In the Matter of an Arbitration

Between

Cambridge Memorial Hospital

and

Ontario Nurses' Association

Termination Grievance of S.M.

AWARD

Before:	Dana Randall, Chair
For the Employer:	Seann McAleese, Counsel Susan Harris-Howe Susan Toth
For the Union:	Rob Dubrucki, Counsel SM, Grievor Brenda Pugh Deanna King

Hearings in this matter were held on January 21, February 24, March 17 & 21, May 2, September 26, 2016 in Cambridge, Ontario. Supplementary submissions were made via conference call on October 20, 2016.

AWARD

Introduction

SM, an RN, was terminated by the Hospital on November 2, 2015. The termination letter reads in part:

> We have concluded that your employment is terminated effective immediately for just cause.
>
> In short, you admitted to engaging in a pattern of theft of narcotics (stealing 2 to 6 Percocet tabs per shift, sometimes diverting them from patients and falsifying the MAR to conceal the theft). You affirmed you were able to control any compulsion stating that at no time did you ingest narcotics, or any other intoxicating substances, during your shift. You further stated that you knew your actions were wrong at the outset but did not disclose your conduct for fear of charges by the Police under the Criminal Code.
>
> This conduct is not only criminal in nature, but also a fundamental breach of trust and standards of practice, all of which are detrimental to patient care and wholly destructive to the employment relationship.
>
> Although the Hospital had initially contemplated a return to work and accommodation, your admissions and our findings, have negated the relevancy of such efforts. Your employment is being terminated solely due to your criminal conduct.

SM grieves both her termination and the Hospital's failure to accommodate her disability, to wit: her opioid addiction.

The Hospital alleges that SM stole Percocets and Tylenol 3s from the Hospital dating back to 2003. The Grievor admits to the theft of percocets dating back to 2011, but not before that date and not to Tylenol 3s at all. It is her evidence that she cannot recall same. She admits that some of the thefts were from patients in her care and that she diverted their prescribed painkillers to herself and left a falsified medical record to conceal same. These allegations are not contested. Much of the Hospital's case is predicated on the admissions of the Grievor.

As the termination letter notes, the Hospital submits that this is not only a fundamental breach of trust and of the employment relationship, but serious criminal misconduct. It is, as a result, a straightforward and obvious just cause case.

The Hospital takes that position, though it is well aware that there has been a clear arbitral consensus in Ontario, that is not supportive of its position. That consensus, made up of 8 or 9 awards, stands for the proposition that an RN, who pleads and proves an addiction to her drug of choice, has a human right's defense to termination for stealing that drug from her employer and from the patients in her care, if she has successfully committed to rehabilitation.

The Issue

While my decision below is informed by a number of distinguishing material facts, it is also shaped by my assessment of the 2 lines of authority relied upon by the parties. The Hospital relies upon a line of court made authority, commencing with the British Columbia Court of Appeal decision in *British Columbia (Public Service Agency) v. British Columbia Government and Service Employees' Union (Gooding grievance),* (2008) 177 L.A.C. (4th) 193, herein referred to as "Gooding", which has been cited approvingly by Ontario courts; see, for instance, *Walton Enterprises (c.o.b. Midas Auto Services Expects) v. Lombardi*, (Ont. Div. Court), [2013] O.J. No. 3306; and *Bellehumeur v. Windsor Factory Supply Ltd*., (Ont.C.A.), [2015] O.J. No. 3317.

The Hospital asks me to find that the courts have held that the arbitral consensus is simply wrong; that Ontario arbitrators have conflated 2 levels of analysis. They have failed to ask and determine the first question: was there discrimination because of the handicap or addiction?, before moving on to the issue of whether the addiction could be accommodated. The latter analysis comes to eclipse the former.

The Hospital submits that, in the case before me, no direct discrimination has been shown. The Grievor was treated in the same fashion as any other employee accused of the criminal offence of theft: she was fired. The Hospital says that there is absolutely no evidence that the decision to terminate was based on factors related to the Grievor's addiction, whether stereotypical or prejudicial views of addiction, or concerns with respect to the costs of accommodating her addiction.

Additionally, the Hospital submits that the Gooding line of authorities nixes the human rights defense of addiction to workplace misconduct, which is criminal in nature, on the basis of indirect or adverse treatment discrimination. Put simply, the Hospital argues that the Gooding line of authorities stands for the proposition that to hold an addict to the same standard of culpability as a non-addict for a

criminal act is not *prima facie* discrimination, because there is nothing arbitrary about the norm being enforced.

In the alternative, and arising from the foreclosure of the discrimination defenses, the Hospital argues that ONA and the Grievor have not made out a sufficient nexus between her drug dependency and her misconduct to warrant a mitigation of the penalty. Essentially, the Hospital submits that the evidence does not demonstrate an addiction of the kind that could be found to compel her criminal misconduct. Short of establishing that SM's addiction was of a kind that rendered her incapable of controlling her behavior, her criminal misconduct cannot be medicalized to the extent necessary to attract, in the language of one award, a 'get out of jail free card'. While this is an old argument that has been rejected by Ontario arbitrators, the Hospital submits that the Gooding line of cases sets the bar higher for establishing an exculpatory nexus for conduct that is criminal in nature.

In the Hospital's view, SM does not meet that standard of compulsion. In fact, the Hospital submits that SM does not bring herself within the standard articulated by the majority of arbitrators in the Ontario consensus.

ONA relies on the arbitral consensus. It is this: in cases similar to the one before me, including ones in which the RN's misconduct is more egregious, arbitrators have reinstated RNs, subject to restrictions relevant to their addictions. They have found that 1) where there is an addiction, 2) which addiction has a nexus with the misconduct (stealing their drug of choice), and 3) where the RN has acknowledged her addiction, taken the cure, and come clean, it is discriminatory treatment for a hospital to then terminate the RN's employment rather than accommodate her addiction. This is the result even when, as here, the RN doesn't make the employer aware of the alleged addiction until after the misconduct is discovered and, as here, the misconduct is criminal in nature.

