IN THE MATTER OF AN ARBITRATION

BETWEEN:

THE GOVERNMENT OF THE NORTHWEST TERRITORIES

(the "Employer")

AND:

THE UNION OF NORTHERN WORKERS, A COMPONENT OF
THE PUBLIC SERVICE ALLIANCE OF CANADA

(the "Union")

Nurse Practitioners Leave and Responsibility Pay Grievance

AWARD

ARBITRATOR:	Randall J Noonan
APPEARANCES:	Thomas Wallwork and Cassidy Ménard, for the Employer
	Michael Fisher and Nikola Sittman, and Aimee McCurdy, for the Union
HEARING DATES:	July 9, 10, and 11, 2024
DATE OF AWARD:	December 11, 2014

A. Introduction

1. On May 4, 2023, the Union filed a policy grievance related to Primary Health Care Nurse Practitioners ("NPs"). The grievance has two aspects to it. The first deals with leave issues and the second relates to Responsibility Allowance.

2. In relation to the leave issue, the Union had received a draft Employer's Standard Operating Procedure ("SOP") entitled "Primary Care Nurse Practitioners – Leave Process and Coordination." While the Union recognized that the document was a draft as opposed to a final policy, the Union alleged that some of the procedures within the draft had already been implemented in the workplace. That allegation was confirmed by an email sent by Matthuschka Sheedy, the Regional Manager for Primary Care, on November 8, 2022:

> Although our NP leave SOP is still in draft format, we used it to approve leave from January to March 2023 and will do so again for the next approval…

3. The Union set out its concerns regarding the SOP in its policy grievance:

> This SOP [sets out] several of the Employer's obligations [imposed upon] our members such as the need to arrange their own coverage when taking leave (1.a.iii) and dealing with instances where two or more employees request the same period of time off (3.a.v.).
>
> These are not the responsibility of our members and are governed by the Collective Agreement.
>
> Most egregiously, this SOP lays out the process for requesting leave. Notably that leave requires four months' notice in advance of the following quarter. This goes against the advanced leave scheduling identified in Article 18 of the Collective Agreement which outlines a very clear process.
>
> Our final concern with respect to this policy is the employer position that leave requests will only be granted, should they not incur overtime.

4. The Employer subsequently withdrew the SOP as it applied to leave provisions. In a letter to the Union dated June 9, 2023, Kim Riles, the Chief Executive Officer for the Employer, wrote:

> It is accurate, the SOP for the Nurse Practitioners' leave request is currently in draft format. However, effective May 26, 2023, the Employer has ceased and discontinued the developing SOP for Nurse Practitioners. Section 3 (b) of the SOP was mistakenly implemented due to an oversight by the Employer. The intent was for the Employer representative to submit to the Union notification of advanced scheduling leave for the Nurse Practitioners in accordance with article 18.02(2) of the Collective Agreement; however, this was not completed. The Employer apologizes for this oversight and will ensure this is followed through in the future.

5. The SOP has been withdrawn and the Union is not seeking damages for the period of time during which it was applied. Nonetheless, the Union has asked for a declaration that the SOP violated the Collective Agreement. The Employer does not take issue with my issuing such a declaration.

6. Notwithstanding that, I find that it is inappropriate, unnecessary, and probably unhelpful to issue a blanket declaration that the draft SOP would have violated the Collective Agreement had it been finalized and enacted. There is certainly no doubt that at least parts of the SOP did violate the Collective Agreement. The Union raised a number of objections to it and the Employer, recognizing that at least parts of it were not in concert with the Collective Agreement, withdrew it. In particular, the Employer agreed that trying to coordinate NP leaves with physicians' leaves could not work with the Collective Agreement. The problem with issuing a declaration is that not all parts of the SOP were discussed between the parties, and the Employer's withdrawal of it seems to be related to only one of the Union's objections. I did not hear thorough evidence on all aspects objected to by the Union, nor was I asked to do an in-depth analysis as to what parts of the SOP violated the Collective Agreement and which parts did not. Given all of that, I decline to make the declaration sought by the Union.

7. The other part of the policy grievance relates to "Responsibility Allowance." The remainder of this award will deal primarily with that issue. The dispute is whether NPs are entitled to a Responsibility Allowance under the Collective Agreement when there is no physician present on an Integrated Health Care Team ("IHCT") and when they act as "Team Default." In those circumstances, the Union claims that the nature of the NPs work changes in both scope and quantity so that they are effectively substituting for physicians. The Employer concedes that the quantity of work changes for the NPs in such circumstances. However, the Employer's view is that NPs, by definition, are not physicians, so they cannot take on the full scope of physicians' duties and are therefore not entitled to Responsibility Allowance.

8. Each party called one witness. The Union called Samantha Brooks, a Nurse Practitioner ("NP") employed by the Employer. The Employer called Mattuschka Sheedy who is the Regional Manager for Primary Care in Yellowknife.

B. Collective Agreement

9. The key Collective Agreement provisions in dispute are in Article 24, the most relevant parts being:

> 24.01
>
> (1) Employees are entitled to be paid for services rendered for the job evaluation and position to which they are appointed at the pay rate specified in the appendices attached.
>
> 24.04
>
> *(1)* (a) *when an employee is required by the Employer to perform the duties of a position at a higher rate range on an acting basis; or*
>
> (b) when an employee is designated in charge of a ward, unit or department on any shift in circumstances which place upon the employee responsibilities greater than those ordinarily assumed; or
>
> (c) when a nurse temporarily replaces another nurse in the position of Supervisor; or
>
> (d) when the head nurse or unit or department manager is not present to coordinate the daily operations of the ward, unit or department, and designates an employee as in charge
>
> The employee shall be paid a responsibility allowance.
>
> (2) Employees in the above circumstances shall be paid:
>
> (a) An amount of ten (10%) of the employee's base salary for acting periods of 5 days/shifts or less; or
>
> (b) An amount of twelve (12%) of the employee's base salary for acting periods greater than 5 days/shifts.

