

**In The Matter of a Dispute**

between

**EASTERN REGIONAL INTEGRATED HEALTH AUTHORITY**  
(hereinafter referred to as the "Employer")

and

**NEWFOUNDLAND & LABRADOR ASSOCIATION OF PUBLIC & PRIVATE EMPLOYEES**  
(hereinafter referred to as the "Union")

**THE GRIEVANCE**

On March 17, 2000, a written grievance was filed by Shop Steward, Mr. William Crane, on behalf of Ms. Rita Abbott (now Butler), Licensed Practical Nurse, claiming violation of Article 4.01, 15.02 and all other pertinent articles of the HS collective agreement.

Full redress was requested.

Arbitration hearings were held at St. John's, Newfoundland and Labrador, on January 16<sup>th</sup>, 19<sup>th</sup>, 22<sup>nd</sup>, and February 9<sup>th</sup>, 26<sup>th</sup>, 2007.

For the Union:	Mr. Jerry Earle, <i>et al.</i>
For the Employer:	Ms. Miriam Sheppard Lib, <i>et al.</i>
Sole Arbitrator:	Mr. David Alcock

The parties agreed:

- 1) with the selection of the arbitrator;
- 2) that the arbitrator had jurisdiction to deal with the dispute;
- 3) that the arbitrator would remain seized of the matter for a period of 120 days from the date of publication of the award to deal with questions of interpretation that might arise out of the

- 4) award, including the *quantum* of compensation, if any, should the parties fail to agree; that any audio tapes used by the arbitrator during the hearings would not be considered the record of proceedings;
- 5) that the person who would be affected by the arbitration award has been notified of the hearings and of his right to attend and has indicated that he would attend solely as a witness and that his interests in the matter would not be represented by the Employer;
- 6) that witnesses would be excluded;
- 7) that the collective agreement and/or statutory time limits for filing the final award were extended to June 26, 2007..

In addition to the foregoing, the parties agreed to the following partial agreed statement of facts:

**IN THE MATTER OF** an Arbitration between  
Newfoundland Association of Public and Private Employees **and**  
the Eastern Regional Integrated Health Authority, regarding a  
grievance involving Newfoundland Association of Public and Private Employees **and**  
the Health Care Corporation of St. John's.

**GRIEVANCE: Partial Agreed Statement of Facts**

1. On March 17, 2000 the Newfoundland Association of Public and Private Employees ("NAPE") filed an individual grievance on behalf of Rita Abbott, now Rita Butler, ("the Grievor"), with the Health Care Corporation of St. John's ("HCCSJ"), which at the time was responsible for the operation of several public health care facilities in and around the City of St. John's.
2. The grievance of March 17, 2000 is attached as Schedule A and the parties agree that this is the grievance to be considered by the arbitrator.
3. On April 1, 2005, the *Regional Health Authorities Order*, Newfoundland and Labrador Regulation 18/05 came into force. Section 2(1) of that order constituted the Eastern Regional health Authority to manage and control the operation of, inter alia, the facilities formally managed by the Health Care Corporation of St. John's.
4. The parties (NAPE, the Employer) are signatories to a Collective Agreement dated June 2, 1998 ("Collective agreement") and the parties agree to tender this document as a consent item.
5. On February 15, 2000, the Employer posted a permanent, full time Urology Technician position as "open to male applicants". The parties agree to tender this document as a consent item.
6. The grievor applied for this position. On March 2, 2000, Ms. Kelly Monaghan wrote the Grievor, stating that she "did not meet the required qualifications" and "Consequently, we could not consider your application further." The

parties agree to tender this document as a consent item.

7. The Grievor met all qualifications except being male.
8. On March 2, 2000, Ms. Kelly Monaghan wrote Mr. Rodney Flight offering him the position. The parties agree to tender this document as a consent item.
9. Mr. Rodney Flight accepted the position. As of the date the competition was awarded, the Grievor had 1612 more seniority hours that [sic] Mr. Flight.
10. There is a difference of opinion between NAPE and the Employer concerning whether a BFOQ of "being male" is established in relation to this position (including, but not limited to, the issue of whether the employer has accommodated the Grievor to the Point of undue hardship), and if it is [sic] not, the appropriate remedy.
11. The parties may choose to introduce further evidence to the Arbitrator concerning this grievance through witnesses. As well, the parties' representatives may agree on further facts and information at this hearing that the Arbitrator may need in order to make his decision.
12. The parties agree advisors will not be excluded from these proceedings.

Dated this 16<sup>th</sup> day of January, 2007.

Signed  
Miriam Sheppard, Solicitor  
Eastern Health

Signed  
Jerry Earle, Labour Relations Officer  
NAPE

The following evidence was entered by consent:

- 1) Partial Agreed Statement of Facts, including grievance form dated March 17, 2000;
- 2) collective agreement, June 2, 1998 - March 31, 2001;
- 3) February 15, 2000 job posting for Urology Technician (permanent, full-time):

**Peroperative [sic]**  
**Urology Technician**  
(Permanent, Full-time)

**Duties:** Is a responsible team member who provides care to patients with genitourinary problems. The service is provided in

association with the urologist. Must have knowledge and skills in urology care equipment and supplies.

**Qualifications:** Licensed Practical Nurse with minimum of two years experience in direct patient care. Graduation from a verified Urology Technician course would be an asset. Must demonstrate skills on decision making, organization and people solving.

**Hours of Work:** 75 hours bi-weekly

**Salary:** HS-25 (\$13.28 - \$14.67 per hour)

**Posting Date:** February 15, 2000

**Closing Date:** February 22, 2000

**Competition #:** 0468-GH-2000

**Open to male applicants**

**Open to Internal Applicants Only\***

**\* All NAPE HS employees of the Health Care Corporation will be considered internal applicants**

Interested applicants please submit resume/application quoting competition number to:

. . . .

- 4) March 2, 2000 letter to grievor advising that her application could not be considered further because the position was open to male applicants only;
- 5) March 2, 2000, letter to Mr. Rodney Flight offering him the position;
- 6) The General Hospital Time Schedule for Urology Technicians for May and June 2000;
- 7) **OBJECTIVES:** for Urology Division Nurses and Urology Technicians:
  1. To provide a high quality of patient care and services by educated Nurses and Urology Technicians with the necessary knowledge and skills to anticipate and contribute to the physical, psychological, emotional and spiritual needs of the patient.
  2. To insure as safe an environment as possible for the patient while under our care by applying our technical knowledge and skills and the principles of asepsis.
  3. To participate in the implementation and co-ordination of an individualized plan of care for each patient to insure continuity of care.
  4. To implement an organizational process that results in an efficient and effective pattern of patient care services in the most economical manner.

5. To assist and anticipate the needs of the physician in the care and treatment of the patient in order that our patients can receive good medical care.
6. To establish a rapport with the patient which will instil confidence and reduce anxiety, thus alleviating many of his fears.
7. To counsel and teach the patient by increasing his self-awareness and independence in relation to his state of health and to assist him in a positive adjustment on his return to the community.
8. To initiate a structured, yet flexible and stimulating environment in which all members of the team can gain job satisfaction and have opportunities to develop their own knowledge and skill potential.
9. To promote an environment conducive to research through participation and co-operation will all the health disciplines in order to improve practice and patient care.

8) January 21, 2000 letter to Dianne Sullivan, Divisional Manager Surgical Day Care Perioperative Program from L. Best M.D.. FRCSC, Urology Division Chief, viz:

Dianne Sullivan  
Divisional Manager  
Surgical Day Care  
Perioperative Program  
Health Sciences Centre  
St. John's, NF  
A1B 3B6

Re: Replacement of Urology Technician

Dear Dianne:

As per our recent conversations I have discussed issues related to replacement of urology technicians with other members of our division.

We feel it is important that the person recruited be of male gender. These individuals deal almost exclusively with male catheterizations and care. They also provide care of male patients when it is related to problems in the genital areas (change of dressings, scrotal supports, etc.).

Most adult males are reluctant to have these procedures carried out by females. It does impact in their outcome and their comfort.

Sincerely.

L. Best, M.D. FRCSC

Witnesses Called by the Employer

Marilyn Nichols, Manager of Consulting Services – Eastern Health  
Kelly Monaghan, Recruitment Officer (at time of grievance)  
Dianne Sullivan, Division Manager Surgical Day Care & pre Admission Clinics  
Gerard Holden, Urology Technician II  
Dr. Douglas N. Drover - Chief of Urology, Memorial University of Newfoundland & Labrador  
Rodney Flight, Urology Technician I

Witnesses Called by the Union

Melissa Colbourne, Licensed Practical Nurse  
Steve Porter, Respiratory Technologist  
Rita Butler, Licensed Practical Nurse

The following items were introduced into evidence by witnesses:

KM#1 Exchange of e-mail correspondence between Rita Abbott and Kelly Monaghan after Ms. Abbott had been advised that her application had been denied:

Thur Mar 9, 2000 3:56 a.m.

From: Rita Abbott

After receiving your letter this evening I became very confused. Why was I not told on Comp. #0409-GH-2000 that the Urology Technician position was not open to females? This was not printed on the job listings in the e-mail postings. I double checked tonight. My next question is "Was I the top senior person in this competition? I am aware that Jim Abbott got the first job. I feel that I was not given all the facts on the matter of male or female. I received this position last summer but at that time had to turn it down. Please let me know as to why it is only male and if in fact I was top person? I will then decide if I wish to take this matter further. Once again thank-you for your time. I will be waiting to hear back from you.

Rita Abbott 7 West St. Clare's.

Mon Mar 13, 2000 4:40 pm

From: Kelly M. Monaghan

Hi Rita

I am sorry for your frustration over your recent application to the Urology Technician position, competition 0468-GH-2000. This position was open to male applicants only, as noted in the job posting displayed on the job boards at all sites. Therefore, as per my letter you were not considered for the position.

The job posting cabinet within the e-mail function of Meditech serves only as an abbreviated version of the job board, for the given week. It does not detail any specifics in terms of duties or qualifications. Employees must consult the job boards for such specifics.

Rodney Flight was awarded this position. He was the third senior male applicant. The first two males elected to decline. As of the date this competition was awarded, you had 1612 hours more in seniority than the successful applicant.

As per our telephone conversation on March 6<sup>th</sup>, the male only requirement was determined to be a Bona Fide Occupational Qualification (BFOQ) after a lengthy, consultative process. While it was not stipulated in the previous summer's posting, when you were offered a similar position, a qualification review had already been requested.

It stemmed from urologist findings that the test results procured from female urology technicians were problematic. This was most common during procedures for elderly male patients – the most common patient profile using this service.

Once again I am sorry for your frustration. Please contact me at 758-1321 if you require any further information. Good luck with your future applications with the Health Care Corporation.

Kelly Monaghan  
Recruitment Officer

DS#1 Job description for Urology Technician 1 (Revised January 2004);

DS#2 Job Description for Licensed Practical Nurse (Revised August 2000);

DD#1 Curriculum Vitae – Douglas Nigel Drover, B.A. B.Med. Sci., M.D., FRCS (C);

DD#2 Journal Article: Amy M. Johnson, MD; Peter F. Schnatz, DO; Anita M. Kelsey, MD; Christine M. Ohannessian, PhD. *Do Women Prefer Care From Female or Male Obstetrician-Gynecologists? A Study of Patient Gender Preference.* The Journal of The American Osteopathic Association, Vol. 105 No. 8 August 2005, pp. 369-379.

DD#3 Journal Article Teaching Brief:: Michael Smith, *Gender Preference Called Barrier to Colonoscopy for Women.* Medpage Today, Putting Breaking News Into Practice. August 04, 2005;

DD#4 Journal Article: Karen E. Adams, MD, FACOG, *Patient Choice of Provider Gender.* Journal of the American Medical Women's Association. Vol. 58, No. 2, Spring 2003, pp. 117-119;

DD#5 Journal Article: John Robinson RGN, RMN, NDN. *A Practical Approach to Catheter-Associated Problems.* Nursing Standard. Vol .18, No. 31, April 14, 2004;

DD#6 January 2, 2007 letter from Douglas N. Drover, Chief of Urology, Memorial University of Newfoundland, to Miriam Sheppard, Solicitor Eastern Health, viz:

Dear Ms. Sheppard:

I am responding to your request of December 28, 2006 requiring a medical opinion as detailed in the letter.

My qualifications include Bachelor of Arts, Bachelor of Medical Science, Doctor of medicine, Fellow of the Royal College of Physicians and Surgeons of Canada since 1992. I am also a member of the American Urology Association, Canadian Urology Association, Newfoundland and Labrador Medical Association. I am currently Chief

of Urology of Memorial University of Newfoundland.

Past positions include a three-year term sitting on the Executive of the Canadian Urology Association as well as a member of the Canadian Urology Association Clinical Practice Guidelines Committee. I was in charge of the OR Committee and as well held a position as Physician Representative on Outpatient Clinical Utilization. I have also been a member of the Urology 4SB Committee and Chairman of Urology for the Day Surgery Committee.

Question 1(a) Catheterization:

There is a perceived difference in patient outcomes and the gender of the person performing this procedure for catheterization. It is possible that patient's anxiety might affect the outcome of this procedure. This is a very intimate procedure done without supervision on male patients exclusively that are under the care of the Eastern Health Board. These are patients that have usually been previously difficult catheterizations or had prior surgical procedures and traumatic attempts at catheterizations can lead to permanent long-term adverse event in outcomes. These are primarily manifest as immediate inability to catheterize with urinary retention and pain and bleeding and long-term with urethral stricture. The worst-case scenario would be traumatic catheterization with introduction of urosepsis and death.

The answer as to why this would be different based upon gender, outcome would be predicated upon the known effect that there is evidence of sphincteric tightening with the introduction of a catheter hitting the male pelvic floor. It is well known that relaxation is essential for male catheterization to allow the easier introduction of a catheter. It is certainly possible and quite reasonable to believe that there is a certain segment of the male population that would find a procedure performed by a female technician without any supervision or choice on behalf of the patient to enhance one's anxiety which then in turn leads to increased pelvic floor tightening which decreases the probability of a successful outcome with the potential complications as above.

We have had a female technician at the Health Sciences Centre previously and discussions between Dr. Best and myself affirm that there were many negative outcomes more so than we have had with male technicians.

While there is really no gender difference in ability to learn the technique or ability to perform the technique, the difficulty comes in the patient's anxiety for having a female who he is not familiar with do such an intimate procedure. This is completely different from a patient who knowingly accepts a female physician doing this and has an acknowledged patient/physician relationship prior to such a procedure. Urology technicians are often called in the middle of the night and will perform the procedure behind closed curtains in a dark environment so as not to disturb the other patients and this obviously is fraught with major complications.

Question 1(b), Bladder Irrigations:

There is no reason to believe that there should be a significant difference in patient outcomes based upon the gender of the person performing such a procedure. This is a simple mechanical flushing in and out and one would not expect a difference in outcome.

Question 1(c), Catheter Changes:

Again as stated in Part 1(a), with catheterization there is a significant perceived difference in possible outcomes depending on the gender of the person performing the procedure. The same explanation applies for this question as applies for Part 1(a), which is labelled catheterization.

Question 1(d), Scrotal and Penile Dressing Changes and Part 1(e) – the same explanation applies to both of these, which are very intimate male interventions. The question here is not so much adversely affecting the outcome of the intervention but rather it comes into play with the patient's perception of what is appropriate.

To preface a statement here from Ethics and Medicine, which is an international journal of bioethics, it is felt that further research in the area of autonomy, gender and preference of patients requires further research. It states that the issues involved are psychiatric as well as medical. It is stated that gender may play a critical role here, both with regard to patient and physician. Further it goes on to state that sensitivity seems to be consistent with the highest ends of medical practice. It is even stated in the Journal of the American Medical Women's Association that patients will prefer physicians of the same gender for urology. There is no specific reference to urology technicians as they are employees at the Eastern Health Board because in my research from international journals and referencing computer data base research, the use of urology technicians in the United States are for positions in which the assistant or technician works directly and at the same time as the Urologist. The urology technician in Eastern Health works independently evenings, through the night, and weekends. This is a unique role and has to be gender sensitive.

We do have literature evidence of patients refusing intimate care by physicians of the opposite gender, leading to adverse outcome. There are no research articles that I can identify based on urology technicians, specifically related to adverse outcome on a research basis. I would never expect this to be done because as stated above, we are in a unique position, but no one can assume that the same or worse outcome would be expected in this particular scenario, as the urology technicians have not established a rapport previously with a patient upon whom he is performing an intimate procedure.

Therefore, looking at outcomes one must not only look at physical outcome but also mental anguish, patient preference, and medical ethics. Along that line it has already been determined and backed by the physicians at Eastern Health that the urology technician does not perform any procedures on females. The big question then is why would the Eastern Health Board have to turn around and now allow females to perform intimate procedures on males without any supervision when the

obvious [sic] is obviously not acceptable.

Part 2, Question 4:

Patient outcome with regards to a procedure applies to physical as well as outcome and patient expectation. The first is the direct physical outcome. We know from a scientific perspective that increased patient anxiety increases skeletal muscle tension in the pelvic floor which will increase the difficulty of catheterization or catheter change, which can potentially affect physical outcome and the physical outcome may lead to permanent damage in the form of stricture disease, urethral rupture or sepsis which could lead to death. Any introduction of increased risk beyond what the patient currently faces is really and truly unacceptable. From a patient's mental perspective, they are already in a compromised urological state and to introduce another adverse variable, such as taking the potential risk of increasing the patient's anxiety by bringing in a technician of the opposite gender to perform a procedure, is really not appropriate nor [sic] acceptable.

As referenced above, we can accept a certain level of difference when a physician has spoken to a patient, counselled in regard to choice, outcomes and potential benefits and then performs a procedure. It is always the patient's right to select another physician and physicians of both genders are available. Similarly, with nursing care on the ward, patients know most of the nurses by name and are dealing with them over an eight to twelve hour shift repeatedly and have a different rapport than they do with a technician.

The first and only time they see a technician may be in the middle of the night when they are uncomfortable and they are performing an unsupervised activity and neither knows the other's name, as it is a brief encounter. The patient then would have no choice as to the provider of that care. If the patient refuses a female then that would require urologic specialist back-up and we in the Division of Urology have already decided that given our position on male technicians performing female procedures and similarly the exact same principle would apply to females performing procedures on males. We would not provide that back-up service.

The final statement for this question has to do with medical ethics. If the aim of health care in the new millennium is to provide a more holistic environment, one also has to be sensitive to the patients' wishes as far as gender is concerned. While the majority of patients, presumably, do not profess a significant difference in gender selection for health care provider, the incidence of such a request is significant enough and increasing to the point that ethically one has to be able to provide such care.

Again, the ethical dilemma that remains here and one that is not answered in these proceedings so far, is why males cannot provide urological intimate care to female patients without supervision and in fact we do not have them do it at all. Yet now, Eastern Health is faced with the issue of being forced into having a female perform intimate procedures on a male. This is contrary to and what has been the standard of care.

Question 5:

The patient population served by the urology technician is exclusively male. The ages of these patients range from 18 - end of life. The vast majority of patients are above the 60 age group. I will state for clarity again that our male urology technicians do not provide urology technical service to female patients. It is exclusively a male patient service.

I trust this answers the questions as written in your request. If further details are needed please feel free to contact me.

Sincerely,

Douglas N. Drover, B.A., B. Med. M.D., F.R.C.S.(C)  
Chief of Urology, Memorial University of Newfoundland

RB#1 List of Qualifications and Experience for Rita Butler - prior to the filing of the grievance:

1. EKG (electrocardiogram) Certified.
2. Post Basic Gerontology
3. Suicide Intervention
4. Manipulation
5. Self Mutilation
6. Therapeutic Crisis Intervention
7. 12 years experience in acute nursing care
8. 99 - 01 preceptor for PN, students for the centre of Nursing Studies
9. 1½ year on arthritic floor (7 East) as well been floated many times to 6 East and West when short staffed (Orthopedics [sic] & General Surgery
10. In class study from Education Department at St. Clare's for the insertion of catheters in both male and female patients
11. Medical Terminology (in training).

SN#1 August 28, 2006 memorandum from Larry Kelly circulated throughout the Leonard A. Miller Centre concerning the scope of future services to be provided by urology technicians, viz:

Hello Everybody:

Throughout this summer the Urology Technicians have been unable to provide routine catheterizations in the rehabilitation units from Monday to Friday. They have however, been providing routine catheter changes for persons with indwelling catheters of long standing anywhere in the Miller Centre and Veterans' Pavilion.... the reason being that many patients with long term catheters have some sort of complexity. The nursing staff on 2 North have incorporated routine in and out catheterization into their care planning.

The Miller Centre has traditionally had Urology Technician services for routine catheterization. The other sites within Eastern Health does [sic] not have this

service. The manager responsible for this service informs us that they are unable to continue the service for routine catheterization, except in the case where people have indwelling catheters that require changing on a monthly basis, or for patients/residents who present with conditions that cause difficulty with the catheterization procedure. The two main reasons for this change is related to the increasing workloads of urology technicians and the rising costs of taxi transportation.

Routine catheterization is within the scope of practice for RNs and LPNs. The Urology Technicians are available to lend support in training staff to become competent in male catheterization, and will also be available for difficult cases on an ongoing basis. All other routine catheterizations will need to become part of total patient care within the Miller Centre.

We're cognizant of the fact that this adds one more duty to your already busy work shift. Please discuss any concerns or education/training needs with your manager or myself.

Thanks,  
Larry.

- SN#2 Agenda for Caribou Memorial Veteran's Pavilion Staff Meetings for September 15<sup>th</sup> and 19<sup>th</sup>, 2006, including New Business Item 3.3 – Routine Catheterization;
- SN#3 Minutes of Staff Meeting September 15<sup>th</sup> and 19<sup>th</sup>, 2006, referencing New Business Item 3.3 – Routine Catheterization, viz:

Larry Kelly sent an e-mail regarding this - Urology Technicians will no longer be doing routine cath, however, all our residents require special cath so this will continue.

The following are the relevant collective agreement provisions:

**4.01 Employer Shall Not Discriminate**

The Employer agrees that there shall be no discrimination with respect to any employee in the matter of hiring, wage rates, training, upgrading, promotion, transfer, layoff, recall, discipline, classification, discharge, assignment of work, or otherwise by reason of age, race, creed, colour, national origin, political or religious affiliation, sex, mental and physical disability, or marital status, nor by reason of his/her membership in the Union.

.....

**12.04 Decision of the Board**

The decision of the majority shall be the decision of the Board. Where there

is no majority decision, the decision of the chairperson shall be the decision of the Board. The decision of the Board of Arbitration shall be final, binding and enforceable on all parties, and may not be changed. The Board of Arbitration shall not have the power to change this agreement or to alter, modify, or amend any of its provisions. However, the Board shall have the power to dispose of a grievance by any arrangement which it deems just and equitable.