ONA submits that the case before me is indistinguishable from the cases giving rise to the consensus. If anything, the Grievor's misconduct is less egregious than in many of the other cases. For instance, she did not use at work and she never came into the Hospital off-shift to steal drugs. She has committed to her rehabilitation and is highly unlikely to relapse. There is no reason, therefore, in ONA's view, not to reinstate the Grievor with restrictions relevant to her disability in accordance with this line of authority.

ONA submits that the court decisions relied upon by the Hospital are either distinguishable or not binding and should not persuade me to abandon the well-established arbitral consensus in the province. On the basis of all the factors deemed relevant by Ontario arbitrators, the Grievor qualifies for re-instatement subject to CNO restrictions and others which could be ordered or negotiated.

Process

I heard from four witnesses over the course of several days. The Hospital called Susan Harris-Howe, the Manager of the Emergency Department and the Grievor's direct supervisor. Ms. Harris-Howe directed the investigation into the Grievor's misconduct. The Hospital also called Susan Toth, its Director of Human Resources. She testified that it was the Hospital's practice to terminate employees, who it had found to be guilty of theft.

ONA called the Grievor and Dr. Veenman, an addiction specialist, who came to know the Grievor when she was resident at Homewood; he continues to supervise her aftercare program and monitoring.

On September 26, 2016 the parties made final submissions. After same, I noted that none of the Ontario arbitration awards relied upon by ONA had considered the impact of the Gooding line of decisions on their analysis. I directed the parties to provide me with any case law that brought the 2 lines of authority together. That led to more case law being filed on October 19, 2016 and a conference call with supplementary submissions on October 20, 2016. Two arbitration awards, significantly on point, had been issued between the September 26th hearing date and the conference call less than a month later, with strikingly different results. I will turn to a discussion of both in my reasons below.

Facts

Few facts are contested. Amongst other things, the Hospital relies upon numerous admissions by the Grievor.

The Grievor is an RN with more than 28 years of impeccable service at the Hospital. In 2014, when the issue of the Grievor's misconduct was first raised, she held the position of Patient Flow Co-ordinator in the Emergency Department, which is also referred to, more colloquially, as the 'Flow Coach'. Without dilating,

this is both a very responsible position and a very independent one, which involved SM having unsupervised access to the entire Hospital. (I note, by way of remedy, ONA submits that the Grievor should be reinstated to the Flow Coach position, although with numerous restrictions.)

At the time of discovery, the Grievor was about to be promoted to the position of Manager of the Emergency Department. It was not clear to me whether this was to be a permanent promotion or more in the nature of an 'acting' one.

On August 15, 2014 , a colleague of the Grievor noticed that percocets were being taken out of the Omni Cell by the latter in suspicious circumstances. The Omni Cell is a computerized drug vending machine that requires an RN to enter his or her passcode, the patient's name and the drug being dispensed. The concern was brought to the attention of Susan Harris-Howe, the current Manager of the Emergency Department. There was particular concern because the Grievor was about to be promoted to Ms. Harris-Howe's position.

Harris-Howe spent three days doing an audit and concluded that the Grievor had been taking percocets out of the Omni Cell for several months for patients that she was not caring for and in circumstances where there were no doctors' orders for same.

The Hospital confronted the Grievor with the allegation on August 21, 2014. The Grievor, whose first response was not to admit wrongdoing, did admit same after a timeout with union representation. She admitted taking the percocets and that 'there was a problem'. It would be fair to say that the parties agreed that she should see her doctor and get help. Little else was resolved. While the magic words: addiction and/or disability were not uttered, no doubt the Hospital was put on notice of the kind of case it was facing.

The Grievor then went off work on STD and LTD from August 21, 2014 to August or September, 2015. During that time, the Grievor attended the Homewood in-patient treatment program for addicts. She was admitted on November 19, 2014 and discharged on December 23, 2014, a total of 35 days.

The Grievor characterizes her current medical diagnosis as "opioid addiction currently in recovery". She sums up her addiction as follows: 'I was using percocets and abusing Tylenol 3s that were not prescribed for me and for reasons other than pain management'. It appears from the Homewood

Discharge Summary that she “loved the euphoria and the relief she got from her grief” when using percocets.

Unfortunately, the Grievor’s evidence respecting the onset of her drug dependency and its escalation does not amount to a coherent narrative. At various times, she has said different things. She was depressed after the passing of her husband and used percocets for relief from her grief; on more than one occasion, she’d had percocets prescribed for pain relief arising from different physical injuries. As we will see below, Dr.Veenman testified that a drug dependency is triggered by a specific drug experience. That experience “turns on a switch in the brain”. From that moment on, a person’s dependency on that drug, which drug becomes their drug of choice, is significantly determined. This notion of a switch being turned on is a big part of the addiction narrative. The Grievor’s evidence does not fit well with that narrative. While I would not expect her to testify to specific dates, some evidence of the arc of her addiction is required, both with respect to its commencement and escalation. Her evidence with respect to both of these features of addiction was just not very good.

For instance, I have little idea with respect to the commencement of her drug dependency. She claims not to recall stealing Tylenol 3s from the Hospital dating back to 2003. The Hospital’s case re the stealing of same is not challenged by the Association because it is ironclad. In my view, the Grievor’s alleged failure to recall such thefts is not credible. Frankly, I am unable to believe that someone would not recall thefts from their employer, which occurred over the course of years, and which required strategic planning. Nor am I persuaded by the Association’s suggestion that this failure of recall is a result of “the fog of addiction”. Without establishing a triggering event, it is significantly more difficult to conclude that she was addicted when she commenced stealing the Tylenol 3s.