> Such pay shall be calculated from the time on which the employee commenced to act, for the period in which the employee acts.
>
> (emphasis added)

Job Descriptions

10. The Employer has issued job descriptions for both NPs and for Family Practitioners. The NP job description sets out the following:

> **PURPOSE OF THE POSITION**
>
> The Primary Health Care Nurse Practitioner is an autonomous practitioner who supports integrated healthcare teams within a Primary Care Clinic and is responsible for providing clients with advanced health assessment, diagnosis, intervention, and appropriate follow-up to ensure clients receive timely health assessment and diagnosis, optimum support, and continuity of care.
>
> **Scope**
>
> Located in Yellowknife and reporting to the Regional Manager, Primary Care, the PHCNP works as an atomic practitioner within the multi-disciplinary primary health care team, providing comprehensive health assessments, making diagnoses, and developing interventions within scope of practice. The incumbent works in a variety of program areas and community settings including within a clinic site; in a client's home; a public or community outreach setting (such as the Centre for Northern Families and Stanton Territorial Hospital), and is expected to remain calm, controlled, and professional in all situations.
>
> The primary health care clinics include a number of multi-disciplinary healthcare practitioners providing comprehensive patient assessment, coordinated intervention/plans of care, case management of complex or high need clients, personalized teaching and client follow-up. The practitioners include but are not limited to physicians; public health practitioners; midwives; nurse practitioners; and mental health and addictions practitioners; some of whom report to other managers.
>
> …
>
> The PHCNP provides comprehensive nursing care including, but not limited to, health promotion, illness, and injury prevention, supportive,

curative, rehabilitative and palliative care. The PHCNP is also required to collaborate with primary health care practitioners to increase the capacity for self-care and provide direction as an educator, leader, researcher, and advanced clinical practitioner.

The PHCNP consults and/or refers clients to other healthcare practitioners as appropriate, at any point in the assessment of a client or when planning, implementing, or evaluating client care when the condition is such that: diagnosis and/or treatment plan is unclear or beyond the scope of the PHCNP to determine; required care approaches or reaches the limits of scope of practice; is potentially life-threatening or a chronic health problem destabilizes. The degree to which a physician becomes involved will vary from: providing an opinion and recommendation at one end of the spectrum to assuming primary responsibility for care of the client at the other.

The PHCNP is also responsible for providing care and support for NP colleagues including, but not limited to, outreach clinics and public health services.

11. The NP job description then goes on to list five headings of responsibilities of NPs with many duties listed under each major heading. The major headings and some of the related duites are:

    1. Provides advanced health assessment, nursing care and services to clients on a routine and emergency basis (if appropriate) to promote a healthy lifestyle; to prevent and/or reduce incidence of disease, disability, and death; to support rehabilitation and to restore health; and to support a client to die comfortably and with dignity.

        - Systematically assesses individual health status through the collection of an appropriate history, performance of physical assessment and the ordering and interpretation of diagnostic tests.
        - Establishes a diagnosis through analysis and synthesis of data from multiple sources; communicates health findings and establishes a plan of care with the client;
        - develops a plan of care based on client need, independently or in consultation with a physician or other member of the primary health care team.
        - Implements a comprehensive care plan, which may include the prescribing and dispensing of pharmaceuticals, in accordance with established regulations, policies, practices

and safety procedures as well as non-pharmacological interventions.

- Refers clients to other practitioners as determined by scope of practice and client needs.

2. Develops, facilitates, implements, and modifies client and family education/teaching based on the needs of the client.

3. Conducts health surveillance and preventative activities that may improve the health of the population. This is done in conjunction with clients, healthcare practitioners and agencies.

4. Provides expert and specialized knowledge on primary health care related to nursing in the NWT to provide direction and leadership to enhance the NWT integrated service delivery model.

    - Provides coaching and clinical leadership to peers, students, and other members of the healthcare team to develop skills necessary to achieve the standard of care.

    - Participates in research and special project initiatives to contribute to evidence-based practice. This includes reviewing literature on current clinical practice, recommending change to clinical practice standards, protocols and procedures based on an assessment of evidence and analysis of resources to implement change.

5. Workplace Health and Safety: employees of the Authority are committed to creating and maintaining a safe and respectful workplace for employees and patients/clients. Building a safe and respectful workplace is everyone's responsibility.

12. The NP job description sets out a lengthy list of knowledge, skills, and abilities expected for the position. In terms of educational qualifications, the NP job description indicates:

Typically, the above qualifications would be obtained by:

Completion of a nursing degree, completion of a Master's program in nursing, certification as a Nurse Practitioner and five (5) years of relevant clinical nursing experience.

Equivalent combinations of education and experience will be considered.

13. Theare are two job descriptions for family practitioners, that is, Family Practitioner 1 ("FP1") and Family Practitioner 2 ("FP2"). The FP1 job description has the following provisions:

General Position Summary:

The Family Practitioner provides family practice medical services to the residents of Northwest Territories Health and Social Services Authorities (NTHSSA) service area in one of the primary care clinics. The FP1 provides services normally received in a primary care clinic.

The Family Practitioner is part of a team of professionals including Nurse Practitioners, Midwives and other allied Health and Social Services Professionals providing primary care services. The FP1 participates in health and social service program planning and the development of other related professionals.

Specific Responsibilities

The specific responsibilities for this position require the Family Practitioner to:

- provide family practice services within Yellowknife Clinics.
- Book an average of 18 to 22 patients in a full clinic day.
- May be required to provide medical services to one or more communities.
- Complete patient charts; shadow billing records and third-party billing information and timely manner.
- Will provide other clinical services as agreed upon with the Medical Director.
- Participates as a member of the committee involved in the development and/or improvement of health and social services programs.