....

#### **15.02 Information on Postings**

Notices of new positions or of vacancies inside the bargaining unit shall contain the following: title of position; qualifications; required knowledge and education; skills; wage or salary rate or range; and whether shift work could be involved. Such qualifications may not be established in an arbitrary or discriminatory manner. All job postings shall state "This position is open to male and female applicants".

#### **15.04 Role of Seniority in Promotions and Transfers**

Both parties recognize:

- (a) the principle of promotion within the service of the Employer;
- (b) that job opportunity should increase in proportion to length of service.

Therefore, when a vacancy occurs in an established position within the bargaining unit, or when a new position is created within the bargaining unit, employees who apply for the position on promotion or transfer shall be given preference on a total seniority basis, whether seniority is temporary or permanent, for filling such vacancy, provided that the applicant's qualifications meet the required standards for the new position. Appointments from within the bargaining unit shall be made within four (4) weeks of posting.

#### **15.05 Trial Period**

- (a) The successful applicant shall be placed on trial for a period of two (2) months. . . .
- (b) Twelve Hour Shifts

The successful applicant shall be placed on trial for a period of 325 working hours. . . .

## **BACKGROUND AND EVIDENCE**

### **Facts Not in Dispute**

In addition to the Partial Statement of Agreed Facts, the following facts are not in dispute:

The Employer operates an acute care hospital within which the Division of Urology provides medical services to a predominantly male patient population with genitourinary problems. This particular patient population segment has historically received catheterization and other associated intimate care from an exclusively male staff of six (6) Urology Technicians, with the exception of one female urology technician who held such a position between 1995 and 1997, but for reasons not disclosed at the hearing she is no longer in that position. Prior to the February 15, 2000 job posting, which is the subject of this dispute, all other job postings for urology technician traditionally had been open to both male and female applicants. Indeed, in 1999, the grievor applied for and was offered a temporary position as urology technician, but she chose not to accept it at that particular time. It was common ground that no significant changes to the job of UT I occurred prior to the February 2000 posting.

Despite the prohibition in Article 4.01 against discrimination on the basis of sex and the requirement in Article 15.01 that job postings must state that they are open to both male and female applicants, the parties agree that these articles do not preclude the Employer from attempting to establish the existence of a *bona fide* occupational qualification BFOQ in these particular circumstances. The Employer has accepted this onus.

Eastern Regional Health Integrated Authority is responsible for, *inter alia*, medical care facilities in St. John's at the Health Sciences Hospital (Acute Care), St. Clare's Hospital (Acute Care) and The Leonard A. Miller Centre (Mostly Rehabilitation and Veterans' Long Term Care). The urology technicians' base is Day Surgery at the Health Sciences Centre (HSC) where they perform

catheterizations on male urology patients and also assist urologists in cauterizations, some sexual dysfunction procedures, penile and scrotal dressings and supports, provide follow up education and instruction to patients and close family members. They also perform unsupervised catheterizations and assorted intimate genitourinary care on male inpatients on the urology floor. UTs are on call to other Divisions within the HSC where catheterization difficulties on males might be encountered, such as Emergency, and any patient floor. In addition, where authorized by a urologist, UTs are also subject to similar calls at St. Clare's. All such procedures are unsupervised. Until the summer of 2006, UTs also performed unsupervised routine catheterizations and associated genitourinary care on male patients at the Miller Centre. This service was not provided to any other outside medical facility in the city. Due to increased demands on UTs' time, it was decided to discontinue this service and have a UT train both male and female LPNs at the Miller to do routine male catheterizations.

#### Viva Voce Evidence

Testimony was received from witness over a period of four (4) days.

#### Testimony of Marilyn Nichols

Ms. Nichols, Manager of Consulting Services, was Manager of Human Resources at the time of the grievance. She explained that the Employer had previously posted UT positions open to both males and females. The decision to restrict it to males only was made for the February 15, 2000 posting after she had been contacted by Kelly Monaghan, Recruitment Officer, who had received the request from the Division Manager, Dianne Sullivan. In discussions with Ms. Sullivan and Susan Rumsey (Human Resources Officer in the area), Ms. Monaghan and Ms. Nichols were informed that clinical issues were involved that had not previously been put forward because such

issues had not been fully gathered and investigated. Since there were no overall LPN licensing issues involved, no BFOQ discussions were required to be held with the Union. Also, since such matters were newly emerging at that time, no discussions were held with the Union regarding the issue of accommodation.

Aspects of accommodation such as scheduling and bundling of duties, etc., are within Ms. Nichols' responsibility. The Employer has frequently accommodated other employees in other situations to the point of staff saturation or almost impossible situations by scheduling them on all day shifts or all night shifts. The impact on other employees has determined whether accommodation could be undertaken. Of the approximately 100 accommodations each year, 20% would involve scheduling considerations; the remainder would involve changes to actual duties. In Ms. Butler's case, since the addition of a female UT would require another UT to be available for back-up should a male patient refuse her, scheduling issues were also considered. In 2000, there were six (6) UTs. One (1) was a UT II, i.e., the lead technician who worked 8 - 4 Monday to Friday and the other five were UT Is who worked four (4) 12 hour rotating shifts (8 am - 8 pm or 8 pm - 8 am) on weekdays and weekends. According to C#6, sample shift schedules for May and June 2000, only one UT I was on 12 hour nights and one (1) UT I on 12 hour days - except for the occasional circumstance when two (2) UT Is were on 12 hour days. A female UT I could not be put on 12 hour night shifts because she would be the only technician present and no back-up would be available. If the female technician were put on 12 hour day shift, there would normally be nobody available for back-up from 4 pm - 8 pm. Also, if one technician were to be put on permanent day shifts, it would mean that the other four (4) UT Is would have to absorb additional night shift and weekend duty, thereby changing their working conditions to their detriment and also making the job less attractive to future applicants, which would cause a recruitment problem for the Employer. If a UT I were switched to 8 - 4 shift for back-up reasons, nobody would be available

for 2 weekend shifts after 4 pm on Fridays. That would also require the hiring of an additional half UT I position. As far as the UT II is concerned, he could possibly provide backup for only 40 of the 120 hours to be covered weekly.

Ms. Nichols explained that the particular shifts involved are important to staff, sometimes even more so than wages or salary, because shifts are very much related to quality of life issues. Day shift jobs are sometimes considered preferred positions. Since employees want to know what shifts will be required before deciding to apply for job postings, Recruitment specifies the applicable shift schedules. On-call requirements are also important considerations for employees. If employees are on call, as UT Is are, they must be available to come to work. Therefore, they can't drink alcohol or leave town, etc. These types of restrictions on what would otherwise be their free time, are viewed negatively. If a female assumed one of the UT I positions and was assigned to day shift, the other four (4) UT Is would have to be responsible for more on-call duty. This would also cause an issue to arise over the collective agreement article dealing with the sharing of work on nights and weekends.

UT positions are recruited from the LPN pool. A successful applicant would receive a one level increase in pay, less night shift and weekend work, and would probably enjoy less demanding work. If shift adjustments were required to accommodate a female technician, more night and weekend work would be entailed in the job, thereby making the position less attractive to applicants. Also the Employer's concern would be increased turnover among those already in UT I positions.

Also considered was the idea of having another male from another floor "float" when needed for male urology catheterizations. There are 20 male LPNs in the system, eighty (80) percent of them at the Miller centre. Five (5) or six (6) are on call. Those at the HSC are on 12 hour shifts. Not all the male LPNs are available at work at the same time. Therefore, the Employer cannot rely

on having a male LPN in the building in the event he is needed to float. Also, six (6) or more weeks of training would be needed before competency in male catheterizations and other genitourinary procedures and care is attained. Even if all the male LPNs could be trained to this competency, they would have to be regularly rotated through the Urology Department in order to keep their skills current. Keeping 20 LPNs, who already have their own duties to perform, also trained and currently competent in male catheterization requirements would be an onerous undertaking.

Also, at the HSC there are 845 RNs, 45 of whom are males, 10 of them casuals. Those male RNs work primarily with critical care patients in the ICU. It would not be appropriate to remove a male RN from such a situation for the purpose of performing a male catheterization procedure.

Ms. Nichols indicated that, prior to Ms. Butler being offered the temporary position in 1999, a female UT I had been employed for awhile. It was Ms. Nichols' understanding that clinical concerns regarding outcomes for patients had been raised by urologists during the period the female was in that job.

#### Testimony of Kelly Monaghan

Ms. Monaghan was the Recruitment Officer responsible for receiving staffing requests from divisional management and arranging the necessary job postings to solicit applicants. She explained that standard postings usually apply except where program directors find it necessary to make changes. This is more likely to occur in critical care areas where the most senior applicant will probably not possess the required skill. A review process is undertaken before changes in qualifications are made. The guiding principle in such cases is to ensure patient care and safety where nursing skills for the area are low. While no changes in duties are involved, the qualification change for critical care areas has been a requirement of 2 years experience in those areas.

Ms. Monaghan indicated that it was unusual to exclude applicants on the basis of their gender. This was the first time a posting was made for male only for a UT I position and the decision to do so occurred after an official review process was undertaken by the Division Manager and the Program Director. This type of review is usually initiated by the Manager of the clinical area and discussions are held with the Program Director to determine whether the qualifications need to be changed. Then the matter is discussed with Employee Relations. Upon receiving the staffing request for male only in this case, Ms. Monaghan initially contacted Susan Rumsey, who had worked with the Division Manager when this change was discussed and it was felt that a strong case for a BFOQ had been made. The Manager of Employee Relations felt comfortable that the clinical concerns that were considered fully justified a change to male only. It was Ms. Monaghan's understanding that clinical concerns were raised by the urologists themselves when a female held the position. Those concerns were then taken to the Program Director. When Ms. Butler was offered the temporary position in 1999, the urologists had not yet amassed the required supporting evidence. Therefore, the request for a male only posting at that time was overruled by Employee Relations. By February 2000, the review process had been completed.

As the Recruitment Officer responsible for the job posting, Ms. Monaghan became involved in the grievance process. She spoke to her boss, Heather Hanrahan, about the changes in the law on the issues of BFOQs and accommodation at that time. For example, *Re Newfoundland Association of Public Employees v. Her Majesty the Queen in Right of Newfoundland, on Behalf of Green Bay Health Care Centre* (1996), 2 S.C.R. 3 [1996] S.C.J. No. 54 was discussed, as were the clinical concerns regarding the UT I position.

Ms. Monaghan also had a telephone conversation with Rita Butler on March 6, 2000, after she received her letter stating that her application would not be considered further. Ms. Butler was surprised by this decision considering that she had been offered the same position on a temporary

basis less than a year before. In response to Ms. Butler's March 9<sup>th</sup> request for an explanation, Ms. Monaghan wrote an e-mail on March 13<sup>th</sup> outlining the rationale taken by the Employer (see KM#1). This correspondence explained *inter alia* that Ms. Butler possessed all the qualifications except the male only requirement, that Ms. Butler had 1612 more hours of seniority than the male applicant (Rodney Flight) who was awarded the position. Also indicated was that "the male only requirement was determined to be a BFOQ after a lengthy, consultative process, which review had already been requested" but was not completed when she applied for the temporary posting in the summer of 1999. Ms. Monaghan also said that the review process "stemmed from urologist findings that the test results procured from female urology technicians were problematic [which] was most common during procedures for elderly male patients, the most common patient profile using this service." In essence, Ms. Monaghan advised the grievor that she had filled the position in accordance with the qualifications stated on the job posting.

On the issue of accommodation, Ms. Monaghan had earlier discussed a recent firefighter decision by the Supreme Court of Canada (presumably "Meiorin") with the Manager and the Program Director. She initially suggested that they consider posting for both male and female applicants and wait to see what happened before considering accommodation. Other options were also discussed. For example, she suggested having a male and a female UT I on shift at the same time to deal with the comfort level of patients involved. It was felt that this would cause morale problems among the UT Is as a result of adverse scheduling implications. In the end, those ideas were not deemed viable and Ms. Hanrahan made the decision to post for a male only.

In cross examination, Ms. Monaghan testified that, at the time the requisition came in for the 1999 temporary position, the male only issue had arisen but the review process had not been completed. Therefore, it was considered a "wish list." Until a review is finished, the Division Manager would not have authority to post for a male only.

Ms. Monaghan confirmed that for nursing positions in Labour and Delivery, female only is not considered a BFOQ.

When asked by counsel for the Union what the expression “test results procured from female urology technicians were problematic” meant in her e-mail to Ms. Butler on March 13, 2000, Ms. Monaghan indicated that she was not a clinician and, therefore, her use of the words “tests results” was probably not as well suited to the situation as perhaps “patient outcomes” would be. In essence, she took her direction on the BFOQ issue from the Employee Relations Department and from those who had clinical expertise. She had been informed that a female UT I had held the job at one point and that clinical concerns over patient outcomes had been noticed during that period. Ms. Monaghan regretted any inadequacies that might be noted in her choice of wording on this matter, but she attributed any such deficiencies to her own lack of clinical knowledge and the fact that this was the first BFOQ issue she had dealt with.

As for the fact that only females work in Labour and Delivery, Ms. Monaghan expressed her opinion that this is an area for which males have felt it inappropriate to apply. Similarly, she thought that females have normally felt it inappropriate to apply for urology technician positions. In other words, employees have historically recognized and accepted why the staff providing care to the particular types of patients in these areas has been normally gender segmented. She did not know that there was a urology unit at the HSC. Ms. Monaghan indicated that she was also aware that urologists do not do gynecological catheterizations at the HSC.

#### Testimony of Dianne Sullivan

As Division Manager of Surgical Day Care and Pre Admission Clinics since 1996, Ms. Sullivan’s job was to ensure that patient care is coordinated among staff.

The UT Is provide care to an exclusively male population with genitourinary problems. The

range of care includes catheterization, maintenance of in-dwelling catheters, preparation of genital area, some clinical procedures, and some sexual education for patients and their families (less of a role in 2000 than is currently the case.) The UT II, i.e., the senior Lead Hand, schedules work load assignments, acts as a resource person for the UT Is, ensures that the equipment is in working order, and does teaching and training for new staff. In 2000 this position performed procedures that the UT I did not do, such as Trans Rectal Ultrasounds, which is now done by the operating room technician. Qualifications for a UT I position is LPN certification plus (hopefully) 2 years experience; safety and communications skills; able to make own decisions, etc. Qualifications for a UT II position includes the foregoing, plus 3 - 5 years experience as a UT I.

Ms. Sullivan explained that UT Is perform catheter care – both insertion and removal – as well as management and maintenance of catheters, collecting specimens for urologists and apply penile and scrotal dressings, etc. She estimated that catheter care for males in the HSC is 65% of their work, plus some procedures in surgery, plus outside support where needed. She further estimated that they spend 25% of their time assisting urologists in the clinic performing catheterization, flow studies and collecting specimens. The same was required in 2000 except for flow studies, which were performed in surgical day care.

The patient population cared for by UTs is composed of males, the majority of them 55 years of age and older, as well as some younger ones. Those 55 and older have impaired urinary function and are under the care of a urologist.

In 2000 there were five UT Is and one UT II. At present there are four UT Is, two UT I casuals, and one UT II. Training for a UT I position includes 6 to 8 weeks orientation with the UT II, performance of routine procedures and some instruction with the urologists. Ms. Sullivan indicated that it takes a year for a new person to become confident. Compared with UT Is who do not spend much time with urology patients (for example, a basic dressing procedure would take

about 10 minutes), nurses on the floor have more opportunity to spend time with patients bedside, building relationships, doing rounds, taking vital signs, administering medications, etc.

As indicated by previous witnesses, a UT I position was once filled by a female. Ms. Sullivan testified that she was approached by several urologists who expressed concerns about patient outcomes. The Chief of Urology, Dr. Best, canvassed his peers at the hospital and then wrote her a letter dated January 21, 2000 (C#8) in which he indicated that it is important that replacement urology technicians be of the male gender because most adult males are reluctant to have catheterizations and genital area intimate procedures performed by females and that it does impact in their outcomes and comfort. Ms. Sullivan said that Dr. Best was also aware of the SCC decision in *Green Bay*. While the actual male only qualification occurred in 2000, this change happened over time. There was a previous posting for both male and female applicants in 1999, but Ms. Sullivan had already been discussing the matter with Dr. Best, who had come to her in support of the urology technicians' concerns that the position be open to males only. Ms. Sullivan was aware at the time that Dr. Best was still in the process of canvassing his other four (4) urologist peers on the subject.

Asked how she knew what the patients felt about being cared for by a female, Ms. Sullivan said that she was aware of one incident in Emergency in which a male patient was worried who would be in the room when a certain procedure was to be performed. He wanted to be sure that only men would be in the room. This man was accommodated by placing only males in the room with the Doctor. The technicians also have reported that patients ask to wait to have catheterizations performed until female nurses leave the room.

The objectives for Surgical Day Care in 2000 are listed in C#7 informing what the Employer wants to provide for patients in terms of their physical, social, psychological needs, the need for a safe environment, and establishing a rapport with patients and reassuring and explaining

procedures to them so that their anxiety will be reduced. These objectives are also used in evaluating staff during training. They also play a role in making decisions concerning the category of people that would be desirable to perform certain jobs (see particularly Items 1, 2 and 6). Decreasing risks are a prime consideration. For example, the more times a catheterization must be attempted, the risk to the patient is increased and positive outcomes are decreased. When male technicians are involved in intimate male procedures, a certain level of anxiety is diminished and better patient outcomes are created.

Ms. Sullivan explained that technicians can be aware of patients' needs by observing both verbal and non verbal indicators. The latter might involve witnessing tense behaviour in response to embarrassment at being exposed to a female. Many patients are more embarrassed when the opposite sex is present; yet may say nothing, but demonstrate additional anxiety by covering their exposed areas with their hands or constantly pulling their sheets over them. Others may withdraw and not want anybody to enter their room. Gender matching can alleviate those problems.

Ms. Sullivan explained that two (2) accommodations were initially considered for Ms. Butler. If she assumed the regular schedule, she would always be alone on the night shift. The first idea was to put her on permanent day shift with another UT I to back her up. However, since the group of technicians was so small, it would mean a significant increase in night shifts and weekends for the other UT Is. This would make their positions less desirable, thereby creating possible problems for retention and recruitment. It would also entail more training of staff and would exacerbate matters for patients who would have more training procedures performed on them. Also considered was putting someone on call to respond as needed when patients object to intimate care being provided by a female. However, this would require technicians to be on call every second time they were on days off. It would also adversely affect the lifestyles of those on standby, i.e., their activities and off-time options would be restricted because they would constantly have

to be available to come to work. It also was considered not feasible to page someone already scheduled when the need arose because the extra time worked would require that person to be off the next day. On call employees are not pre assigned to any particular work area. They are able to go anywhere they wish, thereby not being available for call-ins in the urology department. Only those on standby would not be able to work elsewhere else. But that would cost them money because standby pay is considerably less than they could earn by working somewhere else. At the end of the day, the Employer could think of no other accommodation, except hiring someone in an additional technician position. Besides the obvious increase in cost, that idea was rejected because there was insufficient workload for an extra person.

In cross examination, Ms. Sullivan said that there previously had been a female in a UT I position who had passed the trial period prior to 1996, i.e., before Ms. Sullivan started work with the Department. Since she had no idea how long that person had been in her position, she felt she could not comment on her work. There have been no females in the UT I position during her tenure – the female technician was on the list, but Ms. Sullivan never saw her. While Ms. Sullivan was in the Department, she had no direct discussions with patients about negative outcomes experienced. If patients had refused female care, Ms. Sullivan learned about it from other technicians who actually worked on the floor. Also, the urologists' point of view, as it was expressed to her, was that male patients experience anxiety where females provide intimate care.

There are currently one UT II, four UT Is, and two temporary UT Is (on call). The temporary UT Is usually go to the Miller Centre to perform male catheterization procedures -- not every day but fairly often. Ms. Sullivan presumed that the Miller Centre staff normally assigned to those patients do catheter maintenance because UT Is do not do all day care for male patients with indwelling catheters.

Other than the male patient who wanted the room cleared of females for a trans rectal

procedure, Ms. Sullivan said she has not had any patients requesting her to have no females present. She agreed that, in the OR, some procedures are witnessed by female nurses, but those procedures are performed by the urologists.

Leading up to the decision to post for male only in 2000, technicians first expressed their concerns to Ms. Sullivan about a female in the position and then the urologists supported their position and expressed their own concerns. No patients expressed any concerns on the issue directly to her. However, during her tenure, since only male urology technicians were on staff, male urology patients had no reason to request a male rather than a female technician. No specific clinical evidence was provided by Dr. Best in his January 27, 2000 letter. Ms. Sullivan was also aware that the HSC is the urology centre for all such patients. She conceded that all medical procedures might cause some anxiety in patients, but male patients are additionally anxious where intimate procedures are to be performed on their genitalia.

Commenting on the consultative process that led to the male only posting, Ms. Sullivan testified that, sometime between September 1999 to February 2000, she was approached by the technicians, she discussed the matter with Dr. Best, Dr. Best spoke to each of his colleagues before writing her the letter of January 21<sup>st</sup> (by that time she had become aware of the Green Bay decision), and she raised the subject with Human Resources who were convinced that a male only BFOQ had been established.

By way of redirect examination, Ms. Sullivan stated that DS#2, the LPN I job description, contained the full scope of duties that LPNs could do, including contributing to holistic nursing assessments of stable and unstable patients, giving baths and rubs, administering ostomy care, enemas, vaginal douches irrigations and catheterizations, but the range of duties actually performed would depend on the area in which they were employed. For example, there would be fewer dressings performed on medical wards than on surgical wards.

On the urology service, i.e., male patients who are seen by the urologists, catheterizations are more difficult because males have a longer passageway, which the prostate gland surrounds and sometimes obstructs the ureter. While male catheterizations are more difficult and pose greater risks of harm, female catheterizations also have their difficulties, particularly in locating the urinary meatus.

In adult acute care outside of the urology area, there are all types of patients and ages for whom catheterization would likely be routine. However, on the urology floor, only approximately one (1) percent of catheterizations on the male patients would be considered routine. Although the UT I no longer “Assists doctors with vasectomy by scrubbing for surgery, cutting out and tying sutures as directed” as contained in the UT I job description, Ms. Sullivan testified that UT Is do the catheterization and preparation of the genital area for vasectomy procedures. The patient age group for vasectomies is between 25 - 35 years, some of whom might be anxious about the procedure, some not.