In addition, SM did not provide clear evidence with respect to the escalation of her addiction. The number of percocets she was using when she was caught stealing from the OmniCell was not made clear. When interviewed by the Hospital, she admitted to stealing from 2 to 6 percocets per shift, and a Homewood intake note has her taking as many as 8 a day, but I have no direct evidence from the Grievor of a progressive escalation of her dependence.

I could conclude, from Dr. Veenman’s evidence, that the Grievor’s addiction escalated because that is the very nature of addiction, but the Grievor’s evidence does not clearly support that notion in her own case. In my view, her evidence could as easily be taken to support the finding that her dependency was not

unilinear; that there were periods of full blown addiction and other times when she was less dependent; when she was not using or using less.

The evidence with respect to the Grievor's experience of withdrawal is, in my view, also material to the above.

The Homewood Discharge Summary notes that the Grievor had not used since August 15, 2014 when she presented for admission on November 19, 2014 (a urine test confirmed same) and that 'there were no signs or symptoms of withdrawal seen during her admission'; at that time, she "denie[d] any significant withdrawal". This is consistent with the Grievor's evidence before me: that she had no or minimal issues with respect to physical withdrawal.

It appears from both the Discharge Summary and the Grievor's evidence that the main indicia of her opioid addiction were that "she would be pre-occupied with use during her days off". The Grievor put it this way in her evidence:

> Most of my mind and thinking was about how and where I was going to get my drug of choice. While I was in full-blown addiction, the things that I did were completely out of character and against my morals. I would in my own mind deny I had a problem and nobody knew; and the guilt and shame and stigma that comes with being an addict makes it hard to disclose the problem.

The Homewood Discharge Summary also notes:

> [The Grievor] was an exemplary patient in program. She connected well with peers and engaged well in the process of the program. She participated enthusiastically in all groups and phases of program, including, as a nurse, the Inpatient Health Professionals' Group and the out-patient Caduceus support group. By discharge she had demonstrated a good understanding of the steps necessary to maintain sobriety, and had established good connections with 12-step recovery supports in the community. [She] was discharged with solid recovery plans.

The Grievor is now in a very structured and demanding aftercare program. She participated in Homewood's own 9 month aftercare program; she attended AA for 90 straight days after Homewood and continues to attend AA meetings at least every other day. She is under the care of Dr. Veenman, an addiction specialist, who she met at Homewood. She maintains a very rigorous urine program under

his supervision that tests for alcohol and a broad range of drugs at least every 3 days. She has never had a positive test in circumstances where one drink or one 222 would trigger same.

The Grievor is also subject to restrictions imposed by the CNO. Dated January 28, 2016, 3 months after her termination, those restrictions are essentially as follows:

1) She is not allowed to administer or have access to narcotics;
2) She can only engage in the practice of nursing in a setting where another regulated healthcare practitioner is available to monitor her practice;
3) She must provide random, supervised urine samples for analysis, at such frequency as determined by Dr. Veenman, but subject to a host of CNO timelines; and
4) She must inform any new or prospective employers that she is subject to these Conditions.

In August or September, 2015, the Hospital was advised by Employee Health that the Grievor could return to work with certain restrictions. The Hospital and ONA engaged in a series of negotiations regarding that possibility. At the same time, the Hospital, and Ms. Harris-Howe particularly, began a more far-ranging investigation of the Grievor's misconduct, which showed that the Grievor had not only been stealing percocets for a few months, but all the way back to 2011.

On October 22, 2015 the Hospital met with the Grievor and ONA. The Grievor now admitted that she had been stealing percocets since 2011 and she admitted that, in addition to taking them from the Omni Cell, she had diverted them from patients. Put simply, she admitted that she would give a patient, who was to be administered 2 percocets for pain, only one and she would pocket the second for her own use. Of course, the patient's chart would not reflect the misappropriation. This revelation was of great consequence to the Hospital. It meant not only that some patients were being denied appropriate pain relief at the time, but that, because not properly documented, they might be over medicated in the future.

After that meeting, Ms. Harris-Howe decided to delve into the pre-2011 records. Those records, some of which went back to 2003, revealed not only Percocet misappropriation going back to 2006, but also Tylenol 3 misappropriation going back to 2003. While ONA does not challenge that evidence, the Grievor, even before me, did not candidly admit to either the Tylenol 3s or to the extended

timeline. She testified that she could not remember. She was either unwilling or unable to fix the date of her opioid dependency. This failure of candour appears to be 'the straw that broke the camel's back' of the Hospital and convinced it to terminate the Grievor.

Additional Facts

The Hospital relies on the following additional facts, most of which are admissions by the Grievor:

1) She agreed that prior to being caught, there were no outward signs of her dependency; other employees, Management and patients all saw her as a competent RN; when this matter chrystallized, the Grievor was not only respected by Management and her colleagues, she was on the brink of promotion.
2) She had no performance issues, which might have suggested substance abuse; none of her colleagues were aware of her problem.
3) She said that she "knew all along that what she was doing was wrong", but feared coming forward both because she was embarrassed and ashamed and because of potential legal consequences, including being fired or criminally charged.
4) She testified that she never used the percocets on shift or came to work under their influence; rather she only used them at home during her off shift days or after shifts, when she went to sleep.
5) She was never compelled to come into the Hospital off shift to steal the percocets.
6) She stated that she could go on vacation without using; that she took vacations without needing to have or travel with a 'stash'.
7) Even after taking "the cure", the Grievor has not admitted the extent of her misconduct. She testified that she could not recall thefts before 2011 or ever misappropriating Tylenol 3s, in circumstances where the Hospital investigation shows thefts of Tylenol 3s dating back to 2003.
8) At odds with the evidence of Dr. Veenman, which I will turn to next, the Grievor testified that she did not suffer from physical withdrawal symptoms.

Dr. Veenman's Evidence

Dr. Veenman is an addiction specialist. He is associated with Homewood and facilitates its Cadeusus program. Cadeusus is a drug addiction recovery

program devoted entirely to healthcare professionals. The evidence suggests that drug dependency is an occupational hazard for doctors, nurses, pharmacists and other healthcare professionals, who have regular access to opioids.