- Participate in the development of medical residence, nurse practitioners, student nurses and other related professions as arranged through the Medical Director or Chief Executive Officer.

Other Related Duties

Performs other related duties normally associated with being a Family practitioner or other duties assigned by the Chief Executive Officer or delegate.

Job Requirements

(a) Education:
  (i) Dr. of Medicine with license are eligible for licensure to practice in the NWT.

  (ii) Certification through the College of Family Practitioners of Canada (CCFP).

14. The FP2 job description is almost identical to the FP1. The only noticeable difference is that the Specific Responsibilities of the FP2 include "Participate in the Community call group."

C. Testimony

Samantha Brooks

15. Ms. Brooks obtained a Bachelor of Nursing and became a Registered Nurse ("RN") in 2013 in Toronto. She became a Community Health Nurse and moved to the Northwest Territories in 2014. The extra educational requirement for that position is a post-graduate certificate in remote nursing. She obtained a Master's of Nursing degree and became a certified Nurse Practitioner in 2021.

16. Ms. Brooks described the responsibilities of an RN, a Community Health Nurse, and a Nurse Practitioner. An RN provides direct patient care in a variety of settings such as a hospital or a community care clinic. An RN may also perform administrative roles. With their additional training, Community Health Nurses do some things that an RN cannot do, for example dispense medicines from a formulary, use a working diagnosis (suspected but not official), and provide care in the community including acute care and home services. A Community Health Nurse may also do suturing, casting and pap smears. They will work in remote communities in which a doctor may be present for only a few hours per week.

17. Nurse Practitioners have additional training and nursing experience and do things beyond the scope of RNs and Community Health Nurses. They are allowed to diagnose, treat illnesses, and prescribe medicines. An NP can order and interpret diagnostic tests such as x-rays, CT scans, and lab work. NPs can create a treatment plans for patients. These tasks are similar to tasks performed by family physicians in a clinic setting.

18. Ms. Brooks testified that Physicians and Nurse Practitioners in the Northwest Territories work in IHCTs within Primary Care Clinics ("PCCs"). An IHCT will typically consist of 2 to 3 physicians (Family Practitioners), an NP, a Licensed Practical Nurse ("LPN"), and a Program Assistant. In one of the PCCs, there are also Community Health Nurses on the teams.

    - The Program assistant does the administrative work, including booking, telephone calls, faxing and messages from patients to health care providers.

    - The LPN is typically responsible for taking the patients' vital signs, preparing for procedures, and can see patients on their own for certain pre-existing orders (for example, when a patient comes in every month for a prescribed injection, the LPN may administer that injection).

    - The primary care provider for a patient may be either a physician or an NP. Typically, NPs will care for patients with more stable and less complex issues. Physicians will typically deal with patients with more complex needs or who have destabilized.

19. Notwithstanding those differences, Ms. Brooks testified that there is significant overlap in the types of patients seen by NPs and physicians. She said there is no clear way to determine whether a given patient will see one or the other. When assigning a patient to either a physician or an NP, there are several factors considered including patient preference and the amount of time allocated to doctors and NPs to see patients.

20. In relation to the time allocated to see patients, Ms. Brooks advised that physician appointments are set for 15 minutes while NP appointments are set for 30 minutes. If a patient has multiple issues, they will be referred to the NP because of the greater length of time available.

21. Patients are assigned to a team. The physicians on the team are assigned a panel of patients for whom they are the primary health care provider. Those panels will typically have about 1000 patients but sometimes as high as 1200. If a patient receives care for emergencies, their follow-up will be with the physician to whom they are impaneled. NPs, in contrast, do not have a set panel of patients.

22. However, only about half of the population are assigned to IHCTs. Patients who have not been assigned to an IHCT and are not impaneled to a Family Physician are called "unassigned patients." The health care providers in the PCCs treat patients who have been assigned to teams, but also allow for same-day appointments for unassigned patients who will see either a physician or an NP at the clinic. Physicians and NPs have spaces left open on their schedules to see unassigned patients.

23. Ms. Brooks described her typical day in the PCC as an NP:

- She will start work at 8:00 am;
- the first half-hour is reserved for a team huddle to discuss what to expect for the day: Are they short staffed? Do they know if problem patients were coming in that day? What are the schedules for the various team members for that day?
- The next 15 minutes are taken up with administrative responsibilities including reviewing what is in their inbox and reviewing prescriptions.

24. In describing the inbox, Ms. Brooks said it will have relevant electronic medical records for patients they have seen or will see. Those records contain the patient's health information such as any paperwork on the patient's chart, any investigations or lab results, diagnosis and status of the patient. There is a communications function that allows health providers to discuss particular patients. The inbox will have messages from specialists and other services. On an average morning, she will have fewer than 10 messages in her inbox.

25. In continuing to describe her typical day, Ms. Brooks said that she will see patients from 8:30 to 11:30 am. She will then take a 15-minute break followed by 15 minutes of administrative time. She will have a scheduled lunch break between noon and 1 pm. After that, she will see patients until she takes an afternoon break followed by one hour of administrative time from 3:30 to 4:30 pm. Ms. Brooks said that she tries to clear her inbox every day, but that is not always possible. For example, there will be times when she calls a patient who does not answer, so issues related to that patient will remain in her inbox to be dealt with later. She will normally have between zero and three items left in her inbox at the end of her day.

26. She will typically see 10 patients per day. Most of those patients will have had prior appointments, but there are two time slots left in her calendar to see unassigned patients who come in that day. Those unassigned time slots are usually booked by 9 am.

27. In relation to consultation with physicians regarding her patients, Ms. Brooks testified that it can range from none at all to a complete transfer of a case file. Consultation may range from an informal discussion to a written item to referral to a specialist.