Finally, in answer to the arbitrator’s questions, Ms. Sullivan testified that the HSC has the only urology technicians in the country of the type described in this case. In other jurisdictions, Interns and Residents in medical school would support the urologists by performing catheterization procedures. Ms. Sullivan said that if no urology technicians existed here, male catheterizations would fall to the nurses. Because of the difficult nature of such catheterizations, the result would be to call in the urologists more often. Clearly, it would be the male patients who would bear the brunt of that. While other medical facilities do have urology patients who sometimes present at the emergency department, at the HSC the whole urology service is dedicated to males with difficult genitourinary problems.

### Testimony of Gerard Holden

Mr. Holden holds an LPN certification and has worked with the Employer since 1978 as a medical attendant, a paramedic, a urology technician I (as of the fall of 1994) and as a urology technician II for the past 1½ years. Much of Mr. Holden's testimony involved a detailed description of the types of procedures performed by UT Is, the technical nature of various types of catheters, and an explanation of the peculiarities of the anatomy of male patients. There is little dispute, if any, about this particular evidence.

According to Mr. Holden, UT Is are responsible for the following procedures for all male urology patients in the HSC: testing, catheter insertions (including deciding what type of catheter to use in certain situations), urinalysis, bladder scans, bladder irrigations, collecting specimens, dressings, dilatations. When assisting urologists, UT Is prepare for cystoscopies by inserting catheters through the penis into the bladder (care being taken where prostate problems are encountered) to a certain point and the urologists proceed from there. UT Is also clean the patients in the scrotal area. Mr. Holden testified that there are few differences today from the year 2000 where catheterizations, testing and other urinary procedures are concerned, with the possible exception of catheters being made of better material. In his estimation, catheter insertions and changes account for 70% to 90% of a UT I's time. Other time is devoted to educating patients, their families and care givers on the various types of catheters, how to clean the patients, how to insert catheters themselves, and what problems might be encountered. Patients and caregivers are told that they should visit a hospital if they experience difficulty passing urine. Male catheterizations at other hospitals occur far less often than at the HSC. For example, at the Clarendville Regional Hospital, only one or two a month are experienced; while at the HSC Mr. Holden will do that many in a single morning. As for bladder irrigations, a UT I will assist a nurse or nursing assistant if difficulties are encountered in insertion or removal.

Mr. Holden indicated that the age of male urology patients can range from 2½ to 100, but most (an average of 60% to 70% per month ) are 50 - 55. Since 2000, the urology patient group has been getting younger because they are tested and diagnosed earlier.

Privacy for patients undergoing procedures in the hospital is always paramount. Unless the patient is in a private room, Mr. Holden always pulls a screen around the bed. A patient having a procedure in his genital area cannot be exposed in a corridor because it would be too embarrassing. As often as four times a day if necessary, urology inpatients might have their catheters checked and be cleaned and washed.

For a UT I, a typical day's work would include checking the work sheet list, getting report, setting up clinics, checking supply carts in emergency and day surgery, etc., checking patients who they will be seeing that day, assisting doctors in different clinics, inserting and removing catheters, changing penile dressings and scrotal supports, and teaching. In addition to urology patients, UT Is also attend cancer clinics to perform catheterization procedures. From 60% to 80% of a UT I's work involves urology patients, but the number of procedures (catheterizations, bladder scans, etc.), varies each day depending on the particular physician involved.

In his capacity as a UT II, Mr. Holden acts as a go-between between Dianne Sullivan and the various doctors. He also schedules UT Is, assesses all products, teaches Nurses and LPNs, and oversees problems on the floors if called. In addition, he does most, if not all, procedures that UT Is do where schedules permit. Mr. Holden works 8 - 4 Monday to Friday, during which time he goes where he is needed, such as the HSC wards, emergency department, the operating rooms, intensive care units, and the Miller Centre, Experience is the difference between a UT I and a UT II. One needs approximately 5 years experience as a UT I in order to answer the various questions that will arise.

Every six weeks a new patient schedule is posted two weeks in advance. Mr. Holden knows

all the regular patients (60% of them are older men) because they visit the clinics every month or six weeks. Some return every two weeks. In addition to the routine, doctors may require certain procedures for particular patients. When they come to the clinics, their stays are short, usually after catheterization procedures.

At one time seven (7) urology technicians were on staff, then six (6), and now there are five (5) UT Is and one (1) UT II. Mr. Holden indicated that he has been told that, due to new innovations in urology work, his own position will not be filled after he retires. UT Is work 12 hour shifts. Sometimes they are called to St. Clare's Hospital operating rooms and intensive care units if staff there encounter catheterization problems with male patients. All such outside visits are authorized by the urologists because the urology technicians have extensive catheterization experience and training. It normally takes two years for new staff to become comfortable with the various procedures. As it is with any vocation, the more experience one has, the more they are able to troubleshoot. Where male patients are concerned, significant damage could be caused if catheters are forced through strictures in the urethra or if scar tissue is encountered. Such damage may require surgery to correct.

In addition to regular patients in the urology clinics, there are always new ones each time. Also UT Is encounter new patients in emergency triage and day surgery. UT Is are the first ones called to such areas when problems are encountered. If they can't perform the procedures, then the urologists themselves will be called.

Male urology patients come from every part of the province. Those who are inpatients on the urology floor are not long term, neither are they long term in ICU or a medicine floor where UT Is are called to perform catheter insertions, attend to problem catheterizations, collect specimens, etc., all of which take a matter of minutes, or perhaps hours in certain situations. Procedures are done in patients' rooms, normally four patients to a room, where, as a matter of common decency,

screens are pulled across to provide privacy. These patients will have to be undressed to expose their penises and scrotal areas, which are washed and prepped while they lie flat on their backs. In emergency or a hospital ward, treatment rooms, or outpatient clinics, privacy will be assured by UT Is. It was Mr. Holden's experience that patients do not want to be naked and exposed to others. Therefore, he felt it would be inconsiderate of patients' feelings not to give them the privacy they need.

For the arbitrator's benefit, Mr. Holden introduced four (4) catheters all numbered differently, described the features of each one, and explained the circumstances that would cause one to be chosen over the others. C#9 is the most commonly used indwelling catheter appropriate for approximately one (1) week, which is placed in the bladder so that urine output may be monitored. However, if he encountered a "bleeder," Mr. Holden explained that he would choose a bigger catheter to encourage flow. The bigger the number, the bigger the catheter. For example, C#10 is a #16 French catheter which is used mainly when C#9 (the simple straight catheter) has been used. The tip of C#10 is slightly curved to accommodate a swollen prostate. C#11 is a 3-way catheter with large openings at the ends, which is used where a bad bleeder is encountered and it is necessary to get clots out. Although this is not the standard catheter, it is the best one for this situation. C#12 is a single use catheter used for collecting specimens or when someone needs to be catheterized often.

Catheters are used when patients can't urinate, to monitor output, to collect specimens, for testing purposes, to drain blood, or to place drugs in the bladder. The number of catheterizations performed depends on the urologists' decisions. Generally catheterizations account for an average of 60% - 70% of a urology technician's day and on occasion could be as low as 50% or as high as 90%, but for Mr. Holden the percentage varies because on some days his teaching responsibilities increase. On weekends catheterizations normally amount to 90% because there are no clinics and

urologists are not around. Therefore, the type of patients to be cared for is different. Virtually all the patients are male. Currently there are only six (6) women in long term urology care. For those women, nurses employ a super pubic catheter procedure, i.e., an insertion into an opening below the belly button, which requires no exposure of the genital area. When male patients are involved, the only person in the room (for privacy reasons) is the UT I. Some discussion usually ensues about the patient's problems, particularly his private concerns about his "plumbing" and his sexual dysfunction. Mr. Holden recognizes patients' discomfort by their behaviour. For example they may become agitated, nervous, blush, or appear uncertain, which usually manifests itself in demands for explanations. Where symptoms of this nature occur, Mr. Holden will talk to them and explain things in detail, thereby settling them down so that the required procedure can be performed without difficulty.

When a procedure is ordered for a patient, the UT takes the necessary supply of materials and equipment, introduces himself and explains what he is to do (i.e., expose and clean him and insert the catheter). New patients require more explanation. Once the patient is exposed from the waist down, the UT cleans the penis with soap, opens the tray, gets the lubricant ready, places one hand on the penis (that hand is then contaminated), pulls back the foreskin, holds the penis at a 90° angle, lets the patient know that he is beginning to insert the catheter, and continues the insertion through the urethra (some 7 to 10 inches). The contaminated hand never leaves the penis. If a problem is encountered, the penis is held at a different angle. Once urine begins to flow, the catheter is pushed further into the bladder and water is administered and drained. An output bag is attached, the colour of the urine is examined, a record is made and the patient is then covered. A normal catheter can be inserted in 60 seconds or so. If that does not happen, the catheter is discarded and a new one is obtained from the tray. Patients would normally be exposed from 5 - 10 minutes. However, Mr. Holden indicated that he has had difficult patients exposed for as long as 2

hours.

In Mr. Holden's view, the most difficult type of patient is a young male about 14 years old at the Janeway Children's facility. Children at that age are very aware of their anatomy and are difficult to convince to be catheterized. Most long term patients tolerate the procedure more easily. However, relaxation is an issue – infrequently some refuse to have the procedure performed. Mr. Holden agreed that there are lots of occasions in a hospital when patients need to be exposed. He has worked primarily with males, but occasionally in rare circumstances he has assisted with female catheterizations. Normally any time a female patient on the floor requires a catheter, a female staff member does the procedure. Most catheters for urology patients are changed every 4 - 6 weeks, in which case the same procedure as above is followed.

For bladder irrigations (not done as frequently as in the past), a 3-way catheter is used, a bag of fluid is hung or a catheter syringe can be used manually. These procedures can occur on the floor, in emergency or in the ICU. Only the urology technician is present in the room. He inserts the catheter, administers the fluid (about 30 mil) into the bladder for a normal flush, and then connects a normal saline solution. The same procedure is employed for inserting either a 2-way or a 3-way catheter, i.e., touching the penis is always required, and the time it takes can be minutes or longer.

Dressings for the scrotum, perineum, or penis are usually done twice a day or as often as necessary. Packings on the scrotum for erosions, etc., are also required. The procedure involves obtaining a sterile packing from the tray, an explanation is given to the patient, the site is cleaned, washed out and rinsed with a saline solution, the dressing is applied and taped in place. Only the UT is in the room unless the urologist comes in. For these procedures, patients are exposed for approximately 15 -20 minutes. Patients on the Floor would be fairly accustomed to having dressings changed. However, there is always some discomfort because of the intimate nature of the area

involved.

Assisting the urologists might entail inserting catheters , inserting a scope into the penis, or putting on dressings. UTs also assist in cauterization of warts on the penis or scrotum, which does not occur every day, but is performed in day surgery, usually on males in their 20s. The patients are prepped, the procedure is explained, the UT holds a vacuum hose while the doctor deadens the area and burns the warts. Then the UT cleans the area. For such procedures, only the doctor and the UT is in the room. These patients require confidentiality and privacy because they are self-conscious, agitated, nervous, and are inclined to tense up. The average time they might be exposed is 10 - 15 minutes, but sometimes they are exposed for an hour. This makes them fidgety, not relaxed and in a hurry to get out of the room. After cauterization, the patients have to be counselled not to have unprotected sex for certain periods of time.

Where sexual dysfunction issues are involved, patients might be instructed (by video) to use a pump device to achieve an erection. UTs also may have to explain certain injections the doctors might administer to cause an erection. Such counselling, where required, is the same now as it was in 2000, but the availability of drugs such as Viagra, etc., permit the doctors to counsel patients privately in the treatment room. If a video is necessary, the UT will explain and show it in a private room. If injections are administered, the UTs may have to report to the doctor whether erections have occurred. On the whole, Mr. Holden felt that such patients seem to be embarrassed and agitated about sexual dysfunction procedures.

Mr. Holden testified that there had been one female urology technician in the past. He could recall only one time when he was in the same room with her. He recalled that she was there in 1994 and probably for 1½ to 2 years afterwards. While she was employed, Mr. Holden said that there were two or three occasions when male patients said they did not want a female doing their catheters. He learned about these occasions when the female UT told him that the patients did not

want her; they wanted a male instead. He presumed that any reports of that nature would be made to the Supervisor. As he recalled, only one or two specific patients refused to have the female technician perform procedures on them. Mr. Holden also indicated that, on occasion, a male patient has told him that he did not want him to do a procedure because he did not like him.

In Mr. Holden's view, the success rate for catheterizations depends on the ability and experience of the technician, the patient's state of mind and how well the technician is able to relax the patient. If a female were to perform the procedure and the patient had an erection, problems would be encountered because of the patient's tensed muscles. Mr. Holden said that he has encountered patients who have tensed up during a catheterization. In his experience, 30 - 40 year old patients tend to be embarrassed. However, elderly patients, who have most likely been accustomed to being cared for by females, probably would not be concerned if a male or female performed catheterizations on them.

Mr. Holden indicated that no male patients have requested that a female perform their catheterizations. If a patient refuses him, it is because he does not like him, not because of his gender. During his brief visits with patients, his conversations involve small talk such as the weather, where the patient comes from, etc., and often the patient raises issues concerning sexual dysfunction. In his view, there is no question that a female technician could perform catheterizations, etc., on men; in fact his wife would be quite capable, but in his opinion females should not do so. He believed that a male UT can relax other males better than a female UT can, especially when discussing a patient's concern about his sexual dysfunction, the size of his penis (a topic that is commonly mentioned by patients, usually providing some explanation why it isn't as big as it once was), or his particular problems urinating. As a male, Mr. Holden felt that he simply knew that patients would not carry on such conversations with a female. Even those with some bravado usually change their behaviour when it comes time to expose their genital areas.

Doctors, nurses and LPNs can do catheterizations, but all male patients are done by the male UTs because there is sufficient patient volume in the HSC Hospital to justify the hiring of urology technicians. At St. Clare's Hospital, catheterizations on males are done by whatever staff are available there, but typically no urology patients would be involved – a urology patient being defined as a person unable to make his water because of prostate problems, bladder or kidney stones, penis or scrotum problems, or cancer. A male patient on urology already has some urological problem, whereas a male patient on a medical floor or at St. Clare's Hospital might not be able to urinate because of the effect of some drug. However, when a urology problem occurs, a male UT is called. Also, when a nurse or a doctor on a medical floor tries a catheterization and encounters problems, a urologist is called who, in turn sends a UT to perform the procedure.

Urology technicians are intended to administer to urology patients only. Unfortunately there are not enough technicians to handle all the hospitals in the area. Only four (4) technicians are on shift rotation now, whereas there were five (5) in the past. This means that urology technicians do not work together.

In cross examination, Mr. Holden explained that his wife and other females are equally capable as males in performing catheterization procedures. But in his opinion, it is legitimate that there be a requirement that a urology technician should be male. He felt that there is no difference between a female applicant insisting on going to urology and a male applicant insisting on going to obstetrics. While he agreed that male patients might be nervous about a new male technician doing a catheterization, he believed that their nervousness would be short lived.

Since Mr. Clyde Rice was the head technician while the previous female urology technician was employed, Mr. Holden said that he would have no knowledge of any negative outcomes arising from procedures performed by the female technician. He worked on the shift opposite to her with some minor overlap only. Mr. Holden has seen no documentation concerning the few times when

male patients indicated that they did not want her. He has also seen no documentation for occasions when patients said they did not want particular male technicians.

Mr. Holden estimated that, in a 24 hour period, 20 - 25 catheterizations might be performed, some of them pre scheduled. He believed that the urologists sometimes did catheterizations particularly when patients were under anaesthesia, but since he is not present at such times, he could not guess how many occurred.

Mr. Holden believed that male urology patients would be more nervous with a female than with a male technician and would probably turn females away. More young urology patients with sexual issues are being seen now. It is more embarrassing for them knowing that they could later run into a female technician at a shopping mall.

The urology technicians train both male and female Residents during their rotations, but the technicians are the ones called to perform catheterizations. Mr. Holden presumed that the doctors perform the procedure if the technicians are not available, but he did not know whether females or only male doctors did them. If a doctor encounters a difficult catheterization, the UT Is are called. They also do the procedure when a patient comes to the HSC from an outlying hospital where a female might have initially tried it. Mr. Holden estimated that 1 - 2 cases of urethral ruptures causing bleeding are sent from outside hospitals to the HSC each week. He has no knowledge of any such complaints around the HSC.

As for the occurrence of infections, Mr. Holden said that any invasive procedure may be the cause. However, he did not see that as a male/female issue.

On the Rehab unit at the Miller Centre where there are many male patients 18 years and older, Mr. Holden has trained all the male and female nurses and LPNs how to perform male catheterizations. This was necessary because there were insufficient urology technicians available to perform work at that location. On the Rehab unit, intermittent catheters may be necessary (every

4-6 hours). Mr. Holden estimated that a female could be performing this work 2 or three times per shift. From what he hears, Mr. Holden understands that the staff prefers that the male LPNs do that procedure. There are also long term male patients at the Miller Centre who will be cared for by women (mothers, wives, girl friends, etc.) for the rest of their lives. The establishment of such long term relationships makes care by females less of an issue. In contrast, where true urology patients are involved, no long term relationships exist as far as catheterizations, etc., are concerned. Therefore, it makes sense for male urology technicians to perform such procedures.

Mr. Holden explained that no shave preps are done anymore because it irritates the skin. Therefore, that is not a male/female issue. He also agreed that the provision of privacy for patients is not confined to urology. He further agreed that he has taught doctors (particularly those in family medicine), nurses and LPNs how to perform catheterizations. Although catheter care is done by the staff on the floors, that is acute care involving a different type of patient than in urology). Urology patients are not the same as normal acute care patients. Mr. Holden agreed, however, that males and females can develop rapport with repeat patients. His personal estimate is that his work is 60% with male urology patients and 40% with male patients off service (outside the HSC). He also agreed that he has seen male patients squirm, grunt and grab the bed rails when a male UT has done the catheterization. He has also had some patients from outside ask for a doctor or a nurse, but he has convinced them that he is the appropriate one to perform the procedure.

In his teaching of others, Mr. Holden never covered the topic of relaxing patients. In his view, he would never teach anybody how to reduce a patient's anxiety because that subject is covered in LPN training. In the two years he worked while the female technician was employed, Mr. Holden heard about problems on the floor but he was not privy to any written complaints. He agreed that complaints have been made about some male UTs.

In redirect examination, Mr. Holden said that females have the requisite knowledge and

training, but the ability to perform is not the same as knowledge. A female prepping a young patient for a catheter who has an erection faces problems with tears, ruptures, and trauma to the prostate, etc.

As for documentation concerning issues with females, Mr. Holden saw none while he was a UT I, however, since he has been a UT II, he has seen 3 or 4.

At the Miller Centre Rehab unit, there are a large number of male quadriplegic patients who are involved in long term care, usually by females. There are not sufficient numbers of rehabilitation patients requiring the services of UTs.

The prospect of urology technicians causing infections is lower than for outside service providers.

Mr. Holden indicated that there are no Residents or Interns in the urology division. Therefore, there are no such people available to do catheterizations. Occasionally there might be an occasional Resident on rotation from surgery or family practice, but only urology technicians are called to perform catheterizations.

Finally, Mr. Holden said that he was aware of two specific incidents during the time the female UT I was employed when he was told by patients that they did not want her back again; they wanted a male instead. Although they reported that she was rough, that was not the reason they did not want her.

#### Testimony of Dr. Douglas Drover

Upon presenting his credentials, Dr. Drover was accepted as an expert witness in the practice of urology. During his testimony, he commented on the content of DD#6 his January 2, 2007 letter. Since the positions taken in the letter are reasonably clear, it is unnecessary to reiterate all of its subject matter at this point. Therefore the following represents some of his comments,

observations and conclusions.

Dr. Drover has been on staff at the HSC since 1992 and also has maintained an outside private office. His charts indicate that, since 1992, he has counselled some 17,000 general urology patients (except paediatrics), 75% of them male and 25% female. Typical problems among the males include prostate cancer, prostatism, kidney stones, and erectile dysfunction. He estimated that 25% of his patients required the involvement of urology technicians with whom he has worked on a daily basis either directly or by telephone. Dr. Drover stated that he is very familiar with the duties performed by urology technicians and he is aware of any failures on their part because the urologists become involved in such matters. He could remember only one female who previously had worked as a UT at the HSC; all the other UTs have been male.

Dr. Drover explained that the urology department at the HSC is the only full time provider of urology services for patients throughout the whole province. On the west coast there is a minimalist community-based service, but no major urological services are provided. In central there is only one doctor who is qualified, but most of his patients are seen at the HSC. When patients are candidates for surgery or present with urological complexities, they are transferred to St. John's. The urology technicians who perform procedures on urology patients are trained by Eastern Health, but are guided on a daily basis by the urology physicians. These technicians provide coverage 24 hours a day, 7 days a week, performing scheduled catheterizations, emergency catheterizations, and handling post operative complications. They work independently of other hospital staff. Their training and experience makes them specialists in their area and enables them to handle most problems on nights and weekends. Dr. Drover further explained that there is nowhere else in the country where urology technicians are employed with such a high level of responsibility. Their role makes the urology physicians' lives bearable. In the United States, some technical jobs exist for which the incumbents are trained as assistants to the doctors, and on the west coast some

catheterizations are performed, but the procedures there are nowhere near the volume and complexity encountered at the Eastern Health urology department.

The male urology patient population at the HSC are 60+ years old, all of them having presented to emergency with specific urinary trauma, or as post operative patients. The urology technicians' duties consist of more than 90% catheterizations. They also assist with the removal of genital warts in day surgery and apply penile and scrotal dressings.

It was Dr. Drover's experience, as well as those of the other five (5) urologists in the division with whom he discussed the gender issue, that male urology patients prefer that male technicians perform their catheterizations and apply their penile and scrotal dressings. All the urologists have had weekly experience with male urology patients who will not have female nurses in the room for urology procedures, especially wart removal and other procedures involving sexual dysfunction. Similarly, female patients have indicated that they do not want males to prep them. In all such circumstances, if the patients are apprehensive or embarrassed about opposite gender staff being in the room, the doctors ask them to leave.

Dr. Drover testified that best practice care is followed by the urologists, who do everything they possibly can to avoid negative patient outcomes. He said that success rates are now being determined by a holistic approach in which attention is paid to psychological as well as physical outcomes - the latter being the subject of most evidence-based documentation. The urologists' experience is that elderly male urology patients prefer males to perform their catheterizations and dressings. Younger males do not express much gender preference. Current literature data indicates that a large minority of women prefer female caregivers for intimate care (see DD#2, a 2005 Article: Do Women prefer Care From Female or Male Obstetrician-Gynecologists? A study of Patient Preference). In Dr. Drover's view, such a large minority at 33% is significant where gender preference is expressed and it is reasonable to extrapolate that the preference of male patients for

male staff would be no different. Another 2005 publication, DD#3: Gender Preferences Called Barrier to Colonoscopy for Women, related that 43% of 202 women studied said they preferred a female endoscopist and only 1.4% preferred a male. Among those preferring a female, 87% reported that they would be willing to wait 30 days or more for the procedure to be assured of a having a woman endoscopist.