Dr. Veenman, who first met and diagnosed the Grievor at Homewood, continues to supervise her recovery and her urine testing program. He has a large private practice, which is entirely devoted to addicts. Many of his patients are healthcare professionals.

Dr. Veenman, who characterizes addiction as “a psychosocial biophysical disease”, does not seek to disguise that he is an advocate for drug dependent patients, like the Grievor. When presented with the 7 criteria set out in the DSM IV for finding a substance abuse disorder, he was of the view that she exhibited 6 of them. On that basis and in his view, the Grievor had a severe opioid addiction.

Without attempting to be exhaustive, the Doctor testified that:

1) Her use had escalated over time from 2 percocets to 6 or 8 daily, because, in keeping with an addiction, she had developed a tolerance. He opined that taking 8 percocets, without having developed a tolerance, could be life threatening.
2) Despite the Grievor’s evidence to the contrary, he testified that she would have suffered withdrawal symptoms, including diarrhea, aches and pains, shivers and sweats. His opinion was not based on direct evidence. The Grievor had been clean for 2 months prior to her admission to Homewood.
3) Her time was entirely preoccupied with ensuring that she had enough of her drug of choice; she experienced constant cravings for the drug.
4) The addiction leads to distorted thinking and to conduct at complete odds with the patient’s character. It leads to a failure to fulfill obligations, both at home and at work, and to social isolation.
5) Despite addicts being aware of all the negative consequences of their addiction, they are unable to stop.
6) Addiction affects the addict’s decision-making. Addicts employ a host of mental ruses to deny, minimize, rationalize and justify their conduct in pursuit of their drug of choice. Such foggy or distorted decision-making is part and parcel of their addiction.

ONA took Dr. Veenman to a statement from a discussion paper prepared for WSIAT, dated October 2009 and revised September 2013, entitled simply: Addiction. Question 9A in that paper asks: “Are Addictions a ‘Personal Choice’”? Dr. Veenman fully adopts the answer provided in the paper:

> While it is clear that in many cases individuals who misuse drugs and alcohol can make the decision to stop using addictive substances, in many cases of more severe presentations of substance use disorders, these addictive behaviours become involuntary [20], and the personal choice element is circumvented. In such cases, professional assistance is often needed. This likely relates to the observation that chronic drug and alcohol use can cause permanent changes in the brain's reward and reinforcement centres based on neuroimaging studies in populations with addictive disorders...

The Association relies on 8 awards that address the same issue that is before me. In each case, arbitrators have re-instated RNs, who have been terminated for the theft of drugs from hospitals and/or patients, in circumstances where the RN has pled an addiction to that drug, proven same, taken "the cure" and continued to live clean. In chronological order, the awards are:

> *William Osler Health Centre and ONA* (Katie Ward), (2006), 85 C.L.A.S. 7 (Keller); *Collingwood General & Marine Hospital and ONA* (Smart), (2010), 195 L.A.C. (4th) 124 (Jesin); *Thunder Bay Health Sciences Centre and ONA* (Gabriele), (2010), 104 C.L.A.S. 263 (Sheehan); *St. Mary's General Hospital and ONA* (Harris), (2010), 199 L.A.C. (4th) 75 (Stephens); *London Health Sciences Centre and ONA* (BS), (2013), 230 L.A.C. (4th) 22 (Hayes); *Hamilton Health Sciences and ONA* (Pinsonnneault), (2013) 117 C.L.A.S. 6 (Herman); *Sensenbrenner Hospital and ONA* (Dagenais), unreported, July 6, 2015; *Sunnybrook Health Sciences Centre and ONA* (Discharge), [2016] O.L.A.A. No. 361 (Jesin)

While these cases have fact situations which distinguish one from another, they are sufficiently similar that the latter awards cite all of the former ones. All but one – *Collingwood General*, which is a relapse case and, therefore, has little relevance to the case before me – involve RNs, who when caught stealing drugs, admit to a history of theft and addiction, both of which come as a complete surprise to the hospital. There had been no indication in the RN's employment history of such problems. In fact, a number of the RNs were long service, with exemplary records. All of that is on all fours with SM's case.

In addition, again on all fours with the present case, the RNs admitted themselves to a residential program, committed themselves to recovery, and were, at the time they were seeking a return to work, clean and subject to CNO restrictions and/or a rigorous urine testing and aftercare program. In reinstating them, arbitrators often opined, based on the evidence, that the RNs were excellent candidates for rehabilitation.

For our purposes, the crux of these cases is the arbitrators' finding that each of the RNs had a drug addiction, which had a clear nexus to their workplace

misconduct: stealing their drug of choice. In each of these cases, after acknowledging that, on a just cause analysis, termination was the appropriate remedy, the arbitrators have turned to a human rights' analysis, found *prima facie* discrimination on the basis of addiction and re-instated in accordance, often, with restrictions to be negotiated by the parties.

While the constellation of facts has been very similar, the legal analysis has followed 2 or 3 different paths. In several of the awards, the arbitrator has found that the addiction was such that the RN was compelled to steal the drugs in order to feed their habit. For instance, in *William Osler*, Arbitrator Keller, in rejecting the argument that the RN was not addicted when she commenced her thefts, writes: "Although not yet an addiction it was a compulsion over which, according to the [expert] evidence, the grievor had no control". And,
at the time of discovery, the grievor had a full blown addiction, which the addiction expert concluded meant: "She had no option, if she were to live, than to use."

In most of these cases, the RNs' misconduct is more egregious than that exhibited by SM: stealing a greater numbers of drugs, using at work, sometimes "shooting up at work", coming in off shift for the sole purpose of stealing additional drugs. One of the potential ironies of the analysis that I plan to embark upon is that the more egregious the conduct the more likely it can be found to be compelled by addiction and therefore "excused"; and the less egregious, the less likely that the defense will be made out.