28. Ms. Brooks testified that "pretty often" there are no doctors in the PCC. Even if a physician is working on a given day, they may not be at the PCC. Some days there is a physician at the PCC, but only for a few hours.

29. When a physician is not present, the NP will look after complex care patients, depending on how urgent a matter may be. If the care required is beyond the ability of the NP to conduct, the NP may call an emergency response line and access a physician on call.

30. Each PCC team has a "Team Default," which is an electronic inbox to which "forwarded" or "signed-out" messages are sent. So, for example, if a physician assigned to the team is away, that physician's inbox will be forwarded to the Team Default. The purpose of that system is to ensure that messages are not missed, are looked at and considered by someone, and that that person ensures that appropriate action is taken in relation to the messages.

31. Ms. Brooks said that there used to be a system in which one individual health care provider would sign out to another, but now everyone signs out to the Team Default. [The person assigned to the Team Default inbox is called, for ease of reference, the Team Default – so the term Team Default can refer either to the Team Default inbox and to the person in charge of monitoring that inbox.]

32. Ms. Brooks said that one of the health care providers is assigned as Team Default for one week at a time although the assignment is sometimes for only part of a week.

33. Ms. Brooks testified that NPs have been assigned as Team Defaults more than physicians. That is because the NPs are full time employees while all of the physicians in the PCC are part time and work in the clinic "a couple of days a week." A scheduler sends out a schedule of Team Defaults for the coming number of months. The clinic NPs have no input as to who is assigned that task.

34. Ms. Brooks said that typically an NP will see 10 patients per day whereas a physician will normally see 20 patients. If the NP is Team Default and no physician is present, the NP's workload can triple in terms of the number of tests or investigations that need to be ordered and the follow-up as the NP will deal with their own patients as well as those that would otherwise be dealt with by a physician.

35. In November 2022, Dr. M, one of the physicians on a team to which Ms. Brooks was assigned, took an extended parental leave. There was no locum available to cover that

leave. Dr. M had a panel of 1200 patients who would become the responsibility of whoever was assigned Team Default. That became Ms. Brooks' assignment "until they could figure something else out."

36. When given that assignment, Ms. Brooks was concerned about being responsible for all of Dr. M's impaneled patients. She had gone through a similar lengthy period as Team Default before Dr. M was first hired. The physician Dr. M replaced had left several months before Dr. M was hired. During that time, Ms. Brooks acted as Team Default. As an illustration of the above, Ms. Brooks recounted her experience with a patient with a foot ulcer as a complication from diabetes, a condition which she would not normally have dealt with. That patient had been on the panel of patients of the physician who left. In the period before Dr. M was hired, Ms. Brooks became responsible for that patient. She consulted with other physicians, but care of the patient was transferred back to her. The other physicians did not accept responsibility because that patient was not assigned to their teams. When Dr. M was hired, Dr. M then provided care for that patient.

37. During the time that Dr. M was on parental leave, Ms. Brooks was responsible for Dr. M's patients for a period of 2-3 months. The Employer then got a long-term locum who took over Dr. M's patients. Following that, the Team Default duties were split between Ms. Brooks, the new long-term locum and another physician.

38. Ms. Brooks explained the concept of Most Responsible Physician ("MRP"). Each patient has a listed MRP. When acting as Team Default and the primary physician is not available, the NP temporarily takes on the MRP responsibility.

39. In relation to consulting with physicians during the times when acting as Team Default, Ms. Brooks acknowledged that she could do so, but pointed out that those physicians do not take on care and responsibility for the patient. The NP keeps that responsibility, even for complex matters. She also testified that NPs have been berated when consulting physicians who are not on that team as the physicians will say that the issue should have been dealt with in primary care. When not acting as Team Default, it is routine for an NP to go through a whole day without the need to consult. However, when acting as Team Default, there is never a day without the need for consultation.

40. Ms. Brooks said that no health care providers on the IHCT other than NPs cover for the Family Practitioner physicians. NPs would never cover for specialists.

41. In terms of the inbox messages, when not acting as Team Default, an NP would normally have fewer than 10 messages, documents to review, and investigations per day. When acting as Team Default, on the other hand, they will have around 75 messages, 150 documents, and 40 investigations per day to review. This involves cases of greater complexity than normal and the workload is significantly increased.

42. In cross-examination, Ms. Brooks agreed that when she is not Team Default, she is responsible for her own messages and that she would act on anything she was comfortable with. She also agreed that she would refer to a physician matters outside her scope.

43. In cross, it was suggested to her that she did not take over the physician's entire practice when she was acting as Team Default. She disagreed and said she was assuming responsibility for the practice.

44. Ms. Brooks was asked if she was in charge of the clinic when she was Team Default. She said that, in the absence of a physician, she was in charge.

45. She was asked in cross-examination whether she referred out patients if they had complex problems. She said that was not automatically the case. Prior to referring a patient, she would review the patient's condition as presented, review the chart, review or know the appropriate treatment plan for the patient, and determine if any testing or additional investigations were required. She said there is nothing simple about that process, you can't just say, "please take this patient."

46. Ms. Brooks agreed that the process of referring a patient was the same whether she was Team Default or not. However, it is more complicated when she is Team Default. As an example, she said that if she is covering for a particular physician, and gets back a cardiac MRI, she may not know why it was ordered, what to do next, or what it means for the patient's illness. She won't know where the patient is in the trajectory of health care. In her routine practice as an NP, she would not get cardiac MRIs. She does get test results back in her normal NP practice, but they are different in complexity and volume.

47. Ms. Brooks testified that she sometimes covers for other NPs and that her volume of work increases when she does so. However, she said that it does not increase by 2 to 3 times as it does when she's covering for physician, and it does not involve higher complexity cases.