Commenting on the academic notion that there should be no difference if males or females provide care to patients, Dr. Drover took the position that male urology patient expectations are different. While psychological outcomes are themselves a consideration, the critical question that must be answered is whether psychological outcomes will affect physical outcomes. If the answer is yes, then the patients' choice is more significant. Dr. Drover considered it reasonable to infer from the literature that a certain proportion of men would refuse women, thereby creating potential risk for negative physical outcomes. The particular concern that arises for male urology patients is the risk of damage occurring during catheterizations. Dr. Drover explained that, when male urology patients become anxious or uptight there is an increase in pelvic tension, which tends to close the passageway for the catheter, thereby making the procedure difficult. Since most elderly urology patients prefer male staff for their catheterizations, an additional level of anxiety will be introduced to the procedure should a female perform it. The immediate risks of catheterizations under those conditions would be excessive bleeding, rupture of the urethra and pelvic area, and sepsis (a bacterial infection that could cause death).

In DD#4, an individual gynecological case history article: Patient Choice of Provider Gender, the author argues that:

... When a patient requests a provider of a specific sex, the request should be investigated to define the patient's underlying values. An attempt should be made to confront a patient's stereotypical and discriminatory beliefs, with the hope of educating the patient and causing a change of heart. But the ultimate responsibility of the physician is to care for each patient with respect, even if the patient's beliefs are abhorrent. The appropriate goal of the physician is to maximize the patient's

chance of regaining health, not to educate the patient regarding his or her prejudices. Thus, if an individual patient cannot be persuaded otherwise, such a request should be honoured as acting in the patient's best interests. At the same time, physicians should work both individually and collectively against discrimination and prejudice whenever they are found.

As a general premise Dr. Drover considered this approach to be instinctively reasonable. However, he felt that where additional anxiety is caused because the patient's preference for same sex care is not provided, and that anxiety increases the physical risk of the procedure, a safety concern is created. In his view, if patients perceive a same sex provider to be important to their care, then it is not up to doctors to second guess them.

In Dr. Drover's opinion, male and female catheterizations are totally different. He explained that, since the female anatomy is straight, catheterization is relatively simple. With males, the prostate is commonly involved. This requires insertion of a longer catheter tube with a curved tip. The penis is held by one hand at an angle for 5 - 7 cm until resistance is felt, then the penis is brought to a parallel position to change the angle. Otherwise the urethra behind the prostate could be perforated. In males, prostate cancer, prostatitis, etc., and previous surgery will require different types of catheters. Essentially, Dr. Drover's point was that male urology patients are very different from other male patients in terms of the complexity of problems faced. In the urology division, the urologists regularly give their blessing to urology technicians to handle many different cases, including patients brought in from outside. It was Dr. Drover's experience that the technicians are better able to perform male catheterizations than other providers who may find that persisting with a difficult catheterization would exacerbate existing problems and risk potential harm to the patient. He indicated that failed first attempts are bad enough, but second attempts might tear the urethra apart and require catheterization through the belly instead. He also indicated that the use of an improper catheter would increase the risk of damage to the patient. In addition to performing difficult catheterizations, urology technicians also perform other procedures that are considerably

traumatic for male patients, namely, assisting in the removal of genital warts, applying penile and scrotal dressings, sometimes for prostheses for erectile dysfunction.

Dr. Drover stressed that the physicians in the urology division do not want their patients to suffer needlessly. Although no firm data has been collected on the issue, the urologists do have considerable experience with same sex preference by their male patients. It is upsetting to patients that hospital areas are not always private, but it is particularly upsetting to experience the unfamiliarity of having one's genitals touched by a person of the opposite sex in a hospital. Procedures such as catheterization, dilations for strictures and penile wart removal truly warrant appropriate male care. It is Dr. Drover's experience that young male patients under 30 years of age almost invariably ask who is going to be in the room. For the next older male population (30 - 50 years), catheterizations are not usually difficult and procedures for sexual dysfunction are relatively few. Therefore, gender preference is not much of an issue. However, the requirement for intimate care significantly increases in the 55 and older age group. In that male population, gender preference becomes prevalent because of the complexities of their conditions, their particular upbringing, and the intimate nature of the specific procedures involved.

There are female nurses and LPNs in the urology department who, in Dr. Drover's opinion, are equally capable of performing catheterizations and other procedures on male patients. However, only male urology technicians are employed for this purpose because of patients' gender preference and because the patients know that the technicians are urology specialists. Patients also know that they have rapport with the urology physicians. When a urology technician sees a male patient for the first time, an element of concern initially arises regarding the procedure to be performed. Cold visits are typical for the technicians. Any anxiety over procedures associated with such visits would be exacerbated if females are there to perform them. This presents difficulties even for female urologists generally, a good proportion of whom Dr. Drover understands, usually find themselves

transferring into Gynaecology or Paediatrics. In his opinion, when catheterizations don't work in other hospitals and patients have to be sent to the urology department at the HSC, it usually means that the female nurses in those outlying areas have failed to perform the procedure, which urology technicians can readily do.

If a female were to be hired as a urology technician, Dr. Drover indicated that there would have to be male backup available whenever a patient refuses her, a situation which would create staffing problems. For patient safety and well-being reasons, physicians must be aware of patient preference. There are degrees of intimate care. For example, bathing a patient is intimate, and appropriate care must be taken to ensure privacy in such cases, but performing a medical procedure which involves handling and manipulating one's genitals is much more intimate and embarrassing. Dr. Drover testified that performance ability is not the issue where male urology patients are concerned -- females can perform the work required. The real issue is the patient's response to the gender of the provider, which, if negative, increases the risk of an adverse physical reaction leading to physical damage. Although the urologists have identified this as a real risk factor, Dr. Drover indicated that the physicians do not possess the legal answers if a patient should subsequently launch a legal complaint that he suffered complications as a result of a catheterization performed on him by a female. The number of such cases is not the issue; this type of thing should not happen to anybody if it can be prevented. That is an administrative matter, as is the hiring of staff, which physicians also do not do. However, where a known potential risk for harm to their patients exists, the urologists are obliged to make their concerns known. Physicians subscribe to an oath to provide the best possible care to their patients from cradle to grave. While they are not perfect, they strive to do the best they can, which includes being concerned for the quality of care given to their patients.

In cross examination, Dr. Drover was asked what his role had been in amassing

documentation during a consultative process in 2000 to support a male-only job posting for the position of urology technician and his response was that he was not directly involved in Ms. Butler's particular case at all. However, he testified further that, while the female urology technician was on staff, more than a number of complaints occurred that were discussed at the urology division level. Some patients refused her and sometimes male technicians had to perform the procedures when she could not do so. Dr. Drover indicated that no documentation was created for those complaints. He also agreed that the journal articles he introduced at arbitration (DD#2 – DD#5) were the result of an internet search which he conducted after he was contacted in December 2006 by the Employer's counsel, Ms. Sheppard.

Dr. Drover confirmed that a male urology technician would be on shift at the HSC when procedures are performed on young males in clinics and day surgery during the hours of 8 - 4 o'clock, Monday through Friday. He reiterated his earlier evidence that the urologists' experience indicates that elderly male patients prefer that male staff perform their catheterizations and penile and scrotal dressings, etc. When asked about the Miller Centre, Dr. Drover said that catheterization procedures at the Rehab unit are less complicated than in the urology division and there are now too few urology technicians on staff to assign to such work. He explained that, since a large number of LPNs (both females and males) are on staff at the Miller Centre, patients' gender preference can be accommodated if requested. At St. Clare's Hospital, no urology technicians have ever been assigned to perform routine male catheterizations; instead, regular nursing staff do those procedures.

Dr. Drover testified that he could not personally remember the previous female urology technician or many of the issues in which she was involved. He did recall that a complaint was made about a male technician as well. At the time, it was Dr. Best's role to deal with supervisors and department administration. However, unless something was discussed among the urologists

and the department, it was not considered a problem. Complaints were dealt with by discussion among the urologists, and the Chief would take things from there.

Asked what the words “test results” meant in KM#1, Dr. Drover said he did not know, unless it had something to do with outcomes. Also he said that, until recently, he did not know what a BFOQ meant. He had also been unaware that a female had been offered a temporary position of urology technician in 1999. Around that time, Dr. Best said that he had been approached by the urology technicians. Dr. Drover’s understanding is that, after 1999, administration then put in a request for male only urology technician positions.

Dr. Drover agreed that his letter of January 2, 2007 (DD#6) was his response to Ms. Sheppard’s request of December 28, 2006. He also agreed that patient anxiety, which is mentioned on page 2 of the letter, could be present for any procedure. He further agreed that no specific studies have been conducted at Eastern Health on the gender outcomes mentioned in the second paragraph on page 2. However, Dr. Drover reiterated his belief that the conclusions stated in that paragraph are reasonable because the urologists’ experience provides clear evidence that anxiety can increase pelvic floor tightening when a male does the procedure. Therefore, it is simply reasonable to extrapolate that pelvic tightening is exacerbated by additional anxiety caused by a female performing the procedure. Dr. Drover stated that he did not personally witness any problems caused by the previous female technician. His knowledge of problems came from those that were discussed at the time. He readily agreed that he would have no reservations about a female urology technician being hired as long as there was male back-up available for refusals while she was on shift. He said that, when a male is refused on other floors, there are always female nurses available for back-up. However, there is no same sex nurse back-up on the urology floor. Since his experience is in the urology department, Dr. Drover declined to speculate what this issue would mean for obstetrics.

In redirect examination, Dr. Drover said that there is has been no change in conclusions concerning the pelvic floor tightening issue since 1999. However, he felt that the issue of gender preference has generally been more studied in recent years. In his view, all the information he presented at this arbitration hearing was equally valid more than 10 years ago, but health care providers now have more responsibility to be aware of and be concerned about patient gender preferences.

Asked about his recollection about discussions within the urology department in 1999, Dr. Drover said that he could not recall specific details. He clarified that nursing staff at St. Clare's Hospital performed routine straight-forward male catheterizations, but urology technicians from the HSC have always been called as back-up in case complications or difficulties occur. He also stressed that nurses on hospital floors are continually in and out of patients' rooms during each shift, thereby having more opportunity to become more familiar with the patients and to develop rapport with them. In contrast, a good urology technician might be in a male patient's room once for 10 - 15 minutes.

On the issue of anxiety, Dr. Drover explained that a male patient's fear of a particular procedure is due to the intervention itself and is not gender related. However, the introduction of additional apprehension as a result of being intimately exposed to the opposite sex effectively exacerbates the level of anxiety. Since it is the physician's responsibility to avoid unnecessary anxiety that would increase the risk of harming a patient, the patient's gender preference should be allowed. Based upon their experiences, the urologists' perception is that a difference in risk exists between male and female providers in the catheterization and application of penile and scrotal dressings on male urological patients. Anticipatory anxiety to genital exposure does exist – religious beliefs and cultural backgrounds are often factors. However, whatever the contributing factors may be to this anxiety, if the patient's response is to refuse opposite gender care or to experience pelvic

floor tightening, a significant safety problem is created.

### Testimony of Rodney Flight

Mr. Flight, a 20 year employee, was trained as an LPN and had related experience at the Miller Centre and in orthopaedics. For 16 years, he worked off and on as a UT I and was employed in that capacity at the time Ms. Butler grieved. All of his work as a UT I has been with male patients. Much of his testimony confirmed the evidence given by Mr. Holden on the role of a urology technician and how the procedures required have changed only marginally since 2000. He estimated that catheterizations account for 80% of his work; the remainder is composed of scrotal and penile dressings (10%) and teaching catheterizations (10%). With the exception of the administrative UT II duties, which UT Is do not perform, Mr. Flight's UT I work day did not differ significantly from Mr. Holden's work day as far as checking patients on the urology floor, checking the physician's orders, the clinic schedules, changing catheters, answering calls from around the hospital and answering pager calls involving the Miller Centre and St. Clare's Hospital were concerned. He said that catheter changes are usually known about and some can be planned, but for the most part catheterizations are "up in the air".

The patients Mr. Flight sees are mostly men – 80% are 50 years and older (most experiencing urinary difficulties) and 20% have acute problems or have been in accidents. Although his work is mainly in the HSC urology division, he is often called to other hospitals and other HSC floors. He also is occasionally called to the Miller Centre to catheterize men. Nurses do the routine (non urological) catheterizations there. Mr. Flight essentially indicated that only urology technicians are called to perform procedures on males because they specialize in the catheterization of the male anatomy and because they are able to deal with patients man-to-man.

The issue of privacy throughout the hospital in general and for urology patients in particular

was described basically as Mr. Holden described it. Mr. Flight confirmed that exposing patients' genitals requires that urology technicians provide as much privacy as possible all shift long while they perform catheterizations and other personal intimate procedures. In his experience patients' reactions are similar. For example, when the technician is getting ready to do a catheterization, he will uncover the patient and they will then cover themselves as soon as possible with their sheets or their hands, etc. The men are embarrassed to have their private areas exposed. They will also commonly comment on their penises saying something like: "there's not much left there now – it must be the medication." He indicated that he hears the same expression just about every time, but worded a little differently perhaps. Not much has changed in this respect since 2000.

Mr. Flight is the only person in the room with a male patient unless a male attendant has accompanied him. In his experience, male providers are preferred by male patients for the types of procedures involved. Care must be taken to ensure decency and to ensure that patients are not on edge; if they are tensed up, catheterization may be adversely affected, i.e., sometimes a catheter cannot be inserted. A routine catheterization usually takes 10 - 15 minutes (sometimes longer), and a change takes about 10 minutes. If an in-and-out catheter is required (to relieve the inability to urinate) it might take 10 - 15 minutes if the bladder is full. As long as a tube is in the bladder, the technician must stay with the patient. For a full change procedure (approximately 20 minutes) the genital area remains exposed and all that time the technician is obliged to hold the patient's penis in one hand.

Mr. Flight said that some patients are very uncomfortable about having catheterizations even when their bladders are quite full. Younger patients are uncertain whether they want the procedure done and usually ask whether it is really necessary and want to know what is involved. It is the technician's job to reassure and relax them.

In hospitals, staff do see patients when their private areas are exposed for washing. In

distinguishing such situations from the procedures performed by urology technicians, Mr. Flight characterized washing as an intimate, sterile procedure ( something like surgery), but a much more passive activity compared to the very personal intimacy involved in holding a patient's penis while inserting a tube into it. If a patient fights being washed, it will get done eventually without physical repercussions, but if a patient tenses up for a catheterization, the procedure becomes more difficult and there is a risk of causing bleeding, which is a more serious safety implication. Mr. Flight compared catheterization in new or acute situations to the changing of catheters. In the former, patients are more uptight, anxious and tense, thereby causing more difficult insertions. In the latter, patients are more relaxed because they usually have had it done before. In the case of long term patients at the Miller Centre and the Waterford Hospital, they also know what to expect, although some never get used to it. Changes for chronic patients usually occurs once per month.

Uncomplicated bladder irrigations, continuing irrigations (involving the insertion of a 3-way tube) and trans urethral resections ( where bleeding usually occurs) all require privacy because the patients' genitalia could be exposed for 30 - 45 minutes. Only the patient and the technician are in the room; there is no need for anybody else to be present, unless a spouse or somebody else close to the patient is requested. Patients react to insertions by being very nervous and agitated at first, but since they are usually so uncomfortable because their bladders are so full of urine and blood, they are anxious to get relief. Bathing is not invasive; bladder irrigation is invasive and it involves more handling of the penis and more exposure of the genitals.

Mr. Flight indicated that there are fewer scrotal dressings now than in the past. Where they are done, most occur on the urology floor and sometimes in an acute case in emergency. In all cases, privacy is assured and only the patient and the technician are in the room. Even then, it is Mr. Flight's experience that patients try to cover themselves. Both in these cases and where cauterization of warts is involved, Mr. Flight distinguished the procedures from bathing on the basis

of their invasive nature.

Teaching involves instructing patients how to use drainage bags, how to ensure a sterile environment and how to avoid contamination so as to avoid infection. Five or six years ago, Mr. Flight was required to conduct more information (video) sessions on sexual dysfunction issues in day surgery (about once every day). Now drugs are used to treat those conditions. Sessions would occur in a day surgery treatment room where penile drug injections are performed. The patients must wait to see if a reaction occurs and to determine whether an adjustment might be needed. Pain in the penis from engorgement is possible in such circumstances. The doctor, technician and patient would be in the room. Afterwards, the technician would check the patient to see if erections have occurred. Patients are very embarrassed in those situations and they demonstrate so by covering themselves at every opportunity. In Mr. Flight's experience, these procedures are much more intimate and embarrassing than having to be washed.

During his tenure as a UT I, Mr. Flight never heard of any male patient request a female for catheterizations or dressings, etc. He recalled one female urology technician in the mid 1990s or so who worked on one shift while he worked on the opposite shift. For approximately two years they dealt with many of the same patients. His only contact with her was during report when particular patients were discussed. Some patients said nothing about her. A couple of patients, one an older man and one a teenager flatly refused to have her tend to them because she was a woman. He also remembered being called by nursing to tend to a patient with a full bladder who had deliberately cut his fluid intake and held his urine on the female's shift until the next shift when a male technician (Flight) was scheduled. Generally patients told him that they did not see why they had to be exposed to a woman. Their chief concern was the size of their penises and they would always comment nervously on the fact that they were so shrivelled. In Mr. Flight's experience, a catheter failure could occasionally be caused by an existing physical reason such as an enlarged prostate

or a stricture, but it could also occur if a patient is nervous and tenses up thereby causing difficulties in permitting a catheter to pass through normally. Sometimes the procedure cannot be performed until the patient is able to relax.

Of the total male urology patient population, Mr. Flight estimated that two in ten may have some physical stricture, and one in ten would require a physician to pass a guide wire for a scope into the bladder.

Commenting on his role at outside medical institutions, Mr. Flight explained that his calls to St. Clare's Hospital are not for routine male catheterizations, but only where complications or difficulties are encountered which require the specialized skill of a urology technician in dealing with male patients. At the Miller Centre, there are some male catheterizations required in palliative care or a monthly catheter change is required. Most of the male patients at the Miller Centre are known to the technicians and they have specific urological problems that the technicians know about.

In cross examination, Mr. Flight agreed that any new patient can be anxious and that a new technician can be refused for his relative lack of experience. Recently a male technician was refused for that reason. He agreed that, while the female technician was employed, he was aware of two patients who refused her. He acknowledged that he was not aware whether these matters were taken to management at the time.

Mr. Flight confirmed that urology technicians used to do catheter insertions every six hours in the Miller Centre Rehabilitation Unit, but that service is no longer provided by urology technicians.

On the issue of privacy, Mr. Flight said that where a curtain is used (as is the case for the majority of bladder irrigations) other patients in the room can hear what is going on; they simply can't see. He reiterated his experience that 20 - 30 year old males are more fussy, i.e., they want males to tend to them. He also agreed that when a male patient is escorted to the HSC by an LPN or a PCA (Personal Care Attendant), the escort is occasionally female and occasionally will stay in

the room. It is up to the patient to tell them to leave.

In re-direct examination, Mr. Flight explained that, if patients know that a technician is new, they assume that he is not experienced. But sometimes, they do not know the technician is new, and no problem is thereafter encountered (sort of a mind-over-matter thing).

In the Miller Centre Rehab Unit, mostly routine in-and-out catheterizations are required.

In the four (4) bed rooms where curtains are drawn for privacy, the technicians keep their voices low and are as discrete as possible. This is the usual situation on the urology floor where the male patient population is older and they have had the same kind of surgeries performed and have had the same procedures done by technicians. Catheter insertions and flowage procedures are regularly performed by the technicians. However, Dr. Drover does some other surgical procedures when the patients are anaesthetized, thereby making the procedures easier. As a physician, Dr. Drover knows his patients well and is aware of other conditions they may have, whereas urology technicians are not privy to such information.

In answer to the arbitrator's question what he meant by 20 - 30 year old males being fussy, Mr. Flight explained that this age group seems to be more sensitive about their genitalia. They do not like to expose their penises and the sensation of the medical procedures is greater for them. In contrast, older males who may have had surgery before experience less sensation.

#### Testimony of Melissa Colbourne

Ms. Colbourne has a temporary LPN position on 3 South at the Miller Centre. She commented that the patient population on the Rehab unit is 24, of whom 3 and sometimes 6 are female. She said that the majority have been males ranging in age from 16 to 80 years. On the convalescent unit the age range is 60 to 80 years.

Ms. Colbourne indicated that in June 2006 Gerard Holden, UT II, trained her to do

catheterizations on male patients. She has performed them on males ever since, whereas she previously did catheterizations exclusively on female patients. Within two weeks of conducting this training, urology technicians had no more need to perform male catheterizations on the Rehab Unit. LPNs did them. Patients needing catheter care, including paraplegics and quadriplegics (young men as well) are tended to by LPNs, including the changing of catheters, which is usually done by urology technicians, but LPNs sometimes do them. Although there are male LPNs on shift, females sometimes do the catheterizations. Ms. Colbourne also stated that one male patient was uncomfortable with her age, but not her gender. She further indicated that paraplegics and quadriplegics sometimes have spontaneous erections, in which case she will leave them alone for awhile and return when things are okay. Other care provided to those patients includes bathing & showering and administering bowel programs. Female LPNs also catheterize some patients who are incontinent. Stroke patients require some catheter care and amputees require little, but most LPN catheter care is done on paraplegics and quadriplegics.

In cases where obstructions or prostate problems are encountered, Ms. Colbourne said she would call a urology technician because they are trained specialists in such matters. While she was unsure who does catheter procedures on 2 South or the DVA (Veterans Pavilion), Ms. Colbourne's view was that she is trained to perform catheterizations anywhere in the unit.

In cross examination, Ms. Colbourne testified that she has not been floated to the DVA yet where the majority of patients are male. She understood however that they require the same type of catheter care as any other male patient who must have an indwelling catheter. She also understood that there are nurses on the floor who can change them. If someone cannot void, nurses and LPNs can catheterize him. However, for any complex situations, a urology technician would be called.

Ms. Colbourne testified that, in the last couple of years, LPNs have been assigned many

more duties -- perhaps the only thing they do not do is deal with the doctors. She also agreed that patients in the Rehab Unit are there for rehabilitation, not because they require care for urological problems. The patients there are stable and have no complex problems.

In cases where patients have erections, Ms. Colbourne explained that she covers them and leaves the room for awhile. When she returns a little later, things are usually okay and she is able to perform the catheterization without difficulty. In the case of the male patient who refused her, her age was the issue. Another female subsequently performed his catheterization.