The case most like the one before me is *St. Mary's, supra*. The RN's pattern of use was similar to SM; she didn't use at work; she didn't come into the hospital off shift for the sole purpose of stealing drugs; and the details of her usage and thefts were found somewhat sketchy and wanting. Despite that, arbitrator Stephens rejected the hospital's argument that she was a "recreational user".

> [Dr. Cunningham's] evidence was unconditional – the grievor was addicted to narcotics and the addiction would have compelled her to steal drugs. He was cross-examined about the nuances of the grievor's condition, including her low levels of reported usage and the fact that she did not use drugs while at work, two indicators that appeared to go against common indicators of addiction. In spite of this, his diagnosis was unaffected.

Likewise, the arbitrator dismissed the hospital's submission that, when the thefts commenced, she would not have been addicted, on the following basis:

> …it is my view that such an analysis is not consistent with the nature of addiction attested to by Dr. Cunningham. He described addiction as starting with the first exposure, which he described as a switch being turned on. From that point forward the addicted individual is caught in a progressive pattern of usage that, if untreated, is ultimately fatal. Thus, while the individual may move through various phases, such as progressing to larger dosages, more frequent use, and increasingly self-destructive behavior, the addiction, i.e. the compulsion to procure and use the drug, is present from the outset. Given this evidence, I cannot agree that the grievor was free from addiction or less addicted, and thus more culpable, at the time of the first thefts.
>
> It is my conclusion that the grievor was addicted to narcotics throughout the period of the thefts, and that the addiction compelled her to steal narcotics from her employer.

This concept of compulsion is central to the analysis. If there is addiction, there is compulsion and, if there is compulsion, there is sufficient displacement of responsibility from the grievor to the illness to render the conduct less culpable and therefore not deserving of termination. It is noteworthy that arbitrator Stephens, while accepting the human rights defense, provides a remedy not consonnate with a breach of the Code, so much as one which is consistent with the doctrine of mitigation. While the grievor is re-instated, the arbitrator makes clear that it is she, not the employer, who "should bear full responsibility for the long hiatus in her employment".

So, while the analysis appears to be in the key of disability and the Code, it is not far removed from the older arbitral doctrine of mitigation of penalty based on illness; see, for instance, both *Canada Safeway Ltd. and Retail Wholesale and Department Store Union* (1999) 82. L.A.C. (4th) 1 (Ish); and *Canada Post Corp. and C.P.A.A.* (MacMillan) (2001), 102 L.A.C. (4th) 97 (Christie) and the various tests set out therein. There has been an evolution from considering the illness as a mitigating factor to termination to one where the illness, because a Code protected addiction, is more determinative of the outcome.

The award of Arbitrator Sheehan in *Thunder Bay Health Sciences Centre, supra*, underscores the connection between the human rights analysis, and the older doctrine of mitigation of penalty based on illness. The Arbitrator explicitly cites *Canada Safeway, supra*, in his analysis. Ultimately, Mr. Sheehan concludes that the RN's 'aberrant behavior was unequivocably caused by her addiction, that a disciplinary approach to confronting her behavior was therefore not appropriate; and that, rather, the appropriate framework of analysis is whether the hospital has accommodated the nurse's disability to the point of undue hardship'. The

Arbitrator re-instated the RN, subject to the hospital's ability to accommodate her, but explicitly without any compensation.

While these authorities do not make specific reference to the so-called "hybrid" approach, popularized in British Columbia for a time, they are consistent with that approach. Essentially, the hybrid analysis requires an arbitrator to both apply a disciplinary or just cause analysis to the culpable aspects of the misconduct and a human rights analysis to the non-culpable aspects. The analysis of Arbitrator Hayes in *London Health Sciences Centre, supra* is in accord with the hybrid approach, without explicitly mentioning it by name. The RN in that case was only 26; she had a long history of alcohol and drug dependence. She had first been prescribed percocets in 2006 and described her reaction as "euphoric, you're floating around". She commenced work at the hospital in 2008 and began stealing drugs from the hospital and patients in January, 2010. She began with percocets and then progressed to other narcotics, including morphine and sedatives. She used at home and at the hospital. By the time she was confronted in February, 2011, she was injecting opioids 5 or 6 times a day. She acknowledged that she may well have been drugged at work.

While the arbitrator acknowledges that, on a just cause analysis, the termination would be upheld, he found, consistent with the addiction specialist's report,

> … what I believe to be the only reasonable assessment of the facts. The grievor suffers from a drug addiction. Drugs were available at the Hospital. As her evidence made clear, she did not have control over her behavior which is a principal feature of any addiction. With respect, I do not believe that there is any doubt that the grievor's addiction was the direct cause of her misconduct. While on some level she may well have understood her actions to be wrong, she was not capable of overcoming that understanding due to her disability. As Dr. Judson's reports make clear, denial is a common feature of addictive behavior.

And finally:

> While the concerns of the Hospital were and are entirely rational and understandable, in all of the circumstances I conclude that the employer did as a matter of law, *prima facie*, discriminate against the grievor because of her disability when it terminated her employment.

Neither party before me, maybe in keeping with the silence of Ontario arbitrators respecting it, made reference to the hybrid approach, despite my invitation to do so. I've always thought that it was a nuanced recognition of the practical realities

of addiction; that there is a complex relationship between the culpable and non-culpable aspects of workplace misconduct, when that misconduct is fuelled by addiction.

While I've suggested that Ontario arbitrators have, in the main, followed an analysis akin to the hybrid approach, there is a further complication. As I've noted above, many of those arbitrators have explicitly tied the addiction defense to the 'loss of control' or compulsive nature of the disease. The early B.C. authorities respecting the hybrid approach: see, for instance, *Fraser Lake Sawmills*, [2002] B.C.L.R.B.D. No. 390, suggest that loss of control is not a requirement of the defense; rather, in applying a human rights analysis, a non-culpable component of the behavior is acknowledged. It would be inconsistent with that analysis to then impose a threshold of "uncontrollable behavior".