Matthuschka Sheedy

48. The Employer called Matthuschka Sheedy as a witness. Mr. Sheedy is the Manager of Primary Care in Yellowknife, a role in which he oversees what he termed a "very large family health team" responsible for all services and staff. The NPs report directly to him.

49. In 2020, there were 10 teams. Those teams were divided between two sites, Frame Lake Community Health Clinic and the Yellowknife clinic. Recently there was a reduction to just 4 teams, and all of those are now located in Yellowknife.

50. Mr. Sheedy indicated that when there were 10 teams they could not always be optimally staffed. However, now that there are only 4 teams, there should always be a physician available.

51. Mr. Sheedy said that he did not like to say that NPs "cover" for absent physicians. He said that when a doctor or nurse practitioner is away for more than 24 hours, their responsibility is to sign out their electronic medical records to someone else on the team so that messages don't fall on deaf ears. The messages will be seen and action taken if required. He calls that a "sign out."

52. When a physician is signed out to an NP, the NP gets their own messages and the physician's messages. They look at the messages and, depending on the message, they would take action or send it to someone else if the action required is outside of their scope. During the weeks that an NP acts as Team Default, they get the messages for all members of the team who are away.

53. Mr. Sheedy acknowledged that it is a heavy workload to be Team Default. However, he said that NPs are asked to be Team Default, not to be physicians.

54. Mr. Sheedy said that an NP is not in charge of the flow of patients. It is up to the NP to determine if something is out of scope for them. He said the employer would not ask them to do anything out of their scope. He said the NP's responsibility is to consult with physicians if they're not comfortable.

55. When a patient is assigned to a physician, that physician is their Most Responsible Practitioner. If the physician is away for a long period, the role of the team is to look after the physician's patients to ensure that the patient is seen by the right person.

56. In cross-examination, Mr. Sheedy agreed that both the workload and "potentially" the acuity of patients increases when NPs are Team Default. However, he stressed that the NPs have a duty to consult when the required work is beyond their own knowledge.

57. Mr. Sheedy's attention was drawn to an email from Athena Wells to a number of NPs, dated June 29, 2024, in which Ms. Wells said:

> I just wanted to convey and highlight that Matthuschka and I would be more than happy to pay you whatever you wanted, as we both know how hard you work and would love to compensate you anyway we can. We are however constrained by the collective agreement in this

> instance, which outlines that you must be acting for the level above you and not just delegated a task. Since it's in the hands of UMW, and with the arbitration ahead, we are happy to do whatever the outcome is. Please know we are not trying to stand in the way.

Mr. Sheedy said that Athena Wells did not tell him why she wrote that email.

58. Mr. Sheedy testified about the draft SOP on leaves. He said the attempt was made to consider NP leaves in relation to physician leaves but realized that to do so did not work in concert with the Collective Agreement, so the Employer withdrew the SOP.

D. The Union's Argument on Responsibility Allowance

59. The Union submits that there is no clear demarcation point between the scopes of practice of NPs and physicians. It submits that NPs and physicians do similar work on a daily basis. The Union says the difference is that NPs generally see more stable patients with less complexity while physicians see patients with more acute conditions. Another key difference is that physicians see a higher volume of patients than do NPs.

60. The Union argues that when an NP is acting as Team Default, they are, in effect, required to act in place of the physician and are therefore entitled to responsibility pay pursuant to Article 24.04(2).

61. The Union argues that Team Default coverage means that there is added work, complexity, stress, and responsibility placed upon NPs when they are, effectively, looking after a panel of patients assigned to a physician.

62. The Union submits that this is not simply an issue of added volume, but also involves significant amounts of added responsibility. When acting as Team Default, NPs see patients that they would not normally see and are forced to take responsibility for panel of patients that would otherwise be the physician's responsibility. That, argues the Union, is qualitatively different work from their normal practice.

63. The Union submits that the licensing difference between NPs and physicians should not be determinative. That is because NPs and physicians essentially do the same work on a day-to-day basis and, indeed, experienced NPs may have a broader scope of what they are capable and comfortable doing than would inexperienced physicians. The key differences between the two groups are that physicians are tasked with seeing more patients, for shorter periods of time, and generally will deal with more complex patients within the panel of their patients. However, the scope of practice varies by individual. Iat is not defined by the Employer or by legislation.

64. The Union argues that the job description of NPs does not call for them to cover for physicians. Thus, when they do so, they must be doing a job that goes beyond what is set out as their responsibilities in the job description.

65. In relation to authorities, the Union submits that there are no cases directly on point but refers to the principle of equal pay for equal work. It argues that the "first principles" relating to extra pay are set out in *Sudbury Mine, Mill & Smelter Workers Union v. Falconbridge Nickel Mines Ltd.* (1969), 20 L.A.C. 45 (Weiler) and *Fairview Nursing Home Inc. v. London & District Service Workers' Union, Local 220*, [1983] OLAA No. 116 (Rayner). It argues that in order to be entitled to enhanced pay, it is not necessary that all the duties of the higher position need be assumed, but rather only the essential ones. The NPs take on the essential duties of physicians when they act as Team Default.

66. The Union also cites the following authorities in support of its arguments: *Abbot Laboratories Ltd. v. U.S.W.A., Local 440* (1995), 48 LAC (4th) 251 (Starkman); *Halifax Regional (Municipality) and IAFF, Local 268,* [2001] NSLAA No. 2 (Outhouse); and *Nova Scotia and N.S.G.E.U.* 1996 CarswellNS 675 (Archibald).

67. The Union points out that the Collective Agreement creates a premium for doing the duties of a position at a higher pay range as opposed to equaling the pay of that higher position. The Union submits that that situation is different from, and lowers the threshold from, those cases in which the pay rate of the higher position applies.