#### Mr. Steve Porter

Mr. Porter has been a respiratory technician since August of 1997, but he was a urology technician from 1989 to 1997 during which time he had responsibility for the HSC and the Miller Centre. Around 1995 the St. John's Health Care Corporation took over all the hospital sites and, therefore, emergency calls from St. Clare's Hospital also became the responsibility of urology technicians.

Commenting on the shaving of patients, Mr. Porter said that he has done that task for heart patients on 5 South A, but not for urology patients. Around 1993/94, there was a change in protocol for prepping patients – the procedure ceased in cardiology and urology. The procedure is now performed by OR staff in cardiology. Mr. Porter believed that the nursing staff on 4 South B consisted of all females during his tenure. Care for the male patients consisted of 90% catheterizations (all on the floor) and special procedures (assisting doctors) and 10% dressings.

Mr. Porter recalled that a female urology technician worked full time for 2 or 3 years. She was not scheduled with him on an ongoing basis, but occasionally they were scheduled on side-by-side shifts. Mr. Porter testified that she did shave preps on male patients from the nipple line to the knees and never did he hear male patients tell him that they did not want her to do their

catheterizations or dressings, etc.

Since urology technicians develop a knack for performing male catheterizations, he would only now and then encounter one he was unable to do, in which case he would not force the tube and would contact the urologist. This happened very infrequently. In his opinion, such difficulties could be handled the same way by females as well as males.

Mr. Porter confirmed that the male only requirement was introduced after he left the urology department. He said that patients can become anxious about catheterizations even after experiencing them for a couple of years. In his view, the patient's anxiety level depended on what he was being treated for, not his age. If patients became anxious, his approach was to explain the procedure fully as well as its medical benefits and consequences. Some patients would refuse the procedure altogether, in which case he would assist them with deep breathing techniques he learned in LPN training for all types of anxiety.

In cross examination, Mr. Porter explained that he had not been the female technician's shift partner and would not have known about any complains made about her. He also agreed that, unless the matter was covered in report, he would not have known whether she had to call the urologists. There were no meetings or formal discussions between the urology technicians and the urologists. Since the urologists would not normally discuss such matters with the technicians, he would not have known if patients had been refusing the female technician. Based on his own experience, no patient has ever said to him that they would prefer a male provider. Therefore, he has no evidence that males are preferred over females. Mr. Porter indicated that, although the female technician may have experienced work related issues, he could not say that those issues had anything to do with her gender.

In redirect examination, Mr. Porter said that he had the same amount of contact with the female technician as any other technician except for her shift buddy.

In answer to the arbitrator's question on the predominantly male environment that existed during his tenure, Mr. Porter said that this was the way it was when he went to the urology department and there was not much discussion on the matter, and only briefly when the female technician started work.

Ms. Rita Butler

Since grieving on March 17, 2000, this was the first opportunity for Ms. Butler to voice her concerns formally. The long hiatus clearly did nothing to quell her consternation over the whole affair, and having listened to the testimony of all the witnesses at the arbitration hearing, she was more than anxious to take issue with the Employer's initial decision and some of the evidence presented. In these circumstances, her patience and restraint has been admirable and her continuing upset is understandable.

The grievor is an accredited LPN and was so at the time of the grievance, having graduated in 1990. In her view, her pre grievance qualifications (stated in RB#1) were at least equal to those of any other LPN who might have applied for the permanent position in dispute, and she was also considerably more senior than the male LPN who was ultimately declared the successful candidate. To demonstrate the profound effect that the Employer's decision has had on her career, Ms. Butler recounted the series of employment misfortune that has befallen her since her application was rejected. Unfortunately, since this part of her testimony was made rather quickly, I was not able to capture all of it by longhand. However, while I may have missed some of the detail and the sequence of the events, I can say without hesitation that I have missed none of the significance.

On 7 West, Ms. Butler was responsible for the total care of 4 - 6 male and female patients (average age 40 - 60 years) who were admitted for cardiac catheterization. Initially, there were no male RNs and only one male LPN on 7 West; now the LPN is gone. In the fall of 2003, Ms. Butler

was called by Human Resources and told that her job was being declared redundant. Therefore, she decided to bump to 7B - Rheumatology and Stroke. In less than one year she was laid off again. After one year in Obstetrics, she applied to bump into the Veterans' Pavilion at the Miller Centre. She was there for 7 months when she was called by Human Resources who said that she was being bumped out. Then she successfully applied for a job on the Rehabilitation Unit at the Miller Centre. Human Resources later offered her the job of patient care attendant in the emergency department, a position in which she experienced no respect. Therefore, she took a job on 2 North and was there 4 months when a full time temporary job opened up at the Veteran's Pavilion. Ironically, that vacancy came about when a male LPN at the Pavilion with less than one-third of her seniority left for orientation as a urology technician. Ms. Butler is now temporary full time at the Veterans' Pavilion.

Ms. Butler testified that she has done catheterizations on males (young to geriatric patients) on the Rehab Unit. She was trained by the education department and has been performing male catheterizations ever since 1990. In her view, she performs the full scope of the LPN practice. Ms. Butler stated that the responsibility for total patient care in an acute care setting does not require male providers. If a procedure is required to be done on a male patient, it has been her practice to do it. She recalled that she once had a 29 year old male patient on the Rehab unit who refused all the male LPNs. Sometimes it was possible to accommodate him with a female, but sometimes accommodation was not possible. When that occurred, the other LPNs simply dealt with the situation.

In 20 years, Ms. Butler said she never had a male patient refuse her. In her view, this has been because of her professionalism. In other words, by the time all the talking is done, she has completed the procedure. She agreed that patient anxiety is part of health care – most people realize that medical procedures must be performed and that it does not matter if a male or a female

does it. In this regard, Ms. Butler indicated that she attended a stress relief conference which was held at the Veterans' Pavilion.

The urology technician position she was denied in 2000 was the first permanent position she was able to apply for. In August of 1999, she applied for a temporary urology technician position and was offered the job. When Human Resources called her to offer that job, she was told that they required an answer immediately. Since she had no time to think about it, she declined. In hindsight, she felt that had she accepted the temporary position in 1999, there would have been no issue to arbitrate at this time.

Ms. Butler testified that nobody told her that lengthy discussions had taken place on the gender issue, and she did not know that the position would be later declared male only. During her telephone conversation with Kelly Monaghan, she learned that the Employer had to do research in order to make the position male. Ms. Butler was incredulous that she was being told that she could not do male procedures which she has been doing successfully for 20 years.

Taking issue with Mr. Flight's testimony on privacy and who was in a room when a patient was accompanied to the HSC, Ms. Butler testified that, on January 11, 2007 (i.e., last month), she brought a male patient to the urology clinic where Gerard Holden did a catheter change. The patient was big man. Ms. Butler undressed him and stayed while Mr. Holden did the catheter change. After Mr. Holden left the room, she remained and dressed the man. In Ms. Butler's view, if one escorts a patient, one is responsible for staying with him as part of a one-on-one relationship.

Mr. Flight was the one who got the permanent urology technician position she was denied. In Ms. Butler's view, the older urology technicians are very old school, i.e., they have a boys' club which she can't join. However, the newer technicians think differently. (This information was given to her by a technician and is considered hearsay evidence). In her view, there is absolutely no valid reason that she could not do that job; she was rejected simply because she was not male. All the

Employer witnesses indicated that the majority of the urology technicians' job is catheterizations, which, in her view is what she has done and can do.

As for the issue of scheduling, Ms. Butler's position was that 95% of the scheduling in the urology department is self-scheduling. In other words, for a six week scheduling period, the staff have a choice to put in the days or nights they want. That way staff members can accommodate their family life. Ms. Butler testified that in 20 years she has never needed back up. Whenever she has taken a position, she has simply fit the required schedule and has done her job.

Ms. Monaghan made mention of obstetrics in her testimony. On that subject, Ms. Butler indicated that there were males in the class last year and one of them taught her patient how to breast feed. In other words, he was assigned the same duties as the females in the class. Also there are male and female doctors in obstetrics and they do what they have to do.

Gerard Holden testified that a woman can do the procedures on males, but she should not do so. Yet last summer he taught both female and male LPNs at the Miller Centre how to perform catheterizations. In Ms. Butler's view, this demonstrates that females can do male catheterizations at the Miller Centre and at St. Clare's Hospital, but Mr. Holden thinks they should not do the same procedure in his department.

It is evident from Dr. Drover's testimony that he did not even know what was happening on this matter until Eastern Health called him late last year. Also, none of the articles he introduced dealt with urology.

It is also startling that Ms. Sullivan was not aware that Ms. Butler had been offered the urology technician position on a temporary basis just months earlier. Her evidence was also that it was not the doctors who wanted males only, it was the group of male technicians who did so.

Mr. Flight testified that 80% of his job was catheterizations and catheter maintenance. Yet that is essentially the same as Ms. Butler does in providing total care to her patients. If a patient

needs a certain procedure, the gender of the provider is irrelevant. Being able to accomplish a procedure successfully is solely a matter of the provider's professionalism.

Ms. Butler asserted that, during her career, she has never had a problem adjusting to any job on any schedule she has been assigned. She has been placed on shift work schedules as required.

In cross examination, Ms. Butler testified that she moved to the Veterans' Pavilion from the Rehab Unit in October 2006. She stated that, In the DVA, she is providing full catheter care to males, including flushing, changes, irrigation and insertions. She explained that the patient she escorted to the urology clinic had to see the doctor for bleeding. She also indicated that a catheter can stay in for 7 weeks. Therefore, insertions occur every 7 weeks on her floor. She agreed that the frequency of catheterization is not as high on her current floor, but she reiterated that not since September 2006 have urology technicians come in to perform catheterizations on patients in the Veterans' Pavilion.

In Ms. Butler's opinion, policies and procedures of particular institutions determine who does what procedures. For example, as an LPN, she can administer morphine to patients at the Miller Centre, but she is not permitted to administer an aspirin to patients at the HSC.

Ms. Butler agreed that it is possible that the occasional specialty procedure might be performed by a urology technician on her floor, but she would call the nurse in charge if she encountered difficulty with a patient; she would not call the urology technician.

In Ms. Butler's view, the entire Eastern Health Care system is subject to total patient care, which is provided by females as well as males. She recalled that she worked at St. Clare's Hospital from 1988 to 2003, but never on her floor (medicine) was a urology technician called to perform a catheterization. In fact, she was aware of only once in 12 years that a urology technician had to be called.

### Rebuttal Testimony of Sharon Nolan

Ms. Nolan testified that she has been the division manager for the Veterans' Pavilion for four years. Previously, she was clinic co-ordinator at the HSC and St. Clare's. She has been the grievor's manager at the DVA since 2006 and she had also been her manager at St. Clare's. She described the DVA as consisting of two units, each providing long term care to veterans (predominantly male) with an average age of 81 years, 60% - 65% with dementia. Currently there are 26 beds which is home for 22 residents, 2 of them women. There is a 1 - 4 staff/resident ratio and the main focus is on their ability and providing them with optimal independence.

Total patient care is provided at the Pavilion. One person cannot do everything. Because aggression is sometimes encountered, and baths, etc., also require extra help, two staff members may be on shift. Ms. Nolan said that are currently three residents who have permanent catheters, one super pubic and two otherwise, which are changed every 2 - 4 weeks by urology technicians, not regular LPN staff. Historically urology technicians had been called to do male catheterizations at the Miller Centre where Rehab unit patients, many with special conditions caused by injuries or strokes, etc., were catheterized by the technicians every four hours. On August 2006, the staff were advised that urology technicians would no longer provide regular catheterization services at the Miller Centre, but the Veterans' Pavilion was specifically excluded from this change. In other words, in future, the urology technicians would not perform routine catheter care on Rehab unit patients (a different type of patient from those on the HSC urology floor). However, they would continue to provide catheter care service to the long term elderly residents in the Veterans' Pavilion.

Ms. Nolan said that residents of the Pavilion are long term and, where catheters are required, they are changed every two weeks to a month. Currently there are three in one unit and one on the other unit who require that service. For example, Ms. Nolan testified that a urology technician was called to perform an in and out catheterization yesterday. Regular irrigation and

flushing of existing catheter tubes (but not insertion) is done by nurses on the unit. In Ms. Nolan's view, there is no such thing as a routine catheter in the Veterans' Pavilion because there are so many types involved. Essentially, catheters are changed by the urology technicians, but catheter care (flushing, cleaning, etc.) is provided by nursing staff.

In August 2006, the Program Director sent out an e-mail (see SN#1) to all units at the Miller Centre stating that, due to increasing workloads and the rising costs of taxi transportation, urology technicians could no longer be able to perform routine catheterizations at the Miller Centre and, therefore, such procedures (which are within the scope of RN and LPN practices) would be assumed by nursing staff, who also had been further trained by urology technicians to perform male catheterizations. As a result of this information, the subject was on the agenda for and was discussed at the September staff meeting (see minutes SN#2 and SN#3) where the exception for the Veterans' Pavilion was explained, i.e., staff were specifically told that nursing staff would not be doing routine catheterizations in the Veterans' Pavilion.

Ms. Nolan also explained that, while patients give global consent for medical procedures to be performed on them, many in the Veterans' Pavilion have mental capacity problems and are unable to verbalize effectively. In such cases, if a patient struck out at a staff member, the assumption was that he did not want the procedure done.

In cross examination, Ms. Nolan testified that no LPNs are supposed to do flushing or irrigation of catheters on the Veterans' Pavilion. The urology technicians are responsible for those procedures. However, on the Rehab units, LPNs did do male catheterizations prior to August 2006. Ms. Nolan said that DVA catheterizations have always been considered different because of the specialized training required and the historical assignment of urology technicians. In her 30 years of nursing experience, Ms. Nolan had never done a male catheterization. She also conceded that she had no previous involvement at the HSC in clinical issues in urology and therefore had no

knowledge of any previous female urology technician.

## ARGUMENT

### The Employer

In support of its various positions, the Employer submitted the following:

1. *Human Rights Code* R.S.N.L. 1990, c.H-14;
2. *Re Newfoundland Association of Public Employees v. Newfoundland (Green Bay Health Care Centre)* [1996] 2 S.C.R. 3;
3. *Re Ontario Human Rights Commission, et al. v. Borough of Etobicoke* (Feb. 9, 1982), 132 D.L.R. (3d) 14, S.C.C.;
4. *Re British Columbia (Public Service Employee Relations Commission) v. British Columbia Government and Service Employees' Union (B.C.G.S.E.U.) (Meiorin Grievance)* [1999] 3 S.C.R. 3;
5. *Re St. Boniface General Hospital and The Manitoba Association of Health Care Professionals* (1992), 32 L.A.C. (4<sup>th</sup>) 217 (Baizley);
6. *Re McKale v. Lamont Auxiliary Hospital and Nursing Home (District No, 23)* [1987], 37 D.L.R. (4<sup>th</sup>) 47 (Alberta Court of Queens Bench);
7. *Re Newfoundland (Green Bay Health Care Centre) and Newfoundland Association of Public Employees (Local 3201)* (1989), 6 L.A.C. (4<sup>th</sup>) 81 (Alcock);
8. *Re St. Boniface General Hospital and United Food and Commercial Workers Union, Local 832* (1995), M.G.A.D. No. 64 (Teskey);
9. *Re British Columbia (Public Service Relations Commission) and British Columbia Government and Service Employees' Union* (2000), 94 L.A.C. (4<sup>th</sup>) 275 (Lanyon);
10. *Re Stanley v. Canadian (Royal Canadian Mounted Police)* [1987], C.H.R.D. No. 3 (Elliot);
11. *Re Ronald C, MacGillivray Guest Home Corporation and Canadian Union of Public Employees, Loc. 1562* (2004), 128 L.A.C. (4<sup>th</sup>) 225 (Veniot);
12. *Re Board of School Trustees School District No, 42 (Maple Ridge/Pitt Meadows) and Canadian Union of Public Employees, Local 703* (1993), 33 L.A.C. (4<sup>th</sup>) 63 (Munroe);

13. *Re McGill University Health Centre (Montreal General Hospital) v, Syndicat des employes de l'Hopital General de Montreal* [2007] S.C.J No. 4;
14. *Re Central Okanagan School District No. 23 v. Renaud* [1992] 2 S.C.R. 970;
15. *Re Queen Alexandra Hospital and Hospital Employees' Union* (1977), S.C.C. AAA No. 734 (Gordon)
16. Mary E, Saunders, Q.C., *Gender Issues in Arbitration: A Management Perspective*. (1991) 1 Labour Arbitration Yearbook, pp. 133-141.

The Employer conceded that, since it posted for a male only position and rejected the grievor on that basis, a *prima facie* case for discrimination has been made out. However, the secondary question is whether the Employer has access to and has made out a BFOQ for the position of urology technician in these circumstances.

The job posting describes the required duties as providing care to patients with genitourinary problems in association with a urologist. In other Canadian centres, such care is provided by urology Residents and Interns, but since there are no urology residents within the Eastern Regional Health Authority, this service is performed by urology technicians. The evidence reveals that extremely intimate catheterizations for males accounts for 65% - 79% of urology technicians' duties. Other duties involve scrotal and penile dressings, bladder irrigations with a catheterization component, education and counselling, and assisting doctors in medical procedures. This service is provided on all floors of the HSC, including the urology floor, and some is provided on an on call basis to St. Clare's Hospital, the Miller Centre, Waterford Hospital and other HSC departments. The urology technicians carry pagers and they support the urologists in their clinics and in surgical day care.

All patients requiring urology care as their primary focus come to the HSC, which is the urology centre for the Province where the relevant patient population is male with extremely few

exceptions. The HSC is the only place in the Province where complex urology cases are referred. Nowhere else are there urology technicians like those employed by Eastern Health.

Dr. Drover said that, for particular anatomical reasons male catheterizations are more complex and completely different from female catheterizations. He also indicated that the majority of patients involved are 55 and older. Therefore, the issue being grieved is whether the grievor's rejection because she was not a male was a BFOQ.

It is the Employer's understanding that it is common ground between the parties that the Employer has access to the BFOQ defence under the collective agreement. Therefore, the Employer proposes to only briefly canvass the law on that subject. Afterwards the Employer will move on to the issue of whether there is a BFOQ on the basis of the facts presented – the framework for that analysis will be the tests in the *Meiorin* decision in 1999. The Employer submits that it has shown by the evidence that there was a BFOQ for the urology technician position. Therefore, the second part of its argument will be 1) that the Employer adopted the standard for a purpose rationally connected to the performance of the job; 2) that the Employer adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of a legitimate work-related purpose; and 3) that the standard was reasonably necessary to the accomplishment of that legitimate work-related purpose; and to show that the standard was reasonably necessary, the Employer has demonstrated that it was impossible to accommodate individual employees sharing the characteristics of the grievor without imposing undue hardship upon the Employer.

As a preliminary comment, the Employer pointed out that gender has been successfully argued as a BFOQ in relation to the provision of intimate care and also to testing in hospitals and residential care settings. In that regard, it is fair to note that each case turns its own particular facts. Gender has been successfully argued in cases where there is a negative, therapeutic or clinical

outcome if same gender service is not provided. As a corollary, that brings to play the negative legal outcomes and associated issues.

The second area in which gender has been successfully argued is where there has been an affront to the dignity, privacy and decency of a resident. For cases in which a BFOQ was argued, see 1) *St. Boniface General, supra*, a 1992 Manitoba pre-Meiorin arbitration decision, in which a male applicant was denied a senior technologist position involving the performance of diagnostic mammograms; 2) *McKale v. Lamont, supra*, a 1987 Alberta appeal decision which found that the selection of a male for the position of nursing attendant was based on a BFOQ; 3) *Re Green Bay Health Care Centre, supra*, a majority 1989 arbitration board found that the selection of a male for the third personal care attendant position was justifiably based on a BFOQ; 4) *St. Boniface General, supra*, a 1995 arbitration decision in which the chairperson upheld the awarding of nursing assistant II positions on a gender specific basis and 5) *Re Queen Alexandra Hospital*, a 1997 arbitration decision referring the matter back to the employer for a fresh determination which would include reasonable attempts at accommodation, by the Employer, the Union and the employees affected.

The last part of the Employer's argument would be in the alternative. The Employer very much felt that on the evidence and the congruency with legal authorities, the BFOQ of being male has been established in these circumstances. But should the arbitrator decide that the Employer has failed to discharge its onus in any part of the required test, the Employer submits that the appropriate remedy should not be to place the grievor in the disputed position. Other appropriate remedies have been rendered among the case law as proper remedial responses where there has been absolutely no discussion about accommodation with the three parties who are responsible for accommodation.

Issue No. 1: Did the Employer have access to the BFOQ defence under the collective agreement?

The Human Rights Code is central to the resolution of this grievance. Section 9.(1) addresses discrimination in employment. Among other things, it prohibits discrimination on the basis of sex. However, that

... does not apply to the expression of a limitation, specifications or preference based on a good faith occupational qualification.

The grievance alleges violation of Article 4 of the agreement, which does prohibit discrimination on the basis of sex and does not make mention of a BFOQ exemption. Neither is there any mention in Article 15.02 -- Information on Postings. However, Article 31, which is also alleged to be violated, while not specifically mentioning BFOQ, does state that

All provisions of this agreement are subject to applicable laws now or hereafter in effect....

In the Employer's view, the effect of Article 31 is to make Article 4.01 and 15.02 and any other relevant clause in the collective agreement subject to the provisions of the Human Rights Code, including Section 9.(1) which provides for an exception to discrimination on the various prohibited grounds where a BFOQ exists. Effectively then, the collective agreement provides the Employer with access to the BFOQ defence expressed in the Code.

In support of this argument, the Employer referred to *Green Bay Health Care Centre, supra*, in which the collective agreement also contained similar job posting and discrimination provisions which made no reference to a BFOQ. The SCC rejected the notion that the parties could not contract out of the BFOQ provision of the Human Rights Code. At para. 16 the Court states:

An initial point to consider is the argument that, since the job posting made no mention of the requirement that the applicant be male, the respondent is precluded from putting the requirement forward as a BFOQ. In my opinion, this argument fails. The posting of the position merely sets out the technical requirements for application and cannot be the basis to demonstrate that either the parties contracted out of the Code or that the employer is estopped from relying on the BFOQ provision

Essentially the Court found that the collective agreement was consistent with the Code and that the parties were also free to add more protection against discrimination than the legislation provides

without offending the policy behind human rights legislation. Also at para. 38, the Court found:

Another way of reaching the conclusion that the parties did not preclude application of the BFOQ to the collective agreement is by examining the definition of discrimination in the collective agreement. In determining what the parties meant by prohibiting “discrimination” one must refer to the definition of discrimination which prevails in Newfoundland, namely, that found in the Code. This definition incorporates the concept of BFOQ, pursuant to s.10(1). Parties may contract for more protection than the “base” of the Code, for the reasons stated above. Without more, however, it cannot be said that the parties intended to alter further the prevailing definition of discrimination from that found in the Code.