I will revisit the hybrid approach below, necessarily, because the B.C.C.A. decision in Gooding is a clear dismissal of such an approach, in circumstances where the workplace misconduct at issue is criminal in nature, as is the misconduct before me.

The "Gooding" Line of Cases

The Hospital relies on *British Columbia (Public Service Agency) v. British Columbia Government and Service Employees' Union (Gooding grievance),* (B.C.C.A.), (2008) 298 D.L.R. (4th) 624; *Wright v. College and Assn. of Registered Nurses of Alberta* (Appeals Committee, (Alberta C.A.), (2012) 355 D.L.R. (4th) 197; and *Walton Enterprises (c.o.b. Midas Auto Services Expects) v. Lombardi*, (Ont. Div. Court), [2013] O.J. No. 3306; and *Bellehumeur v. Windsor Factory Supply Ltd.*, (Ont.C.A.), [2015] O.J. No. 3317.

Gooding was the manager of a B.C. run liquor store. He was fired for stealing alcohol from the store. He established that he was an alcoholic and took the cure. A well-known B.C. arbitrator, Stan Lanyon, applied the hybrid approach and, on the basis of the nexus between his misconduct and his addiction, re-instated him. The B.C. Court of Appeal overturned that ruling, finding that it was not discriminatory treatment. The ratio is as follows:

> I can find no suggestion that Mr. Gooding's alcohol dependency played any role in the employer's decision to terminate him or in its refusal to accede to his subsequent request for the imposition of a lesser penalty. He was terminated, like any other employee would have been on the same facts, for theft. The fact that alcohol dependent persons may demonstrate "deterioration in ethical or

> moral behavior", and may have a greater temptation to steal alcohol from their workplace if exposed to it, does not permit an inference that the employer's conduct in terminating the employee was based on or influenced by his alcohol dependency…
>
> I can find no suggestion in the evidence that Mr. Gooding's termination was arbitrary and based on preconceived ideas concerning his alcohol dependency. It was based on misconduct that rose to the level of crime. That his conduct may have been influenced by his alcohol dependency is irrelevant if that admitted dependency played no part in the employer's decision to terminate his employment and he suffered no impact for his misconduct greater than that another employee would have suffered for the same misconduct.

The Court, citing a number of Supreme Court of Canada authorities, re-iterated that the first step in a human rights discrimination analysis is proof of discriminatory conduct by the employer. Was Gooding, as an alcoholic and a member of a protected group, treated differently or arbitrarily because of his membership in that group? The Court found that he was not. He was fired for theft, a crime, as any other non-alcoholic employee would be. Was he subjected to indirect or adverse effects discrimination by having the general rule: theft results in termination, applied to his protected class? Was that a discriminatory burden? As will become clear, the Courts are not sympathetic to such an argument. Theft is a crime. It is a well accepted social norm. There is nothing arbitrary about the enforcement of such a social norm, even against a protected class.

The B.C.C.A remitted the matter back to Arbitrator Lanyon. Bound by the Court of Appeal and therefore absent a human rights defense, he conducted an analysis not dissimilar from that found in the *Canada Safeway Ltd*. decision of arbitrator Ish, *supra* and the *Canada Post Corp.* one of arbitrator Christie, *supra*. Arbitrator Lanyon concluded:

> 52. The usual circumstances that mitigate the penalty of dismissal in respect to theft is where the theft is both isolated and exceptional and an employee is of long service. Other circumstances include where the theft was on the spur of the moment, and the value of the goods were nominal; or where the employer's policies were unclear and there has been inconsistent discipline. Finally, a Grievor must show the potential for rehabilitation and be genuinely remorseful.
>
> 53. Mr. Gooding has shown not only the potential for rehabilitation, but has demonstrated actual rehabilitation, and he has been genuinely remorseful. His recovery and sobriety are both admirable and compelling.

54. However, this theft was not on the spur of the moment, nor was it isolated or exceptional. It was premeditated over a long period of time. There was never any issue about any enforcement of the Employer's policy in respect to the theft of alcohol and the amount of alcohol stolen would not have been of nominal value.

55. As stated in *Fraser Lake Sawmills* "the presence of an addiction or dependency does not necessarily immunize an employee from disciplinary or corrective action." (para. 86) The BC Labour Board in *Fraser Lake Sawmills, supra* quotes from *Raven Lumber Ltd. And International Woodworkers of America, Local 1-363* (1986) 23 LAC (3d) 357 (Munroe) that, although alcoholism is a disease, it neither mandates nor precludes dismissal:

> One can see, then, that in terms of its effect on the employment relationship, alcoholism is viewed by arbitrators as being the same, in all respects, as any other incapacitating condition. It neither mandates, nor automatically precludes a dismissal.

56. I conclude that Mr. Gooding's alcohol addiction, and his subsequent recovery, are not sufficient factors to mitigate his dismissal, given the seriousness of his employment offence.

The Gooding analysis has gradually made its way to Ontario by way of Alberta and Manitoba.