68. As remedy, the Union asks that the grievance be allowed; that a Declaration be issued that the Collective Agreement has been breached; an Order requiring the Employer to pay the Responsibility Allowance to NPs when they act as Team Default; and an Order requiring that the Employer to compensate NPs by paying the Responsibility Allowance for earlier breaches. In relation to the last point, the Union asks that it be left to the parties to determine how far back such compensation entitlement should be but that I retain jurisdiction to determine that issue in the event that the parties cannot reach agreement.

E. The Employer's Argument

69. The Employer argues that when acting as Team Default, NPs are not taking on added responsibilities outside of their scope of practice and are therefore not entitled to Article 24.04 Responsibility Allowance.

70. The Employer submits that in order to be entitled to Responsibility Allowance, an employee must take on responsibilities beyond those of their normal day-to-day work. To succeed, the Union would have to show that the work taken on was different in kind, not just in volume.

71. In relation then to NPs, the Employer argues that in their normal day-to-day work, NPs check their own messages, deal with patients and situations they are able to, and refer to physicians when a situation is difficult.

72. The Employer acknowledges that the expectation is that physicians will see more complex patients than NPs but submits that the line is "fuzzy." It argues that the core job of a physician is the practice of medicine. Under the *Medical Profession Act,* SNWT 2010, c.6, only licensed physicians are entitled to practice medicine. NPs are not licensed physicians and are not entitled to practice medicine. By definition, an NP cannot act in the role of physician. Therefore, when NPs are Team Defaults, they are not performing the duties of a person at a higher pay range and are not entitled to Responsibility Allowance.

73. In relation to the increased volume of work imposed upon NPs while acting as Team Defaults, the Employer argues that the appropriate compensation for that is overtime pay rather than Responsibility Allowance.

74. The Employer relies upon *Interior Health Authority BCNU (Responsibility Pay),* 2014 CarswellBC 4269 (Gordon); and *Yellowknife (City) and P.S.A.C.,* 1997 CarswellNWT 118 (Ready).

Analysis

75. I am satisfied that, when no physician is present and NPs act as Team Default, they do considerably more work than they normally do and accept considerably more responsibility than their normal job entails. The volume of patients they see increases dramatically. They become responsible for attending to the messages related not only to the patients they normally see, but also the messages relating to the absent physician's paneled patients. They become responsible for assessing the urgency of testing or treating those patients. There may be on call physicians available for consultation when the NP feels a given patient's analysis or care is beyond their scope, but the need for such consultation also increases significantly.

76. I am also satisfied that while NPs are not entitled to "practice medicine," in the PCC setting, there is a fine line between what they regularly do and what physicians regularly do. And, as fine as that line may be, it is ill-defined, or, as the Employer called it, "fuzzy." The scope of an NP's or physician's practice in a PCC setting seems to be self-defined.

77. There is no doubt that when an NP acts as Team Default, they are charged with performing a considerable amount of work they do not do on their normal workdays, that is, days when they are not acting as Team Default. It is also true that they are

unable to be labelled as acting physicians when doing Team Default work as they are not licensed as physicians and are statutorily unable to assume that title.

78. Nonetheless, I am not satisfied that the issue turns strictly on licensure. The interpretive issue is not whether NPs actually become physicians on an acting basis (which they are clearly not entitled to do), but rather whether they are performing the duties of that higher paid position notwithstanding their lack of title. In short, it is a not a matter of theory but rather one of practicality that is determinative.

79. In *Interior Health (supra)*, a case submitted by the Employer, the collective agreement provided for responsibility pay "for an employee designated for a minimum of one full shift to relieve in a higher rated position within the bargaining unit." In a community care settling, CH1 nurses often ended up being effectively in charge of the clinic when the higher positioned CH2 nurses were not present. The union claimed that the CH1 nurses were entitled to responsibility pay in those circumstances. The employer argued that the CH1 nurses did not do all the duties of a CH2 nurse and were therefore not entitled to responsibility pay.

80. Arbitrator Gordon compared the job descriptions of the two positions and determined that CH1 nurses were entitled to responsibility pay when CH2 nurses were not present. In reaching that decision, the arbitrator reviewed a number of authorities in the health sector. Relating principles from those authorities to the circumstances of the case being considered, she stated:

> 116. … Where the facts establish that, due to the employer's scheduling decisions, a CH1 nurse must make routine, operational decisions due to the unexpected and unpredictable nature of patient needs, and assumes responsibility for the smooth operation of the shift, it will be found that in charge responsibility has been designated by implication. See *Vancouver Hospital* and the cases cited therein.
>
> 118. Further, I find prior arbitration awards have clarified that is not the matrix of duties performed on any shift that is decisive for the purposes of responsibility pay under article 30. Rather, the more decisive factors are: who is exercising the In Charge role and its accompanying responsibilities?; Who is making the decisions and taking responsibility for the operation of the unit during the shift?; What are the factual realities of the unit?; Who is directly involved in the routine functioning of the unit on a continuing basis during the shift? See *Vancouver Hospital* and the cases the cited therein. On the authorities, it is the case that the CH1 nurse must either perform duties additional to her ordinarily performed duties *or* assume responsibilities additional to her usual nursing responsibilities. *Kitimat General*

> *Hospital.* This determination is a question of fact in each case, and as set out above, I find the Grievor's satisfy this requirement.
>
> 122. On weekends and whenever there is no manager or supervisor on duty at each of the three units, a CH1 nurse is impliedly designated in charge of the worksite because, even though an administrator on-call or supervisor is available at the end of the phone, the realities of the job required the CH1 nurse to be in charge, and the CH1 nurse excepts the accompanying responsibility on the unit during his/her shift.
>
> 123. The CH1 nurses at the three units do not assume all of the duties and responsibilities of the team leader or supervisor during the times an issue here, but I find they either perform a sufficient quantity of duties falling outside the scope of the CH1 nurse job or they assume responsibility for them. They also perform more duties than their ordinary nursing duties during the week; and, importantly, due to the employer's scheduling decisions, they of necessity have effective operational responsibility for the activities and smooth operation of the worksite during their shift. The facts establish that the CH1 nurses exercise the in charge role and its accompanying responsibilities, and are directly involved in the routine functioning of the unit on a continuous basis during their shift.