Since the instant collective agreement does not materially differ from the one in *Green Bay*, the Employer relies on the conclusions of the Court above in arguing that access to the BFOQ can be found on a reasonable reading of the agreement. Although there might be interpretive issues arising out of the job posting itself, the parties agree that the issue in dispute is the BFOQ.

Has a BFOQ been established on the basis of the facts presented?

As indicated earlier, *Meiorin* contains the three-step procedure for determining whether a *prima facie* discriminatory standard is a BFOQ. On the balance of probabilities, the Employer may justify the standard by establishing:

*Step 1: that the Employer adopted the standard for a purpose rationally connected to the performance of the job*

At para. 58 of *Meiorin*, the Court held that:

. . . Where the general purpose of the standard is to ensure the safe and efficient performance of the job – essential elements of all occupations – it will likely not be necessary to spend much time at this stage. Where the purpose is narrower, it may well be an important part of the analysis.

In the Employer’s view, the general purpose of the standard here is patient safety (with some legal concerns), as well as patient dignity, privacy and ethical concerns. These aspects may be found in policies and mission statements, but may also be found in the surgical care Objectives submitted in C#7, which apply to the care of urology patients. Of particular relevance are items 1, 2 and 6,

namely:

1. To provide a high quality of patient care and services by educated Nurses and Urology Technicians with the necessary knowledge and skills to anticipate and contribute to the physical, psychological, emotional and spiritual needs of the patient.
2. To insure as safe an environment as possible for the patient while under our care by applying our technical knowledge and skills and the principles of asepsis.
6. To establish a rapport with the patient which will instil confidence and reduce anxiety, thus alleviating many of his fears.

In the Employer's view, the importance of patient safety cannot be overemphasized. In this case, the 2000 job posting for a male only urology technician was necessary in order to meet the foregoing safety and efficiency objectives.

On a reading of the relevant law, the Employer submitted that, depending on the facts of a particular case, the evidence required for proof is somewhat fluid. For example, impressionistic evidence is not permitted as is indicated in *Etobicoke, supra*. While that case may be considered a little old, it is often cited by later cases on the evidentiary standard required. While scientific evidence is not necessarily required, some persuasive evidence is necessary. In that regard statistical and medical evidence based on research or observation is persuasive. The Employer submits that the Supreme Court of Canada in *Etobicoke* provides authority for that position. Other cases also speak to this issue. For example in *Green Bay*, the arbitration board stated at page 17:

With respect to the objective test, we are satisfied that the Employer has offered more than the mere "impressionistic" evidence offered in the *Etobicoke* case. While we share the same concern as the court did over what may be characterized as "scientific evidence", we are none the less satisfied that something more than general assertions and unsubstantiated expressions that a male is desirable is required to discharge the employer's burden of proof.

....

On balance, we find that the evidence before us is medically based and consists of observable adverse manifestations of emotional and physical well-being on the part of the male residents. We are satisfied that this is much more than mere

“impressionistic” evidence....

In that case, the board accepted the observations and experiences of the professional people who testified rather than requiring scientific research and statistical precision. As far as fluidity of evidence is concerned, it appears to be more clear what evidence is not acceptable, e.g., impressionistic or speculative evidence, as opposed to the type of evidence that is acceptable. In *McKale* at p. 10, Picard J. said:

With regard to the claim of an auxiliary hospital patient for intimate care by a member of the same sex, there ought to be evidence on the following points:

1. the claim, or demand or stated preference
2. the manner in which it is made
3. policy or systems to deal with such claims
4. consequence to a patient both physically and mentally of failing to deal with the claim
5. consequences to staff of failing to deal with the claim

Citing the objective aspect of the *Etobicoke* case with approval, Picard J. found on page 11 that

My conclusion upon applying the objective test to the evidence is the same as that of [*Etobicoke* ], but it is more broadly based. I conclude on all of the evidence that the claim by a patient in an auxiliary hospital for intimate, personal care to be given by a nursing attendant of the same sex has a basis in his contract with the institution, in public expectations and is reasonable in the opinion of experts based on their research and experience in the area. The claim must, so far as possible, be met by the respondent not only to assure the efficient and economical performance of its job but to fulfil its obligations to the patient to treat him with respect and dignity.

I find that the respondent's selection of a male for the position of nursing attendant was based on a bona fide occupational requirement pursuant to s. 7(3) of the Individual's Rights Protection Act. Unlike the Chairman, I find that in this case the occupational group is composed of all nursing attendants. All that I have said supports the need to allow for adaptability of an institution to reflect the nature of its patient population and their needs.

In the Employer's view, it has provided sufficient objective evidence on the five (5) points listed in *McKale above*. In regard to point No. 1, expert testimony and evidence of refusal has been adduced. On point No.2, the urology technicians and Dr. Drover testified on the manner in which patient preference is manifested. On point No. 3, the systems or policy to deal with such claims was explained by Ms. Nolan's evidence that, when patients object to someone of the opposite sex,

accommodation of their preference is sometimes attempted but not always provided. Also the evidence of Dr. Drover and Dianne Sullivan explained that, in urology, there is a tendency to be gender sensitive. On point No. 4, concerning the consequences to a patient of failing to deal with his claim, Dr. Drover's testimony is particularly relevant. Finally, on point No. 5, i.e., consequences to staff, that is a matter which ultimately is subject to negotiation.

Taking the position that the Employer has hit the mark on the evidence adduced, counsel stressed that the Employer's evidence clearly established that a portion of the male urology patient population will and do prefer same gender care. It has not been suggested in any way or at any time that the entire male patient population serviced by urology technicians prefers male care. However, a portion of male urology patients decidedly do prefer males particularly to perform their catheterizations, which, on the evidence, constitutes the vast majority of the technicians' duties. Secondly, faced with a gender that is not their preference, those patients do become anxious. Thirdly, anxiety is a risk factor which may lead to adverse outcomes during male catheterizations.

In respect of the portion of the population who prefer that males perform any of their particular catheterizations, Dr. Drover testified that he searched for studies dealing with urology technicians and studies dealing with that topic, but he found none. However, he did not consider that surprising because the position of urology technician at Eastern Health is unique. While people call themselves "urology technicians" at some other institutions, they do not have the same job duties as those employed at Eastern Health. Given the absence of publications regarding relevant urology technicians, Dr. Drover referenced a number of articles on gender preference that were available from other areas. From DD#2: Do Women Prefer Care From Female or Male Obstetricians?, he learned that women did have a gender preference and that 33.5% had a gender bias, of which 80% had a bias for a same sex provider. It was his expert opinion that he would expect the same type of result from male urology patients. DD#3 – Gender Preference Called

Barrier to Colonoscopy for Women, indicated that University of Michigan researchers have found that “some women prefer to delay or avoid colonoscopy if they aren’t sure the procedure will be done by a female doctor.” Dr. Drover explained that a colonoscopy is a very invasive procedure and that he noted in the article that 43% women said they would prefer a woman endoscopist and 5% said they would not have the procedure at all. This is generally consistent with the Employer’s position that there is a preference among male patients, but there is a spectrum of preference. Dr Drover also testified that, in his expert medical opinion, patients do not refuse a procedure each and every time they are anxious. Rita Butler also testified that there is a certain amount of anxiety associated with procedures and that people do not refuse them very time they become anxious. Therefore, the Employer submits on the evidence presented that it is appropriate to say that there is a patient preference, which in some people, albeit a significant minority, manifests itself as a refusal. But that is not to say that there are not others who are anxious and also have a preference for same gender care.

With respect to the refusal issue, i.e., to patients for whom failure to provide their gender preference is a complete barrier to the procedure, both Gerard Holden and Rodney Flight spoke to experiences when a female provided catheter care. Mr. Holden worked with the previous female technician only when there was overtime. He testified that there were a couple of instances where a patient refused to be catheterized by the female technician. He also testified that he had conversations with the female technician regarding males who said they did not like her being around. Rodney Flight, however, worked the opposite shift to the female technician’s shift, meaning that they had the same patients but on different shifts. He testified that two patients refused to have anything to do with the female caregiver, and in one case a patient refused to drink water and was taking pain medication so that he would not have to be catheterized by her. Counsel submitted that the evidence of the Union’s witness, Steve Porter, with regard to his experience with the previous

female urology technician, should be given little weight because he was in limited contact with her and also because, by his own admission, he would not have been in a position to be aware of or know of any problems with her.

In the result, it is submitted that, in regard to the issue of there being a portion of the male patient population having a gender preference that, if not fulfilled, causes them anxiety, which in its extreme manifestation causes them to refuse a procedure. It is not fair to conclude that, because only a couple of instances of refusal have been discussed in evidence, that this is the entire extent of the issue. The Employer's position is that the evidence indicates that the extent of gender preference is much greater and that, faced with a gender that is not their preference, those patients would become anxious.

Dr. Drover testified that psychology affects physical outcomes and that, in his medical opinion, a male urology patient faced with a gender not his preference will become anxious and will be affected by problems associated with the procedure. On the basis of his own experiences in the urology department, he talked about patients who did not want persons of the opposite gender in the room, in which cases, those persons would be asked to leave. On the issue of the requirement to prove the relationship between the gender of the person performing the procedure and ensuring that the patient is relaxed, counsel referred to two cases which are directly on point. First is *St. Boniface General Hospital* (1992) at para. 35, where the arbitration board stated:

The question that cannot be answered, either by evidence such as a survey of the type the Hospital undertook, or the experience of health care professionals who work in the area, is exactly what the relationship is between gender of the technologist and ensuring that patients sufficiently relax to ensure diagnostic results. In our view, this is not a matter which must be proved, given the other facts established and the potential risk involved.

The potential risk in *St. Boniface, supra*, was not achieving a proper diagnostic mammogram result. In the case of male urology patients at Eastern Health, the potential risk is patient safety, i.e., possible physical damage due to the increased level of anxiety caused by catheterization performed

by a person whose gender is not the patient's preference. Similarly in *Stanley*, a 1987 Human Rights tribunal decision, at p. 30 the chairperson wrote:

. . . One does not require expert evidence to know that being observed in states of undress or using the toilet by strangers of the opposite sex would cause embarrassment and a loss of dignity to anyone, including a prisoner, who has been raised in the belief that it is something to be avoided. In this case expert evidence was given on this issue, and while the evidence of the experts was not consistent as to the degree to which being viewed in states of undress or using the toilet by a female guard would accentuate the stress experienced by a typical male prisoner in a lock-up, all but one agreed that there would be some accentuation.

As far as people's reaction to matters of intimacy is concerned, the procedures required to be performed by a urology technician are certainly no less intimate than those described above. Therefore, in the Employer's view, expert evidence is not required to establish the embarrassment, loss of dignity and anxiety experienced by male patients where an exceptionally intimate and invasive procedure such as catheterization is performed by a person other than their preferred gender.

Thirdly, anxiety is a risk factor which may lead to adverse outcomes during catheterization. Dr. Drover explained that the population of patients in question, i.e., male urology, are difficult cases. Counsel submitted that this is perfectly consistent with the evidence concerning the Miller Centre where, for reasons of urology technicians' insufficient staffing and time, routine catheterizations have been taken out of the mix. Urology technicians are directed towards a difficult patient population, one with complex urology issues. Mr. Flight and Mr. Holden both testified that it is difficult to insert a catheter when a patient is tense. The expert evidence of Dr. Drover is that from a clinical perspective, this issue is not debatable - - anxiety increases pelvic floor tension pulling everything up tight which, in turn, makes it more difficult to catheterize a patient on the first attempt. He said that by traumatizing a patient in subsequent attempts, the result may be a mess, e.g., possible permanent scarring, strictures of the urethra, pain, infection, bleeding and urethral rupture. Dr. Drover further testified that in regard to patient outcomes there is a responsibility to

avoid something that could result in negative outcomes. On this point, the Employer submits that the evidence supports that a female urology technician could (but not always because not every patient will react this way) result in adverse outcomes to patients. Dr. Drover also spoke to the fact that there were adverse outcomes when the female technician was there: there were verbal complaints that he was aware of and in his expert opinion there were more complaints involving the female.

Dr. Drover also stated that there is a responsibility to avoid negative outcomes. The legal implications of this type of thing is dealt with in *St. Boniface, supra*, at p. 53, viz:

... the second concept of the therapeutic or medical impact (an area in which, unlike general concepts of public standards, trained medical personnel do have particular expertise) must still be examined and determined. In our respectful view, if that is established, it is sufficient to set a BFOQ which is also sufficient to curb the normal operation of Article 16.03 and as indicated earlier then becomes a "qualification" under Article 4.13. We would suggest that, within the Hospital context, the appropriate balance of competing interests and rights has to be resolved in favour of the result that provides for appropriate medical care to the patients and their families.

The Employer submitted that the appropriate balance of competing interests in the instant case would have to be resolved in favour of enabling the Employer to continue to provide a safe and appropriate level of medical care to male urology patients. With regard to the corollary issue of safety, the legal implications are huge. Dr. Drover testified that, the urologists are put a difficult position because they have agreed on a risk factor that they cannot ignore. Numbers, statistics and probabilities may be discussed, but if the risk is realized and something happens to even one patient, that would not be acceptable. That is relevant to the legal issue. He stated further that the responsibility of the physician is to eliminate every possible risk. The Employer submitted that it has led the appropriate evidence to show that the posting was necessary to ensure patient safety and to ensure that legal issues were not unduly compromised. At page 38 of *MacGillivray Guest Home*, arbitrator Veniot states:

It does seem to me to be unreasonable and a hardship to this employer to be asked, in effect, to turn its principles inside out and force care by a female caregiver, to whom that resident objects, upon an unwilling patient.

It is clear from that remark and his subsequent comments that, what the arbitrator was dealing with was the issue of consent and the exposure of the Employer and the caregiver to legal liability. Consent not only goes to the issue of privacy, but also to the cost of protecting the security of the person. *MacGillivray Guest Home*, is a 2004 decision, which the Employer submits does shed some light on the importance of considering the legalities associated with safety and that it would be an undue hardship to force an Employer to expose itself to that sort of risk. On the evidence presented, it is clear that the Employer has proven that the posting for male only for the urology technician's position was necessary in part (there are obviously other reasons as well) to ensure the safety of the male urology patients at Eastern Health.

The other issue here is dignity and expectations. All of the procedures to be performed by urology technicians are very intimate and the patients are exposed. It is not uncommon to have intimate care within a hospital. However, the evidence provided by the urology technicians in this case demonstrated how the procedures they perform are not only intimate, they are invasive. For example, for catheterizations, the majority of their duties, the patient is exposed from the waist down and technicians are involved in holding a patient's penis in one hand for a couple of minutes to as long as 20 minutes all the while the patient's whole genital area is exposed. In the case of the other procedures they perform, such as packings, scrotal and penile dressings, patients could be exposed up to 20 minutes. And for cauterization of penile warts, exposure could be 10 - 15 minutes. In the case of patient counselling, that is not as significant as it once was, but there are occasions when the technician is required to check on patients who have been given a drug for erectile dysfunction and is expected to observe the state of their erections. Clearly, this kind of intimacy is much more sensitive and personal than other hospital procedures such as washing patients.

Mr. Holden's opinion was that there is no issue of females' ability to perform the required procedures, but he believed that they should not do so where male urology patients are concerned. In the Employer's view, he is correct. When he made that statement, Mr. Holden was referencing the nature of the tasks: urology technicians are involved in erectile dysfunction and urology issues, i.e., making water, voiding, urinating, etc. He also testified that, even male-to-male, patients make statements to him about their penises shrinking, an extremely sensitive and embarrassing admission, which, along with their attempts to cover themselves, indicates to him that males are more comfortable with other males. The Employer submits that, in the face of such sensitivity, it is not appropriate to expect those particular male urology patients to check their dignity at the door when they enter the hospital and be forced to have care provided by someone not of the gender they prefer. Mr. Holden also indicated that younger patients had issues with women caregivers, except in long term care where they have become accustomed to being cared for by mothers, spouses, and other female caregivers with whom close relationships by necessity have been forged. There is significant opportunity to establish rapport with opposite gender caregivers in long term care. Little or no opportunity to do so exists among male urology patients whose medical care is of a short term nature. Mr. Holden's experience was that 14 year old males are the most difficult to catheterize because they are most conscious of their bodies. Dr. Drover testified that he had gender preference experiences on a weekly basis with younger patients who exhibited anxiety, especially those about to have genital warts removed wanting nobody else but the doctor and the male technician in the room. Dr. Drover also testified that male patients to be scoped, do not want females in the room. In addition to younger patients, the Employer submitted that, especially where safety is concerned, one must also keep in mind the elderly group of male urology patients. Both groups have a gender preference issue depending on the nature of the procedure to be performed where the genitals are to be exposed. For those patients, the Employer must ensure that they are

not subjected to undue indignity.

With respect to scrotal and penile dressings, both involving intimate care, Dr. Drover stated that the gender preference issue there flowed from the fact the urology physicians and appropriate clinical staff do not want their patients to suffer and that this is inextricably connected to the patients' perception of what is appropriate. When the procedures to be performed on those males involve their genitals, they are in uncomfortable territory. Ms. Sullivan testified that, in her area, being aware of gender sensitivity means being aware of how it is manifested in patients' reactions to intimate procedures. For example, they often continually cover themselves with sheets or hands when exposed and they often make it known that they do not want females to come in the room. Both urology technicians testified that there was a significant issue of privacy and that they provided what whatever privacy they could depending where in the hospital (e.g., private vs. 4 bed rooms) the procedures were to be performed. Although the evidence is that some patients do not care, the evidence is also that a lot of patients act nervous and agitated and blush – they do not want to be naked in front of somebody else, especially where the far end of the spectrum of intimate procedures is concerned. Therefore, dignity has become an ethical issue for HSC providers. Dr. Drover testified that there is an increased responsibility on health care providers to be more aware of patient preferences and demands. In that regard, he referenced DD#4 article *Patient Choice of Provider Gender*, in which the author is adamant that gender bias should not be condoned, it should also be noted that the author made it clear that, when patients express a preference for a certain gender, physicians should focus on treating the patients, not on educating them. Dr. Drover further referred to article DD#5 *A Practical Approach to Catheter Associated Problems*, which essentially stands for the proposition that patients have a right to be catheterized by persons of their own sex.

Dignity, decency and privacy previously have been accepted as a basis for BFOQs in certain contexts. The case law on this issue may be found in *British Columbia (Public Service Employee*

*Relations Commission*, a 2000 arbitration decision, stating at p. 7:

However, given the nature of the services, the type of residents in terms of age, illnesses and backgrounds, the duties of health care workers and nurses, all these factors combine to make the **gender** of a worker a **bona fide occupational** requirement. Although they may not conduct admission showers, health care workers on midnight shift are required to check all residents in their room every 15 minutes, must supervise washrooms, teach appropriate hygiene habits, counsel residents, restrain residents when necessary for medication, check special observation residents every 15 minutes, teach socialization skills, ensure the safety and security of the residents and act as a role model.

. . . .

... I find therefore that the policy of gender balancing in scheduling is consistent with the practice and policy of the Youth [page 286] Forensic Psychiatric Services in ensuring that the service is “. . . child centred and respects the integrity, dignity and rights of the adolescence . . .”. Further I find that such gender balancing is consistent with the personal dignity and privacy of the residents.

This case clearly accepted dignity and privacy of the youth residents as justification for a BFOQ based on gender. Therefore gender balancing can be consistent with patients' dignity and privacy.

A second 1993 arbitration case on this issue is *Board of Trustees (Maple Ridge/Pitt Meadows)*, in which the arbitrator found that the employment of male only matrons carrying out a personal toileting function for two male adolescents who had expressed such preference, was a BFOQ for the position. The award states at pages 8 and 9:

. . . Was the “male only” requirement for Matrons carrying out personal toileting functions on these two handicapped adolescent boys, objectively view, reasonably necessary to assure the accomplishment of the objectives of the school in operating an integrated school for the purpose of meeting the [page 75] needs of the students on an educational, social, physical and psychological level?

Posing the question in that manner, we conclude that the answer must be in the affirmative, that is, in the circumstances at hand, the “male only” requirement must be found to have been a bona fide occupational qualification. In arriving at that judgement, we have considered the evolution of society's treatment of special needs students; the evidence of that evolution having found its way into established public policy; the growing appreciation by education professionals of the importance of the personal dignity of each of the individual students within their care and charge; the fact that the “male only” requirement on the disputed postings was not the automatic result of an abstract policy but rather was the consequence of the issue having arisen in individual circumstances individually considered; and generally, the

overwhelming impact of the evidence surrounding the development and personal circumstances of the two boys for whom the personal care by Matrons was needed.

Also in *Green Bay Health Care Centre*, the board found in the particular circumstances of that case that the providing of intimate care to elderly residents by males was a BFOQ for the position. This case is not only an authority on the proposition that the provision of intimate care to elder residents can be a BFOQ, but it is also on point on the issue of how the quality of care is received by patients, viz, at p. 18:

We are satisfied on the evidence before us that the residents' requests for male care were reasonably grounded in a qualification that would be necessary for the performance of the work. We do not in any way suggest that Ms. Howe or any other equally qualified female attendant could not administer personal care to males with full respect, dignity and decorum. We do suggest, however, that one factor affecting the quality of care is how it is received. To the extent that the male residents have demonstrated an inability to receive female care, being male is a necessary qualification for the caregiver. A situation analogous to this might be what transpires between the sender and the receiver in an attempt to communicate. The sender might well perform his part perfectly, but if something within the receiver prevents him from properly getting the message, then the communication has not been successful; at most it would be of inferior quality. That, we submit, is what happens with older male residents whose personal values and standards will not permit quality care to be achieved by a female, even if that care is administered by a competent, caring and sensitive woman.

In the case of the urology technician's position, there is no question that the grievor can do the job; she certainly has the ability to perform the required procedures. However, the issue is not how capable the urology technician is; rather, the issue is how the technician's care is received by the patient. Essentially this is a two part equation for the delivery of intimate care. Safe and successful care cannot be assured unless the patient has the ability to accept it properly. It is the Employer's position that, when it comes to the second part of the equation, i.e., how the patient population reacts to a female in this particular job in these particular circumstances, it is absolutely essential that a male perform the required intimate care procedures, particularly invasive procedures, upon male urology patients at Eastern Health HSC. For additional support on this point, the Employer referred to *McKale* and *Stanley* where gender was considered in matters of privacy.

Step 2: that the Employer adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of that legitimate work-related purpose

The Employer submits that this test has also been met.

