often she exhibits a lack of tact or

consideration to others. I have discussed this issue with Pat and expect much improvement by next evaluation.”

Jones learned in May 1997 that she had ovarian cancer. The hospital granted her request for leave from work from May 10, 1997, to June 29, 1997, so that she could undergo surgery and follow-up chemotherapy. When Jones returned to work on June 29, she resumed all her duties on the subacute unit. The hospital adjusted her days off to accommodate her chemotherapy schedule. Jones’s chemotherapy was successful, and she achieved complete remission.

Jones’s prior job performance did not change upon her return to work. On July 25, 1997, Jones received telephonic notice of a written reprimand from the hospital for reportedly yelling at a patient in the subacute care unit and telling the patient to be quiet. In August 1997, she received two written reprimands on two separate occasions. One notice informed her that she was subject to immediate termination for any further rude treatment of patients, staff, or family members. The other notice was for reportedly talking to a colleague who also worked in the subacute care unit “in an unprofessional and demeaning manner.”

That same month, Jones was terminated for speaking in an unprofessional and demeaning manner to a patient’s family member in the presence of the patient.

The union grieved her termination in accordance with the standard grievance procedure in the contract. The hospital denied the grievance, and Local 123 filed for arbitration with the American Arbitration Association, as required by the contract. An arbitrator has been selected to hear the dispute, and the parties are in the process of preparing the case for arbitration.