81. Key to the decision in *Interior Health* is the concept that the factual realities of the situation in the workplace are determinative and that it is a question of fact in every case as to what actual work is being performed. It is what is actually done as opposed to the theoretical ability to take on all of the higher-rated position's responsibilities.

82. The other case submitted by the Employer is *Yellowknife (City) supra.* In that case, the collective agreement provided for "acting pay" when, among other things, an employee was performing "the duties of the position having a higher maximum salary than the one held by the employee for a temporary period…" At paras. 37 and 38, Arbitrator Ready said:

> 37. The most contentious issue between the parties involved the second hurdle, i.e., whether the work performed by the Grievor, while on-call, attracts a higher (MII) rate of pay. In respect of this issue I asked the test set out by Arbitrator Adell in *Dehavilland Aircraft Co. and U.A.W.* (January 1970), as quoted in *DuPont Limited and Canadian Chemical Workers* (1979), 24 L.A.C. (2d) 121 at pp. 124-125. Arbitrator Adell stated:

> I accept the burden is on the Grievor in cases of this sort to prove to the civil standard that the Grievor is performing the significant job duties of a higher classification majority of his time, and I also except that the character of the work actually performed is the essential matter to be evaluated in a grievance of this nature.

38. In *Canada Valve Ltd. and International Moulders and Allied Workers' Union* (1977), 16 L.A.C. (2d) 258, Arbitrator Burkett had opportunity to apply this test to the factual circumstances before him:

> The burden is one which requires a Grievor to establish that the work in question is beyond his classification, that it falls within the "central core" of the higher classification and that he has the skill and "ability" to perform it.
>
> Does this mean that the Grievor in this case is required to establish that he can do the full range of the lathe operator's job? We think not. We are dealing in this case within alleged temporary transfer to a skilled position. The Grievor is not claiming that his regular job duties bring him within the higher classification, nor is he claiming that he is qualified to be a lathe operator and perform all of the tasks required of a lathe operator. Indeed, the evidence establishes that the Grievor does not have the skill or ability to perform the full range of tasks which may be required of a lathe operator…
>
> The board must decide if the Grievor was assigned a job which fell within the lathe operators' classification and if he satisfied all of the requirements directly related to the particular job in question and not to the full range of jobs which a lathe operator is required to perform.

83. Arbitrator Ready concluded in that case that the grievor had failed to establish that the work performed fell within "central core" of the work belonging to the higher classification, and he denied grievance.

84. As set out above, the Union argues that the principle of equal pay for equal work is a factor to consider. That principle was enunciated in *Sudbury Mine, Mill (supra)*, at para. 18:

> One of the main purposes of the weight classification system, particularly if supplemented by a specific temporary assignment provision as here, is to create uniformity and equality in payments for the same work. It is simply unfair for two employees doing the same

> kind of work, perhaps even working together, to be paid substantially different rates where no differences in skill are exhibited.

85. In *Fairview Nursing Home (supra)*, the arbitration board adopted the "central core" analysis, but also found that it is not necessary for a grievor to perform each and every function of the higher rated position to attract higher pay:

> 14. A second principle clearly established by various awards in this area is that the employee claiming higher job classification must be carrying out the essential duties of higher job classification: see for example, *Re American Standard Products (Canada) Ltd. and U.S.W., Local 2000* (1973), 2 L.A.C. (2d) 431 (Brown). In order for the grievors to succeed, they must show that they are, in fact, doing the work that forms the "central core" of the higher classification. The grievors must establish that they are doing substantially the work of the classification and not simply an isolated marginal relatively insignificant duty: see *Re Dominion Stores Ltd. and Retail, Wholesale & Department Store Union* (1976), 13 L.A.C. (2d) 433 (Rayner), and cases cited therein…
>
> 17… It seems to me that the test that the grievors have to meet is whether they carry out the central core of the higher rated classification, not whether they in fact carry out every single aspect of the job.…

86. In *Abbott Laboratories (supra),* the collective agreement set out different rates of pay for "semi-skilled operators" and "Skilled Operator 1." The Grievor worked in the former category. Mr. Taylor was a Skilled Operator 1 working as a packing line operator. At para 8:

> 8. It was also not disputed that the Grievor fills in when Taylor is absent from work for vacation, illness or other reasons. This would involve approximately 10 to 12 full shifts per year. It was also not disputed that the Grievor fills in for Mr. Taylor when Mr. Taylor is taking his lunch break or when Mr. Taylor falls behind in relieving other employees. This happens approximately once per week for up to one hour spread throughout the shift. The Grievor estimated, and the employer did not dispute, that he may spend approximately 20% of his working time filling in for Mr. Taylor.

and at paras. 28-31:

> 28. On the other hand, is clear that the Grievor in this matter possesses the skills and ability to do the job of packing line operator and in fact

> performs that job on as-needed basis approximately 20% of the time that he is at work.
>
> 29. There is no language in the collective agreement which indicates the intention of the parties that employees should be paid at a standby rate or should be paid in a higher rated classification if they perform work in that classification for less than a full-time basis.
>
> 30. The collective agreement only provides rates of pay for employees who are performing certain types of work.
>
> 31. Thus, in accordance with the provisions of the collective agreement, I have concluded that the Grievor should be paid the semi-skilled operator rate when he is performing work within that classification and that he should be paid packing line operator rate for the period of time that he is filling in for Mr. Taylor or otherwise working in the position of packing line operator.