Dr. Best's January 21, 2000 letter to Dianne Sullivan was written after the August 1999 temporary job posting and prior to the February 15, 2000 posting for a permanent, full time position. This letter contains a clear message from the urologists (the specialists in the area) to the divisional manager that they feel it is important for urology technicians to be male and also that it impacts upon patient outcomes and comfort. Dr. Drover's evidence essentially supports the message of that letter in that his testimony was that it was crucial for urology technicians to be male and that it does impact on patient outcomes and comfort. It is submitted that this letter is evidence of the Employer's good faith in posting for a male only for the position. This was the first time the concerns of the urology specialists were documented prior to a job posting. In the summer of 1999 when the position of temporary urology technician was posted and the job offered to the grievor, this process had started but had not finished. In counsel's view, to do nothing once Dr. Best's documentation had been received would have been irresponsible and bad faith of another kind. In other words, the Employer had no choice; once the urologists had drawn the Employer's attention to the problem, the Employer could not turn its back on the matter.

Kelly Monaghan testified to the issue of the change in qualification. She stated that she received it from the manager. She gave other examples within the corporation where the duties of a position had not changed but the qualification did, e.g., in specialized nursing areas such as the OR where the necessary skill level required two years experience to gain entry into the area. This demonstrates that changes do occur in other positions as a result of reviews on the particular circumstances of a position. Clearly, just because a job itself has not changed, there may well be other factors that would impact on the Employer's need and ability to change a qualification for the job. Dianne Sullivan testified on the process that was followed for the urology technician position.

She said that she had been approached by the urology technicians requesting that the position be made male only and that the urologists had been approached for their response to this request. Although there may be some disagreement about who approached whom first, counsel submitted that the matter not only occurred 7 years ago, but it is really irrelevant. At the end of the day, the important point was that the manager, the technicians and the specialists discussed the issue and they were all convinced that male only was a legitimate issue of sufficient concern to take the very rare step of posting the position as male only. Marilyn Nichols testified that clinical factors are one reason why qualifications change and that, when the request came to her based upon that reason, the decision was not made light heartedly. In fact, when Kelly Monaghan first received the request, she contacted Human Relations to confirm that the manager had presented clinical evidence to support the change or had the documentation for clinical evidence available. The Employer's representatives also discussed the case law and decided that, in light of *Green Bay* and the clinical evidence, the case for male only for the urology technician's position had been supported. This was confirmed by Dianne Sullivan's evidence. Ms. Monaghan's testimony also clearly indicated that a qualification review had been initiated but had not been completed in the summer of 1999 when the temporary position was previously offered to Ms. Butler. She noted that, at that time, clinical evidence was being considered and amassed and that the manager had not been given approval by HR. Marilyn Nichols also testified as to the internal discussions regarding the Employer's inability to post for male only in those circumstances and the need for clinical information from the manager. In light of this evidence, counsel submitted that it reflected the serious attention which the Employer gave the matter before making a final decision.

The foregoing demonstrates the Employer's recognition that the groundwork had to be done before a male only posting could take place. It is significant that the position in 1999 was temporary and the request for male only was not accepted at that time. To claim that there was no issue at that

time is speculative and not supported on the evidence. Further, there was no need for the Employer to consider whether or not it could accommodate the grievor at that time, or whether a female could perform the job.

There were some discrepancies between the reasons given by Kelly Monaghan in her e-mail to Rita Butler concerning her reference to testing and her testimony that she meant catheterization procedure. But as Ms. Monaghan noted, she is not a clinical person and she is not qualified to speak to clinical issues. Therefore, counsel submitted that very little weight should be given to that inconsistency. Ms. Monaghan also testified that accommodations were considered by the Employer before denying the position to Ms. Butler in 2000. For example, she indicated that it was considered whether a male could be hired to work with her, but there were concerns about the minimal amount of work available for an extra technician, as well as the financial hardship associated with having two technicians instead of filling the one position that was posted. Another point to be considered was Dr. Drover's evidence that, having identified that a female technician would create a risk factor, the urologists and the Employer were put in a difficult position such that the Employer was obliged to react responsibly to avoid that risk.

With respect to the issue of who does catheterizations at the Miller Centre, St. Clare's Hospital and the Waterford Hospital, the evidence shows that nursing staff at those institutions do routine catheterizations on non-urology patients. Ms. Colbourne's evidence was that the urology technicians are called to the Miller Centre where obstructions or prostate problems are encountered, because they are trained specialists in such matters. The same situation applies to the other hospitals where difficulties may be encountered during routine catheterizations or when a urology problem is identified. Ultimately, however, where the patient population is predominately male urology patients as is the case at the HSC, male urology technicians are the appropriate caregivers.

Ms. Butler testified that she currently performs catheterizations on her floor at the Veterans

Pavilion at the Miller Centre. That testimony was contradicted in reply evidence given by Ms. Sharon Nolan who said that urology technicians continue to perform the catheterizations on the elderly male patients at the Veterans Pavilion, however, due to staffing and time constraints, the technicians no longer perform routine catheterizations on the Rehab unit as they previously did at the Miller Centre. If this conflicting evidence must be settled as a matter of credibility, counsel submitted that Ms. Nolan's testimony should be preferred because she is not biased, has no motive and has nothing to gain. In contrast, Ms. Butler has everything to gain by her evidence. In the alternative, if the arbitrator does determine that this evidence can be reconciled, the Employer submitted that the arbitrator should find that the catheterizations in question are not daily catheterizations but are changed over a number of weeks. Also it was submitted that the Employer's position with regard to safety is not that there will be adverse events every time a catheter is changed. Rather from the perspective of developing an approach to catheterization, the Employer must be prescript, and that with certain patients --not necessarily those Ms. Butler deals with on her floor with whom she has opportunity to establish rapport as their caregiver -- that those patients outside that area can certainly feel anxious and that there would be increased risk to their safety when they have to be catheterized.

In the case of St. Clare's Hospital, Mr. Holden testified that there are no urology patients there and that catheterizations for non urology patients are straightforward. However, on occasion some patients might experience urology problems and those would be the ones for which a urology technician will be called. This is consistent with Larry Kelly's August 2006 correspondence to Miller Centre staff. At the Miller Centre, the evidence is that patients are long term and are more likely to have become accustomed to female caregivers who will be expected to look after them for the rest of their lives. This goes to the issue of rapport. Rodney Flight stated that the urology technicians' involvement at the Miller Centre is with patients who experience trouble with

catheterizations. Counsel submitted that this reflects the mandate of the urology physicians, i.e., to deal with people who have complicated catheterizations. As Dr. Drover indicated, where the male population being dealt with at the urology centre are more complex, the importance of reducing risk factors is much greater.

Basically here are two things to consider in comparing catheterizations at the HSC with catheterizations at the Miller Centre and at St. Clare's Hospital, etc. First, the population that urology technicians service are different. They have urological conditions that are more complicated and they are being catheterized in a different environment. Evidence was led that a urology technician typically spends a matter of minutes with a patient and that there is no opportunity prior to catheterization to establish rapport with the patient. In contrast, nurses or LPNs at St. Clare's or the Miller Centre spend hours with their patients on regular shifts and, therefore, have more opportunity to establish rapport. That is especially true with long term patients who have developed a comfort level with females providing every aspect of their catheter care. In those circumstances, same gender care is not likely to be an issue.

On balance it cannot be said that there were no issues when the female technician previously performed the position. Dr. Drover stated in cross examination that there were more than a number of verbal complaints about the female urology technician when she was there and that there were more problems with the female technician relating to strictures. In DD#6, his letter of January 2, 2007, Dr. Drover states at page 2:

We have had a female technician at the Health Sciences Centre previously and discussions between Dr. Best and myself affirm that there were many negative outcomes more so than we have had with male technicians.

Dr. Drover stated that females performing catheterizations was not an issue in urology until the instances of adverse outcomes were brought forward. After that occurred, it was not possible to ignore the matter.

In the result, on the issue of whether the Employer operated in good faith in changing the qualification, it is clear on the evidence that a process was followed, that there were clinical issues involved, that there was a multi-party inquiry and that there was a considered and principled approach as to how and where urology technicians perform this service. Therefore, it is submitted that the Employer has met the second Step as expressed in Meiorin.

Step 3: that the standard is reasonably necessary to the accomplishment of that legitimate work-related purpose; and to show that the standard is reasonably necessary, it must be demonstrated that it was impossible to accommodate individual employees sharing the characteristics of the grievor without imposing undue hardship upon the Employer.

In *McGill University Health Centre*, a 2007 decision of the SCC, the court stated at page 8 that:

The factors that will support a finding of undue hardship are not entrenched and must be applied with common sense and flexibility (*Meiorin*, at para.63; *Commission Scolaire Régional de Chambly v. Bergevin*, [1994] 2 S.C.R. 525, at p. 546; and *Central Alberta Dairy Pool v. Alberta (Human Rights Commission)*, [1990] 2 S.C.R. 489, at pp. 520-21). For example, the cost of the possible accommodation method, employee morale and mobility, the interchangeability of facilities, and the prospect of interference with other employees' rights, or of disruption of the collective agreement may be taken into consideration. Since the right to accommodate is not absolute, consideration of all relevant factors can lead to the conclusion that the impact of the application of a prejudicial standard is legitimate.

Marilyn Nichols and Dianne Sullivan testified to a number of accommodation scenarios. One of the first things looked at was the schedule, which immediately indicated that urology technician services were being provided by a very small pool of employees. The General Hospital Time Schedule (C#6) for April/May 2000 shows five UT Is, and one UT II, all males. If the grievor had been put in the disputed UT I position, there would have been four UT I males and one UT I female. Ms. Butler would not have been qualified for the UT II position. The UT Is covered 24 hours each day and 7 days each week, all on 12 hour shifts. The UT II worked 8-4, Monday -Friday. Although the situation is not the same today, at the time of the grievance in 2000, there would have been some week days

when two UT Is would have been on with the UT II because there was nobody available to provide relief. But there were many days when only one UT I was on, and on nights, weekends and holidays there was always only one UT I on shift and therefore, no backup was available from the UT II.

In 2007, there is one less permanent UT I position, but there are two casual employees to provide relief. Gerard Holden (the lead hand) testified that all days worked are not the same as far as this patient population is concerned. He stated that on any given day, 70% of the patients seen could be totally new, thereby making it impossible to know beforehand whether any of them had an issue with the required procedures being performed by a female. So, if the suggestion were to be made that the Employer should accommodate the grievor by assigning her to patients with lower risk or to those who have no issue with a female, there is no way that could be done because what will be faced on any given day is not sufficiently predictable. To the suggestion that she be assigned to the UT II position, the answer is that she does not have the requisite years of experience as a UT I to be qualified for that job.

The question next arises whether Ms. Butler could be accommodated by having back-up arranged for her. Dr. Drover's testimony was that a female urology technician presents a risk to patients, but he would not have a big issue with a female technician as long as there could be a qualified male available for back-up. When the scope of such back-up required is considered, particularly keeping in mind the Employer's submission that there is a spectrum of patient preference ranging from a very small proportion of patients who flatly refuse because of their anxiety to a larger proportion of patients who are anxious but go through with the procedure anyway (i.e., they may not refuse a procedure outright even though they are anxious), it is the Employer's position that, given the risk to patient safety, it is essential to understand that what the scope of the back-up would have to be in order to accommodate all of those patients.

When considering who could supply back-up, it has been suggested that it would be chaos if the Employer had to call for back-up every time a patient expressed a preference because a disruption would be caused to patient care. If the UT II was the back-up during his 8 hour shift Monday-Friday, and Ms. Butler was on a 12 hour shift like all the other UT Is, it would mean that for the remaining 4 hours of her shift she would have no back-up. Also, it must be realized that if Ms. Butler were to be placed only on the 12 hour day shift, the other UT Is would be required to work an increased number of night shifts. This would be a disruption to the rights of other employees under the collective agreement -- see Article 19.03 -- Rotation of Shifts:

The rotation of shifts shall be carried out in an equitable manner. Each employee receive at least seven (7) days of day shift in a month, provided he/she may waive this right.

Similarly, there would be a disruption to Article 17.03(a)(ii) – Twelve Hour Shift:

Employees shall receive a minimum of two (2) weekends off out of every four (4) weekends and the Employer shall endeavour to grant every second (2<sup>nd</sup>) weekend off, unless otherwise agreed by mutual consent.

Ms. Nichols testified that schedules are extremely important, even critical, to employees, and when it becomes a challenge to schedule them in accordance with their expectations, they apply to get out of their position because it has become unattractive. Therefore, retention would become a problem. A poor schedule is a very important consideration for the Employer where such a small pool of employees are involved. The substantial increase in the number of nights and weekends that the other UT Is would have to work in order to accommodate Ms. Butler's placement on day shift, would, in Ms. Nichols' opinion, adversely affect the Employer's ability to recruit for the urology technician position. When recruiting, the Employer must always state on job postings whether shift work could be involved (see Article 15.02 – Information on Postings). This is so because employees prefer day jobs. The Employer submitted that the importance of retention and recruiting for this position cannot be overstated. Dianne Sullivan said the training period for the position is 6 to 8

weeks and that it is important to retain experienced staff because one expects to see a progression towards a regular work load following the training period. Also Gerard Holden testified that it could take a couple of years for someone to become comfortable with the position. Furthermore, Dianne Sullivan said that employee morale would be affected by such schedule changes. Although that is not necessarily a determining factor in the law of accommodation, it is appropriate on an analysis of undue hardship to consider what the effect is on the morale of other employees. The Employer submits that, in a very small pool of employees, the effect would be considerable. While the factor of morale is not necessarily determinative of the whole issue, it certainly can be considered as far as undue hardship is concerned.

Ms. Sullivan's evidence is also that patients benefit from having experienced staff perform their procedures because their skill level is greater. In the Employer's view, not only are disruption to the collective agreement and morale factors valid considerations here, but to the extent that retention and recruitment may also be adversely affected, there is an inextricable connection to patient care. Patient care is an extremely relevant factor when considering undue hardship.

Further, if Ms. Butler were to be placed on a 12 hour day shift schedule, rather than an 8 hour day schedule Monday - Friday, back-up would not always be available after 5 p.m. on week days and not at all on weekends and holidays. Ms. Nichols said that it would have cost the Employer approximately \$20,000 annually to hire a male purely to provide back-up for the grievor in the event that a male patient objected to her performing catheterization procedures. In other words, this cost would essentially be for hiring another male employee to perform the same job as the grievor is supposed to be doing. This situation would be further exacerbated today (compared to 2000) because on the current schedule, there is only one UT I on shift while the UT II is scheduled on 8-4, Monday-Friday.

To summarize, the Employer submits that, on a practical analysis of this case, it would incur

undue hardship in order to accommodate Ms. Butler. Significantly affected would be employee morale, an increased cost to the Employer, retention and recruitment, patient care and safety, and collective agreement rights. For authority on the essence of these matters, the Employer referred to *Ronald C. MacGillivray Guest Home Corp.*, in which the arbitrator accepted the provision of care to residents by male caregivers to be a BFOQ and concluded at page 42 that:

It is unreasonable and [page 264] an undue hardship to the employer to put residents and caregivers at risk by insisting that female caregivers provide care to his group.

The Employer submits that this a recognition for the part that safety plays in assessing undue hardship in this sort of context. It is inappropriate to decrease the efficiency of patient care and increase undue hardship in order to accommodate Ms. Butler.

Once it is determined that it would not be appropriate to utilize the UT II to back up Ms. Butler, the question is what other back-up options might there be. One suggestion was to get someone else to carry a pager. Ms. Nichols testified about the effect that carrying a pager and being on standby has on health care workers. Essentially, she said that it significantly interferes with their lives: they can't drink alcohol (even socially), they can't leave the metro area, and they have to be close enough to respond to a call – that is the reason for carrying a pager in the first place. This additional standby requirement would be especially onerous because it would have to be assigned among a very few employees. Ms. Sullivan testified that the impact of this accommodation would be minimal if she had a larger staff. Also, the evidence indicates that being on call is considered by employees to be a negative scheduling issue. Therefore, given the unattractive aspect of the extent of such pager responsibility for existing staff, a negative effect would be expected on persons applying for a position.

If back-up had to be supplied by someone else in the area, it would have to be by appropriate male employees. Ms. Nichols said that there might be 20 male LPNs, but only two or

three are at the HSC and all of them are employed in their own units and on their own schedules. Therefore, their availability when needed is an issue. It was estimated that, to be assured of obtaining a male LPN when one is needed for back-up, more than 20 of them would have to be employed at the HSC. Then there is the issue of how many of those male LPNs would be able to back up in a very specialized area of expertise such as urology. They would all have to be trained for long periods to an acceptable level of competence and thereafter maintain that level of competence despite working elsewhere in jobs of their own. These issues would apply also to the availability and specialty competence of the .5% of male RNs at the Miller Centre and at the HSC where most of them are assigned to intensive care units, which they cannot leave to provide back-up elsewhere.

In the result, the provision of back-up floaters on existing shifts within the HSC to accommodate Ms. Butler is not a feasible option.

One might ask why a casual back-up could not be utilized. At the time of the grievance in 2000, no casual relief technicians were employed. Therefore, there was no such relief available. Currently there are two (2) casual urology technician positions. However, Ms. Sullivan testified that those technicians accept work in other areas when they do not have relief assignments in urology. Therefore, the Employer could not depend on them being available when needed. Also, placing them on standby at \$6.90 per shift (\$10.35 for a 12 hour shift) waiting for 3 hours minimum pay for a 10 -15 minute call-in rather than allowing them to accept other assignments would significantly reduce their incomes and render their positions unattractive to them.

To the suggestion that a trial period should have been available to Ms. Butler, the Employer's position is that Article 15.05 provides trial periods only for successful applicants. However, where a male only requirement is determined to be a BFOQ, then a female applicant would not be qualified for the position and, therefore, would not be the successful applicant and a trial period would not

apply to her. Support for this position may be found in *St. Boniface General Hospital*, the 1995 case, at page 50 where the arbitration board held that:

In situations when the BFOQ is established, in our respectful view, the Hospital is not required to provide the employee affected with a ninety day trial period to demonstrate his/her ability to perform the job since the qualification or requirement ipso facto must be of such a nature as to render the concept of a trial inappropriate (the lack of availability may be one factor when considering appropriateness).

In that decision, the board quoted with approval from page 228 of the 1992 *St. Boniface* award, viz:

. . . If it is legitimate to accommodate the request for same gender professionals, only patients who did not object to a male technologist in the first place would be part of the trial period. The results would then only apply to the group who are likely to be less effective by having a male technologist in the first place. As a result, the test would have little value.

It is difficult to apply even the concept of individualized testing to the privacy issue. It is not the skill of the grievor that is in question, but rather the preference and reactions of patients.

Similarly in the Employer's view, a trial period would be of little value in Ms. Butler's circumstances because the Employer does not challenge her own skill and ability to perform male catheterizations, rather it is the anxiety that male urology patients feel towards female care givers that is the real issue. Since a trial period cannot change patients' preference and reactions, it would serve no purpose for Ms. Butler. Also, based on the evidence in this case, patients who do not wish to have a female performing their procedures, or who express or might feel anxiety in those circumstances, should not be exposed to a female during a trial period. Therefore, a trial period for Ms. Butler or any female would be neither valid nor appropriate.

For authority for its position on disruption of the collective agreement, the Employer relied on *Central Okanagan School District*, a 1992 SCC decision where the Court found at para. 26:

While the provisions of the collective agreement cannot absolve the parties from the duty to accommodate, the effect of the agreement is relevant in assessing the degree of hardship occasioned by interference with the terms thereof. Substantial departure from the normal operation of the conditions and terms of employment in

the collective agreement may constitute undue interference in the operation of the employer's business.

Finally, in the event that the arbitrator concludes that the Employer has not met the test in *Meiorin*, i.e., it has not accommodated the grievor to the point of undue hardship, the Employer submits that, since there has been no discussion about accommodation among the three parties, namely, the Employer, the Union and Ms. Butler, it would be inappropriate to simply place Ms. Butler in the job. If the issue is accommodation, it is clear from the case law that the search for accommodation is a multi-party inquiry. Although there is no requirement on the claimant to generate options, there is a requirement that the Employer, the Union and the grievor be involved. The evidence is that at no point did those discussions occur because the Employer did its own analysis and concluded that it could not accommodate the grievor without incurring undue hardship.

The importance of considering accommodation options was discussed in *Queen Alexandra Hospital*. In that case a Child and Youth Counsellor position was designated as exclusively female and since there was no evidence that management had approached other managers or other employees to canvass accommodation possibilities, the grievance succeeded in part, but the arbitrator sent the matter back to the employer for re-determination to consider reasonable attempts at accommodation. The Employer submits that *Queen Alexandria Hospital* is authority for the proposition that, in cases where there is no evidence that accommodation possibilities have been canvassed, it is appropriate to send the matter back to have it happen and the arbitrator to remain seized.

Although in a different context, a similar result occurred in *Re Board of School Trustees* where the posting of two male only positions for Matrons to look after the toileting needs of two adolescent male handicapped students was found to be a BFOQ. In that case, there were some evidentiary deficiencies and because the evidence fell short of enabling the board to fully assess or quantify the foregone opportunities of one of the grievors, i.e., the foregone opportunities for

other work, the board decided to refer the matter back to the parties for further discussion and an effort at accommodation.

In the result, if the circumstances of a case make it appropriate to do so, it would be appropriate to refer a matter back so that there can be further discussion about accommodation and the scope of that accommodation. However, the Employer stressed that, in the instant case, it is an alternative argument only to suggest that the matter may be referred back to the parties for discussion on accommodation. In the Employer's view, the grievance should be denied.

### **The Union**

In support of its positions, the Union submitted the following:

1. *Re Health Care Corporation of Newfoundland and Newfoundland and Labrador Association of Public and Private Employees* - Preliminary objection re Rita Butler's grievance (January 6, 2002) unreported (Kelsey);
2. *Re Newfoundland and Newfoundland and Labrador Association of Public and Private Employees v. Her Majesty The Queen in Right of Newfoundland and Labrador and Newfoundland and Labrador Health Boards Association on Behalf of Health Care Corporation of St. John's* (August 8, 2002) Supreme Court of Newfoundland and Labrador Trial Division, decision of Dunn, J.;
3. *Human Rights Code* R.S.N.L. 1990, c. H-14;
4. Judy Fudge, *Gender Issues in Arbitration: An Academic Perspective*, (1991) 1 Labour Arbitration Yearbook, pp. 119 - 131;
5. *Nursing Home Residents' Rights Trump Gender Equity in Job Posting Case*. (February 7, 2006), Labour Arbitration, Issue No. 33;
6. *Re Central Neighbourhood House and Canadian Union of Public Employees, Local 4308* (2005), 137 L.A.C. (4<sup>th</sup>) 314 (Harris);
7. *Re Ontario (Human Rights Commission) v. Etobicoke (Borough)* [1982] 1 S.C.R. 202;
8. *Re Sunnyside Home for the Aged and London & District Service Workers' Union, Local 220* (1985), 21 L.A.C. (3d) 85 (Picher).