In *Wright, supra*, an Alberta Court of Appeal decision, there is a lengthy discussion of the issue of whether addiction can be erected as a defense to criminal behavior. The short answer: it cannot. Citing Gooding, the Court writes at paragraphs 63-66:

> The fact that his criminal conduct was motivated (or caused) by his addiction did not elevate the employer's decision to the level of discrimination, because the decision to dismiss for theft was not arbitrary or based on preconceived stereotypes.
>
> The appellants reply that it does not matter if the decision to prosecute was not directly based on their disability. Discrimination can be shown even if an otherwise neutral standard has a greater impact on the identified group. This argument rests on an assumption, not well proven on this record, that addicts are more inclined than the general public to steal and forge documents. There are many addicts who suffer from a disability, but do not engage in criminal conduct. In any event, not every distinction of this kind amounts to discrimination. As the case law shows, human rights legislation contemplated that the distinction be based on stereotypical or arbitrary characteristics engaging human dignity…. Discipline for criminal conduct is based on objectively justifiable social criteria,

> not stereotypical thinking or arbitrary judgment of personal characteristics. While the law recognizes that an addict cannot always control her addiction, the law does require that the addict control her conduct sufficiently to comply with the criminal law.
>
> …both of those cases … confirm the need for a link or nexus between the protected ground or characteristic and the adverse treatment. Those cases conclude that the required link or nexus is incorporated into the core test for *prima facie* discrimination. The strength or proximity of that link or nexus is a mixed question of fact and law, and an important component in the analysis is whether the treatment is in fact stereotypical or arbitrary, and whether it affronts concepts of human dignity. Not any nexus or connection, no matter how remote, is sufficient. The medical cause, while relevant, may not equate to a legally recognized cause.
>
> The consequences of excusing criminal behavior because of addictions would be far-reaching. In criminal prosecutions, addiction is not generally regarded as mitigating, much less as an exemption from criminal accountability…

The Employer also relies on *Walton Enterprises, supra*, wherein the Ontario Divisional Court overturned a decision of the HRTO. The HRTO found that the dismissal of an employee was discriminatory, in circumstances where he had been harassed at work and engaged in a fight with a co-worker. The Court held that the employee had the onus of proving the nexus and found such evidence wanting. The Court, in that context, also references the Gooding decision at para. 39, without clearly adopting same, and in the following terms:

> Both the British Columbia and Albertal Courts of Appeal have held that an employee who engaged in misconduct that rose to the level of a crime could not prove discrimination on the basis of disability where the disability played no part in the employer's decision to dismiss and the employee suffered no greater impact for the misconduct than any other employee would have suffered….

In *Bellehumeur, supra*, the Ontario C.A., citing the ratio of Gooding approvingly, dismissed an employee's appeal against his termination in the following terms:

> The appellant's mental disability, unknown to the employer, at the time he was terminated played no role in the reason the appellant was terminated. He was terminated because he made violent threats against fellow employees.

Gooding is not referenced by the Ontario arbitrators who make up the consensus. And while a B.C. Court of Appeal decision is not binding on me, and the statutory regime in British Columbia is different than that of the OLRA, and

the Court decisions in Ontario are distinguishable, it is surprising that the Court's reasoning has attracted so little discussion, if only to distinguish the reasoning or reject it. The only arbitral reference to Gooding, as of the time this case was first argued, is to be found in *TTC v. CUPE, Local 2*; (2011) 210 L.A.C. (4th) 268 (Stout). The Arbitrator dismissed a grievance, which attempted to erect a defense of cocaine addiction to the theft of copper wire from the TTC, because there was little or no nexus between the addiction and the thefts, other than evidence that the grievor sold the wire in order to buy the drug.

However, in the course of his discussion of Gooding, Mr. Stout criticized the majority's view. In his view, it "is much too narrow and a broader more purposive examination must be made to determine if prima facie discrimination exists." Arbitrator Stout preferred the minority opinion in Gooding, which endorsed the hybrid approach, which had been applied by Arbitrator Lanyon in the first instance.

Two Recent Ontario Arbitration Decisions

Between the time this matter was first argued before me and the supplementary argument on October 20, 2016, 2 awards were issued: *Sunnybrook Health Sciences Centre and ONA* (Discharge), [2016] O.L.A.A. No. 361 (Jesin); and *Royal Victoria Regional Health Centre v. ONA* (P.S. Grievance), [2016] O.L.A.A. No. 373 (Raymond).

Arbitrator Jesin essentially followed the Ontario consensus. The facts of *Sunnybrook* are similar to those before me in the following respects. There was a long history of pre-mediated thefts from the hospital and diversions from patients; she was guilty of a fraudulent cover-up, an initial denial of wrong-doing and a never fully satisfying admission of the full extent of the thefts. She had taken the cure and was subject to rigorous testing and was considered, by her physicians, to be an excellent candidate for remission.

There are 2 distinguishing features. First, her drug use (and addiction) was more serious than that of my Grievor. Her use and abuse was more extreme; she stole and abused a greater cocktail of drugs and more opioids than the Grievor. The evidence also established that she suffered from serious symptoms of opioid withdrawal. At paragraph 18, Arbitrator Jesin writes:

> In her evidence the grievor tried to describe what she was going through while addicted. She suffered heightened anxiety when she was in need of benzodiazepines such as clonazepam. Once she began abusing opiates she suffered severe withdrawal symptoms when the drugs wore off. She testified that she would not otherwise consider committing theft or other criminal behavior but whe she was in need of drugs she could not resist the temptation to divert them.

At paragraph 52, the arbitrator holds:

> In my view this analysis does not give sufficient weight to the connection between the grievor's misconduct and her disability. As I had stated earlier, the majority scientific view is that drug and alcohol addiction are diseases. They lead to an impaired ability to control one's craving and indeed, theft, dishonesty, denial and shame are classic features of the disease. In the health care sector, as we have seen in the cases, theft is a frequent feature in cases in which health care professionals are discharged while suffering from addiction. It is trite that attending at work under the influence of drugs and alcohol is a serious offence. But when the employee suffers from addiction to those substances the Employer will be required to accommodate such an employee to the point of undue hardship and will be prohibited from disciplining such an employee. Similarly, where the evidence establishes that an employee suffers from an addiction to drugs and the employee not only is unable to resist use of drugs while a work, but is also unable to resist the urge to divert those drugs from the Employer, the employee must be treated as any other employee suffering from a disability. In such a case the Employer will be required to accommodate the employee to the point of undue hardship. In this case the grievor was discharged because she could not resist the urge to divert drugs from the Employer and from patients in order to feed her addiction. I would note that Ms. Sauers had suspected that the grievor was working under the influence of drugs before she was discharged. This is much different than requiring an employee with a particular illness to provide doctors notes which employees with other illnesses do not need to provide. In such a case the Employer may be able to establish a reasonable basis for the distinction which does not perpetuate a prejudice. When an employee, however is discharged because she is unable to resist the urge to commit theft or other misconduct in order to perpetuate the addiction, then the discharge is indeed based on a distinction, which perpetuate a prejudice. As employees with other disabilities which prevent them from doing their jobs must be accommodated in jobs that they can do (subject to undue hardship) until their health improves, employees who cannot perform their jobs because of addiction must be accommodated to the point of undue hardship as well.