87. These cases enunciate certain principles in interpreting and applying clauses that provide for an employee to be paid an enhanced rate of pay for doing work in a higher rated classification or position on a temporary basis. The first is that one of the bases of the classification system is to create uniformity and equality in payments for the same work. The next is that to be eligible for enhanced pay, the employee must be performing the central core of the job functions of the higher rated position. It is not necessary that the employee perform each and every duty of the higher rated position, but only central core of the position.

88. Applying these principles to the case at hand, is an NP entitled to Responsibility Allowance when acting as Team Default? I have concluded that they are.

89. Although there is no doubt that there are certain medical functions that an NP cannot perform (for example, major surgery), in the clinical setting there is little difference between the types of work performed by physicians and NPs. Pursuant to the *Medical Profession Act*, only a person licensed to practice medicine as a general or family practitioner or as a specialist is permitted to practice medicine. "Practice medicine" is defined in that Act:

> "practice medicine" means to offer or undertake by any means or method to diagnose, treat, operate or prescribe for any human disease, pain, injury, disability or physical condition, or to hold oneself out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, disability or physical condition.

90. Notwithstanding that provision, the *Nursing Profession Act* sets out the practice of a Nurse Practitioner:

> 6. (1) a nurse practitioner is entitled, subject to the bylaws, the nurse practitioner guidelines and any terms and conditions set out in their certificate of registration,
>
> (a) to apply nursing knowledge, skills and judgement as described in subsection 2 (1); and
>
> (b) to apply advanced nursing knowledge, skills and judgement
> (i) to make a diagnosis identifying a disease, disorder or condition,
> (ii) to communicate a diagnosis to a patient,
> (iii) to order and interpret screening and diagnostic tests authorized in the nurse practitioner guidelines,
> (iv) to select, recommend, supply, prescribe, administer and monitor the effectiveness of drugs authorized in the nurse practitioner guidelines, and
> (v) in the nurse practitioner guidelines.

91. I have concluded that the evidence in this case indicates that the key similarities between the work of NPs and physicians in the PCC clinical settings are:

- they both treat patients and either may be designated as the Most Responsible Practitioner for a given patient;
- they both may diagnose diseases, disorders or conditions;
- they both order and interpret screening and diagnostic tests;
- they both prescribe and administer drugs;
- they both have inbox messages containing information about the patients they see;
- they both have to react to the messages received about their patients;
- they both may consult others, including specialists, in relation to matters beyond their personal scopes.

92. The main differences between the actual work of the physicians and NPs in the PCC setting are;

- that physicians are generally expected to see patients with issues of greater complexity or acuity;
- physicians see and treat far more patients than do NPs;

- physicians are able to perform some procedures beyond those authorized in the nurse practitioner guidelines (although I was not provided with examples);
- NPs normally take 30-minute appointments with patients while physician appointments are generally limited to 15 minutes.

93. The Employer argues that when an NP acts as Team Default when there is no physician available, the NP is doing the same work they normally do, only more of it. Even if that were true, however, I do not think that would be conclusive in this case. That is because, unlike any other case that was referred to by the parties, the job description of the Family Practitioner (who acts as a team member) deals not only with the nature of the work they are expected to perform, but actually specifies a quantity of patients to be seen each day – 18 to 22. When a physician is not present and the NP acts as Team Default, then the NP will see many of those patients that the physician would otherwise see. That means, in my view, that the NP performs a core function of a physician in the clinic setting – seeing and treating the patients that the doctor would otherwise be seeing and treating.

94. However, in my view it is not just a matter of quantity of patients seen that is determinative here. The physicians are assigned large panels of patients. They are responsible for assessing the needs of those patients and for developing treatment plans for them. That panel of patients will include those who fall into the category of more complex and less stable than are patients that NPs would normally see.

95. When there is no physician in the PCC and NPs act as Team Defaults, the NPs take over, in effect, the responsibilities for those patients impaneled to the missing physician. The fact that there may be on-call family doctors or specialists available for consultation in relation to those more complex patients is not sufficient to deal with the change in both quantity and quality of the increased NP workload. It still falls to the NP to worry about the impaneled patients, to check the inbox messages related to them, to analyze test and investigation results for them, and to develop treatment plans for them. The evidence was clear that other physicians are not keen to take on responsibility for patients outside of their own panels, so handing off the care of a patient assigned to their team is not easily accomplished.

96. Given that, I am not persuaded by the Employer's argument that the work is only different quantitatively. I am persuaded that although NPs may not be able to perform each and every task that a licensed physician is licensed to perform, in the PCC setting, when the physician is not present, the NP performs the core functions of the duties of the physician on an acting basis and is entitled to the Responsibility Allowance contemplated in Article 24.04.

97. I am further bolstered in this view by the nature of the Responsibility Allowance. It does not call for employees to be paid at the rate of the higher paid position, but rather

provides a more modest 10% to 12% increase from their base salary. This may well be a recognition that employees performing the duties of the higher paid position are not necessarily expected to do every function of that higher position.

Summary and Conclusion

98. For all the reasons set out earlier, I have concluded that NPs are entitled to Responsibility Allowance when they act as Team Default in the absence of a physician.

99. I hereby order the Employer to pay Responsibility Allowance to NPs in those circumstances.

100. In relation to making whole NPs who have been in that situation in the past, I will, as requested, leave it to the parties to work out who should receive compensation, for how far back that compensation will be paid, and the amount of compensation. I will retain jurisdiction to determine those issues should the parties be unable to reach agreement.

101. I will also retain jurisdiction to determine issues arising from the interpretation or implementation of this award for a 90-day period.

DATED and effective this 10th day of December, 2024.

RANDALL J. NOONAN
Arbitrator