Arguably, this is the high water mark of the Code or medicalized model defense. It dispenses with an approach based on mitigation of penalty; it dispenses with a hybrid analysis. It makes no reference to the Gooding analysis.

Arbitrator Raymond in *Royal Victoria, supra*, does something quite different. He dismisses the grievance. The RN in that case was guilty of far more egregious conduct than the RN before me, but she was, unlike SM, short service. And, unlike the case before me, the hospital had pressed criminal charges and the nurse had pleaded guilty to same. The arbitrator relies on the guilty plea to establish the *mens rea* element of criminal culpability, which, in his view, undermines or, at least, weakens the addiction defense. The arbitrator takes note of Gooding and the line of authority that it spawns, without committing to its being dispositive. He also relies on 2 features of the case which are relevant to mitigation. The grievor's treating physician testified that her reinstatement to employment at this hospital would not be helpful to her rehabilitation; and she was, at the time of the hearing, gainfully employed as an RN at 2 other health care facilities, including an Ontario hospital.

Decision

For the reasons which follow, I am dismissing the grievance. Obviously, given my detailed review of both the facts and the law, I'm not of the view that the decision is an easy one. It was made more difficult by my empathy for the Grievor. In my view, she is a good person and, but for her addiction, she was a model employee. I would go further and find that 'but for' her addiction, she would not have engaged in the serious misconduct which led to her termination.

Having said that, there were problems with her evidence. She was unable to own up to the full extent of her misconduct, which I found very problematic. Being cured of an addiction requires full ownership of the misconduct, which I find, especially with respect to her history of Tylenol 3 thefts, she was unable to do. Taking full responsibility is relevant to numerous considerations: 1) my willingness to mitigate the penalty; 2) my ability to comprehend the triggering event of her addiction and its overall narrative and 3) and most importantly, given the evidence of Dr. Veenman, her prospects of continuing abstinence.

While I have little doubt that she will stay clean and that she could be accommodated by the Hospital with some hardship, my decision is not based on either of those considerations. Without adopting Gooding full bore, I am guided by that line of authority. My view is that much of the arbitral case law has collapsed 2 steps of the legal analysis. Before turning to issues of accommodation, the first issue is whether an addiction to the drug is a defense to the criminal misconduct of stealing the drug from the Hospital and diverting same from patients. Obviously, the misconduct is serious employment misconduct. It

is hard to imagine more serious workplace misconduct. It is an absolute breach of the employment relationship, and a breach of an RN's essential duties to her patients.

In accord with Gooding, I don't accept that pleading an addiction to the drug being stolen, which is to say, establishing a nexus between the addiction and the misconduct, is, in itself, a defense to termination. Put differently, it is not *prima facie* evidence of discrimination. There is not an iota of evidence before me of direct discrimination, to use old nomenclature, which is what the BCCA required in Gooding.

I have no doubt that SM would not have conducted herself in the fashion she did, 'but for' her drug dependence. Nor am I in a position to call into question Dr. Veenman's opinion that the Grievor was addicted and not merely a 'recreational user'. But in my view, which is consonant with the Doctor's evidence, there are degrees of addiction. The Grievor's addiction, based on her own evidence, was not compulsive. She did not use at work. She went on vacation for one or two weeks without using. She suffered little or no withdrawal when going off the percocets. She did not provide a comprehensive narrative of her addiction that dovetailed with Dr. Veenman's evidence. Dr. Veenman testified that the Grievor had a serious addiction, but he was quick to admit that he was a patient advocate.

My findings distinguish this case from most of the awards which make up the arbitral consensus in Ontario. Many of those rely on the compulsive nature of an addiction, which compulsion I have found is not sufficiently evident here. The facts of this case also distinguish it from those awards, which are based on principles of mitigation. While the Grievor is a discipline free long service employee, who 'but for' her addiction would have not misconducted herself, her failure to own up to the full extent of her misconduct, together with other features of the case, disqualify her from considerations of mitigation, given the seriousness of her offence.

While not requiring an employee to meet the criminal defense of being 'unable to appreciate or understand the nature and quality of their actions', in my view, that standard is relevant to cases of this kind. On her own evidence, the Grievor acknowledges that she cannot bring herself close to that standard.

I would be remiss to not mention my concern with respect to general deterrence. It is trite to note that workplace discipline has both specific and general deterrence purposes. At a time when opioid addiction is rampant in the culture

and a major issue for healthcare professionals, sending the message that pleading addiction, only after being caught stealing one's drug of choice, should be strongly deterred. Obviously, if SM had come forward with her problem prior to being caught stealing the drugs, the disposition of this matter would have been different. And while every addict won't be capable of doing that, in my view, based on all of the evidence, SM's capacity to do that was not sufficiently impaired to mitigate the penalty of dismissal and I so find.

Finally, I do note, again, that this analysis raises the spectre of more egregious workplace misconduct by an RN – shooting up at work, for instance – being the basis for a Code defence to dismissal, because proof of a full blown addiction, whereas SM's less egregious conduct, because consistent with a more controlled habit, does not. I am not able to resolve that problem with my analysis, but am of the view that is is consistent with the principles that I have applied.

Disposition

For all of these reasons, this grievance is dismissed.

DATED THIS 19th DAY OF JANUARY, 2017 IN BARRIE, ONTARIO.

_____
Dana Randall, Arbitrator