The Union initially turned its attention to several points made and references to jurisprudence

by the Employer.

First, the Employer has made reference to its ability to provide back-up for Ms. Butler if she were to be placed in the position of urology technician. If the evidence evinced primarily by the Employer's own witnesses is examined, little need was demonstrated where back-up would actually be required. Dr. Drover made reference to a couple of cases where male patients requested a male care provider. Those references pertained to procedures performed in day surgery, probably when nurses were present. Since those situations occurred on the 8-4 shift, Monday-Friday, a second urology technician was and still is always available. The Union submits that there is little to demonstrate that those instances were actual facts and that the previous female technician was involved. Mr. Holden stated an example where he himself was refused by a male patient. The Union questions what back-up was in place for that circumstance; in fact the Union's understanding is that a female nurse actually performed the required catheterization at that time. In the Union's view, there is little evidence of the occurrence of the type of events claimed by the Employer.

Second, when it comes to establishing that Ms. Butler would be refused by a male patient, the evidence is that, for several years, a female occupied a urology technician's position, yet there was not a single piece of concrete evidence presented that she had ever been refused by a male patient. All the information the Employer introduced on such a claim was of a hearsay nature. Similarly, not a single incident was noted where a male technician had to be called in to perform the duties of the female technician.

Third, on the Employer's own evidence, the facility in question is an acute care facility where the majority of patients are females, but only .5% of the staff are males. What was really being described by the Employer is a patient population of approximately 40% males yet only .5% of the staff available to provide acute care or intimate care are male nurses or male LPNs. That necessarily means that females provide the vast majority of intimate care for both male as well as

female patients.

Fourth, with respect to anxiety in relation to urological procedures, the Union notes that it is Dr. Drover's and the urology technicians' evidence that anxiety is a reaction to most medical procedures. It is also the evidence that, with the appropriate training that is provided, LPNs are taught how to deal with and assist in alleviating anxiety. Indeed, Mr. Holden testified that he teaches male catheterizations to LPNs, but does not instruct them on relieving anxiety because the subject is taught as part of their professional training. The relevant point here is that anxiety to medical procedures by urology patients is no more common than it is for all other patients in an acute care facility.

Fifth, Ms. Sheppard argued that Mr. Porter's evidence should be given limited weight. In the Union's view, that argument is not justified. His evidence should be given as much weight as any other witness at this hearing.

Sixth, a significant component of the Employer's argument is on legal issues arising from patient outcomes. However, not a single case has been presented in evidence where there has been a legal challenge made against urologists, urology nurses or urology technicians in respect of any medical care received by a urology patient.

Seventh, the three-step test found at page 14 of *Meiorin* was relied upon as the relevant test in establishing a BFOQ. That test states:

- 1) that the Employer adopted the standard for a purpose rationally connected to the performance of the job;
- 2) that the Employer adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of a legitimate work-related purpose; and
- 3) that the standard was reasonably necessary to the accomplishment of that legitimate work-related purpose; and to show that the standard was reasonably necessary, the Employer has demonstrated that it was impossible to accommodate individual employees sharing the characteristics of the grievor without imposing undue hardship upon the Employer.

The issue in *Meiorin* was the safety and efficient performance of the job by a firefighter, i.e., whether a woman had the ability do the task of a firefighter. The grievor there was subjected to different testing than the males were. Since the issue in the instant case is whether a woman can do the job of a urology technician, *Meiorin* is not on all fours with it.

Eighth, in *McKale*, at page 10, the court stated that there should be evidence of the following where a claim of a hospital patient for same sex intimate care is asserted:

With regard to the claim of an auxiliary hospital patient for intimate care by a member of the same sex, there ought to be evidence on the following points:

1. The claim, or demand or stated preference
2. The manner in which it is made
3. Policy or systems to deal with such claims
4. Consequence to a patient both physically and mentally of failing to deal with the claim
5. Consequences to staff of failing to deal with the claim

With respect to the first point, there has been nothing but hearsay evidence presented on any patient's claim, demand, or preference. Not a single patient and not a single formal complaint or demand has been brought forward by a patient. On the second point, i.e., the manner in which it is made, no answer can be provided because there has been no first hand evidence of a claim in the first place in the testimony of Mr. Holden, Mr. Flight or Dr. Drover. On the third point, policies or systems to deal with such claims, no policy has been introduced on how the hospital handles claims brought forward by patients. On the fourth and fifth point, i.e., consequences to a patient and to staff, there was also no first hand evidence.

Ninth, very few of the cases among the jurisprudence deal with patients in an acute care setting as is the situation in dispute here. Some decisions such as *Green Bay* address a chronic care setting, but the expectations in those settings are very different from those in acute care settings. In *British Columbia (Public Service Relations Commission)*, where the residents were young teenage boys and girls age 13 to 18 with serious psychological problems, having psychotic

episodes, with troubled backgrounds including sexual abuse, this notion is stated at page 7:

However, given the nature of the services, the type of residents in terms of age, the duties of health care workers and nurses, all of these factors combine to make the gender of a worker as significant bona fide occupational requirement. . . .

In determining whether a gender based BFOQ is justified, types of resident population such as the one above are significantly different from the acute care patient population serviced by the urology technicians in this case.

Again in *Ronald C. MacGillivray Guest Home*, at page 20, the employer is described as “a not-for-profit corporation established and licensed to operate a home for special care. . .[for] 106 residents. . . . [with an average age of] 86.1 years.” The home historically maintained a male-only position for some of its male residents and the evidence was that male residents requested male-only care. In the instant case of the urology technicians, while they operated for a long period of time as male-only, there was also a demonstrated period when a female occupied a position. She passed the trial period and went on to work for a period of several years occupying a urology technician position with no more complaints against her than against the other male technicians at that time.

To reiterate, the Union urged the arbitrator to take into account the type of jurisprudence submitted by the Employer. Those cases do not reflect the situation faced in the Eastern Health acute care facility that is the subject of this arbitration.

It was the Union’s position that the arbitrator must take into consideration that the grievance arose in February 2000. At that time, Ms. Butler had some 14 years of seniority when she was declared not to be qualified for a urology technician position because of her gender, and a junior male employee was awarded the job. In KM#1, there is a reference to her being offered the same position on a temporary basis 9 months earlier. Ms. Butler explained her own reasons why she could not accept the offer at that time. However, in the Union’s view, had she accepted that

position, there probably would have been no arbitration hearing now because she would already have been in the position when the permanent job was posted in 2000 and, unless the Employer removed her from the position, she would still be performing the job today.

Article 4.01 establishes that there shall be no discrimination on the basis of sex, and Article 15.02 provides that all job postings shall state "This position is open to male and female applicants." The whole job posting process is contained in Article 15 - Promotions and Staff Changes. Because it was a higher paid position, Ms. Butler considered the posted permanent urology technician position as a promotion for her in accordance with Article 15.04 – Role of Seniority in Promotions and Transfers, which establishes preference on the basis of seniority when applying for a position on promotion. Essentially, not only was Ms. Butler denied the position on the basis of her gender, she was also denied a promotion. The Partial Agreed Statement of Facts confirms that the actual posting was "open to male applicants" and that, as of the date the competition when it was awarded to Mr. Rodney Flight, Ms. Butler had 1612 more seniority hours. Since there is no question about her qualifications or her seniority, the issue comes down to the question stated in C#1" "whether a BFOQ of 'being male only' is established in relation to this position. . . ." In this situation, the burden falls on the Employer to establish that, in relation to the particular position of urology technician, a BFOQ exists. Since a BFOQ legitimizes what would otherwise constitute discrimination, the jurisprudence submitted by the Employer indicates that the evidence in support of a BFOQ must be compelling, it must be objective and reasonably necessary.

*Is the evidence compelling that a BFOQ is warranted; that it warranted discriminating against the grievor by denying her the position and a promotion and that it was necessary for the performance of this particular position?*

In the Union's view, the evidence on this matter has to consist of more than the fair amount of general assertions and unsubstantiated expressions that is being relied on by the Employer in

this case. For example, in her e-mail response (HM#1) to Ms. Butler's telephone call on March 6, 2000, Ms. Monaghan states:

. . . the Male only requirement was determined to be a Bona Fide Occupational Qualification (BFOQ) after a lengthy, consultative process. While it was not stipulated in the previous summer's posting, when you were offered a similar position, a qualification review had already been requested.

The Union submitted that this is not the case. By Ms. Sullivan's own evidence, she was not approached until the fall or winter of 1999 or early 2000. Therefore, how could a lengthy consultative process have been conducted in those circumstances. Also, it was Ms. Sullivan's evidence that she was not approached by anybody other than the urology technicians. On the claim that there was a lengthy review process, the Union suggested that the arbitrator should review the evidence. In its view, there was no such process.

KN#1 also states that the qualification review

. . . stemmed from urologist findings that the test results procured from female urology technicians were problematic. This was most common during procedures for elderly male patients – the most common patient profile using this service.

The Union submitted that it was the urology technicians who approached Ms. Sullivan. Only later did the urologists come forward. Therefore, the qualification review did not stem from urologists' findings. Also, there has been no evidence led on any "test results procured from female urology technicians [that] were problematic." While he alluded to some circumstances, no actual instance and no documented case was brought forward by Dr. Drover in his expert testimony to demonstrate that the female technician performed a procedure which resulted in an adverse effect. It must also be remembered that Dr. Drover was not Chief of Staff at that time.

In the result, what has been alluded to in KM#1 concerning findings about the female technician's performance has not been substantiated. Ms. Monaghan identified Ms. Susan Rumsey as a Human Resources officer who was involved in the alleged extensive consultation process, but, despite sitting with the Employer's side for a portion of one day during the arbitration proceedings,

Ms. Rumsey was never called to testify. Surely, if she had participated in an extensive consultation process that had actually taken place, Ms. Rumsey should have testified on that matter. In the Union's view, when the arbitrator reviews the evidence, he will find that a number of issues were raised that could have been confirmed by appropriate witnesses. Some of those witnesses were not called, even though they could have been.

As for the "amassed clinical evidence" referred to by Ms. Monaghan, Ms. Sullivan testified that until she was approached by the urology technicians, she had not really turned her mind to it; then she heard about the *Green Bay* case and sought it out. Clearly, if there was any clinical evidence amassed, little of it was adduced at this arbitration hearing. Also, if such evidence was purported to be significant for the purpose of justifying a BFOQ, the Union questions why no amassed clinical evidence was brought forward. Indeed, the Union questions whether that evidence actually exists. It should be noted that Dianne Sullivan was not division manager when the female technician was there. Therefore she was not privy to any alleged references and issues concerning the female technician. The Union submits that, if there were issues and references concerning the female technician at the time, that evidence as well as any relevant evidence from patients, should have been led by the relevant division manager at the time, who, as the Union understands, is still an employee of Eastern Health. Ms. Sullivan said she was division manager since 1996 and she testified as to the type of work that was involved in urology and that it took about a year for a new urology technician to become comfortable with the job. All this means is that, to become competent to do the work involved, a technician actually has to spend time doing that work. When Ms. Sullivan was approached by the urology technicians, it was after Ms. Butler had been offered the temporary position in the summer of 1999 and the Employer was about to post for the permanent urology technician position. She brought no firm evidence on requests by patients for male technicians and no documentation to support the claim that a patient had ever made such a request.

In the Union's view, the amassed clinical evidence spoken of by Kelly Monaghan has not been presented at this hearing.

As for the objectives in the urology division that were relied on by Ms. Sullivan, the fact is that these are the same objectives that may be found in any nursing division within Eastern Health.

Messrs. Holden, Porter and Clyde Rice (lead hand) were urology technicians when the female technician was employed. If there was such concern about procedures performed by her, the question must be asked why there was no action on those concerns until the fall of 1999 or the early part of 2000. The evidence is that the technicians waited five (5) years before raising the issue of a male-only requirement. So if there were claims that male patients refused her, or expressions of concern by patients that they did that they did not want the female technician to provide their catheterization and other procedures, one would expect there to have been a record of such complaints. This arbitration has not been presented with a single physical complaint in the form of a letter by a patient, or a patient himself, or any similar type of evidence. Yet there is evidence that the female technician passed her trial period without issue and she worked for several years in that position. If incidents involving the female technician actually did occur during her tenure, it was incumbent on the Employer to call the appropriate individuals who were involved to testify at this hearing. Since the Employer had the ability to bring those people forward, but chose not to do so, the Employer is left with only hearsay evidence of its claims involving the female technician.

Ms. Sullivan testified that the previous female urology technician performed her duties and responsibilities as part of a regular rotation. No special accommodation was necessary in her situation. She functioned for several years in the full capacity of urology technician. There is no evidence that the Employer had to circumvent the rotation while she was there, or that on nights or weekends the Employer had to call someone in to back her up. The evidence is that she functioned in the same job as Mr. Holden with no more complaints against her than against him. Mr. Holden

also testified that there were no more complaints made against her than were made against a couple of junior technicians.

If males were refusing to be cared by the female technician, why was not something done while she was there? If there was trouble with the test results, why was something not done about it at the time? Why was something not done in the five years after the female technician left to ensure that another female would not go into that position? And what specific troubles with procedures occurred while she was in the position? If there were problems with her procedures, the lead technician Clyde Rice could have been called to testify. On balance, the Union submitted that, if problems with the female technician had actually been encountered, the Employer would have been prudent enough to deal with them immediately upon her vacating the position – not waiting until the fall of 1999 when some urology technicians came forward and expressed their own concerns.

The evidence of Mr. Holden was that he was not UT II at the time of the grievance, which was the time that evidence relevant to the BFOQ issue was dealt with. Mr. Rice was the UT II at that time, but he was not called by the Employer to give evidence on the issue of problems with the female technician.

Mr. Holden testified that it took a year for someone to become comfortable doing the urology technician's job. He also explained that he had recently taught LPNs at the Miller Centre to perform catheterizations on male patients and that they could only get better with experience and that experience can only come from performing the procedures. Mr. Holden also said that his own wife is capable of performing male catheterizations (no doubt he gained this knowledge by working with the previous female technician), but he would not want her to do them. He also said that he was refused by a male patient as were other junior male technicians. The Union wonders what back-up was in place for those situations. In the Union's view, the situation was no different for those people

than it would have been for any refusal that the female technician might face. Also the Union wonders where the material evidence is on any of the above claims. All Mr. Holden could recall hearing about were one or two instances where a male patient refused the female's care. That was unsupported hearsay evidence. Therefore, little or no weight should be given to it.

When Ms. Butler was on the stand, the Employer wanted to bring reply evidence for the purpose of discrediting her evidence on services performed in the Veterans Pavilion. Someone was easily reached to testify on that matter. However, the Union found it passing strange that the Employer did not call Mr. Rice (the UT II) Susan Rumsey (Human Resources) or Ms. Batstone (the Division Manager), who were there at the time of the female technician's employment. Since the arbitrator has been asked to make a decision based on potential adverse outcomes, i.e., to acknowledge that male patients would refuse a female technician, if there was evidence that such refusals had actually taken place, it was the Employer's responsibility to call first hand evidence on that matter. The aforementioned individuals were not called to testify. They are still around and could have provided first hand evidence that male patients actually refused the female technician or expressed a preference that she not perform their care.

Dr. Best's letter C#8 was written on January 21, 2000. Dr. Drover, the current clinical chief, testified before this hearing as an expert witness. He was not the chief at the time of the grievance. Dr Best's letter refers to "our recent conversations," which, in the Union's view, confirms that the consultation process was not a lengthy one, but commenced only after the urology technicians first approached Ms. Sullivan. If, as Ms. Monaghan said, an extensive consultation process had been going on previously, Dr. Best, who is still around, could have been called to testify about his own letter. In the Union's view, as is the case with the others mentioned above, an adverse inference can be drawn on the Employer's failure to call Dr. Best in these circumstances. As the matter stands, there is no way to know for certain how long ago discussions had taken place with "the

other members of our division.” If Dr. Best had concerns about the female technician while she was working, the Union would have liked to hear from Dr. Best why he waited until January 21, 2000, to raise them. Could it be that he had learned that a woman had almost obtained a urology technician position as recently as the previous summer? His letter also states that “most adult males are reluctant to have these procedures carried out by females. It does impact in their outcome and their comfort.” This basic statement has not been supported by Dr. Best’s own testimony because he was not called by the Employer. Neither has it been supported by the testimony of Mr. Holden and Mr. Flight. They could only cite a couple of occasions that male patients had been reluctant to accept the female technician’s care. But their evidence was that male technicians had been refused just as often. And as far as “impact in their outcome and comfort” is concerned, absolutely no evidence was made available from Dr. Best to support that claim.

Mr. Rodney Flight, the successful junior candidate, also talked about what urology technicians do. He indicated that he knew that male patients have refused care by male technicians and that no matter how much related experience one has, difficulties are always encountered in male catheterizations. He said that he had worked on the shift opposite to the female technician and there was only minimum interaction between them when their schedules may have overlapped, i.e., she was going off shift and he was coming on. In all he could recall only a couple of hearsay instances when she may have been refused by a male patient. Again, that is no different than his evidence that he knew of a couple of male technicians who had been refused.

Dr. Drover became clinical chief since the grievance was filed. His letter dated January 2, 2007, made some references to discussions he had with Dr. Best. However, whatever Dr. Best said to him is hearsay and the Union has had no opportunity to cross examine Dr. Best on those discussions. Again, the Union reiterated the question, if negative outcomes caused by the female technician was such a significant issue for him, why is there no evidence of any concerns having

been raised and documented by Dr. Best while the female technician was working in urology? It was not until after the urology technicians and Ms. Sullivan discussed the issue in late 1999 that Dr. Best addressed the matter in his January 21, 2000 letter to Ms. Sullivan.

After being contacted in December 2006 by Ms. Sheppard to discuss the gender issue, Dr. Drover scrambled to gather published articles that would support his positions. None of the articles introduced by him were considered at the time of the grievance. No articles of this type were considered when the temporary position was posted in the summer of 1999 and the position was offered to Ms. Butler. The subject of the post grievance articles is female patients' views on male vs. female caregivers. None are about male patients or male urology patients. Therefore, the conclusions drawn in the articles are of little relevance to the circumstances of the instant case. Interestingly, in the Conclusion stated in DD#4 at page 119, the author suggests that:

When a patient requests a provider of a specific sex, the request should be investigated to define the patient's underlying values. An attempt should be made to confront a patient's stereotypical and discriminatory beliefs, with the hope of educating the patient and causing a change of heart.... At the same time, physicians should work both individually and collectively against discrimination and prejudice wherever they are found.

There is no substantiated evidence of formal patient complaints against the female technician and no first hand evidence of any kind that a male urology patient has requested that a female not perform his catheterization or any other procedure for that matter. In the result, the articles provided as well as the evidence of Dr. Drover on this matter should be given little weight.

In his January 2, 2007 letter, Dr. Drover essentially sums up his expert evidence. From the very commencement of his letter, he indicates his cautiousness about his conclusions. For example, at page 2, he says:

There is a *perceived* difference in patient outcomes and the gender of the person performing the procedure for catheterization. It is *possible* that patient's anxiety *might affect* the outcome of this procedure.... *It is certainly possible and quite reasonable to believe* that there is a certain segment of the male population that would find a procedure performed by a female technician without any supervision or

choice on behalf of the patient to enhance one's anxiety which then in turn leads to increased pelvic floor tightening which decreases the probability of a successful outcome with the potential complications as above. (Emphasis added.)

In light of the foregoing tentative expressions, the Union submits that no evidence of any difference in patient outcomes has been introduced. And there is also no evidence of the "permanent long term adverse event in outcomes." All the Employer's evidence is hearsay.

Dr. Drover also wrote: "It is well known that relaxation is essential for male catheterization..." In the Union's view, if anxiety is such an important aspect of male catheterization, then why does Mr. Holden not teach it when he instructs LPNs? The evidence on this indicates that the topic is not part of the program that Mr. Holden teaches because it is already taught as part of general LPN training and that Ms. Butler was well trained in this subject.

There is conflicting evidence on the segment of the male population that has problems with catheterizations performed by females. On the one hand, Dr. Drover's evidence was that he believed that the younger male patient population would not have a problem with catheterizations. However, on the other hand, the technicians who actually do those procedures (Mr. Holden and Mr. Flight) testified that it is the younger population who have a problem with it. The evidence also indicates that the technicians do not do a lot of catheterizations outside of day surgery where the younger patients are treated. Therefore, the question is what is the segment of the male urology patient population that causes the problem. At the Miller Centre, the LPNs perform the catheterizations. If it is the older patients that are the problem, why is it that the Employer has removed that part of the urology technicians' workload and given it to the LPNs?

Dr. Drover also states at page 2:

We have had a female technician at the Health Sciences Centre previously and discussions between Dr. Best and myself affirm that there were many negative outcomes more so than we have had with male technicians.

Why is it that neither Dr. Best, who was clinical chief at the time, nor Dr. Drover, who later became

clinical chief, did nothing until 2000 when they learned that a female had earlier been offered the temporary position, and a permanent position was about to be posted? Why did they wait 5 years if there were such significant negative outcomes? Why were there no documented negative outcomes for the work of the female technician? And why is there no record of any intervention or action taken on those matters?

With respect to the patient anxiety issue in Dr. Drover's letter, it is the Union's position that anxiety is expected for any medical procedure in the hospital regardless whether the procedure is performed by a male or a female. This expectation is dealt with professionally in the training programs for all nurses and LPNs irrespective of their gender. There is evidence before this arbitration by the male urology technicians who testified that, when they were doing the procedure, they have encountered male patients who have grabbed the bed rails and screamed out.

The Union argued that, to support the testimony of Dr. Drover, which was aimed at convincing this board of arbitration that there had been significant occurrences of negative outcomes involving the female technician, specific cases should have been adduced. As far as the examples where some patients said that they wanted the females present to leave the room during their procedures, those events occurred in the day surgery environment, Monday - Friday, 8 am - 4 pm. All of those incidents involved female nurses, not the female technician. Not one specific case has been introduced of a male patient in day surgery asking that the female technician leave the room. And not a single example has been shown where the UT II at the time, Mr. Rice, had to relieve her in day surgery. If those things did happen while she was in the position, they could have been led in evidence. They were not.

If there were concerns about the older segment of the male population being catheterized by females, then other than the lack of human resources, why was it that catheterization services by urology technicians diminished at the Miller Centre. The evidence was that, in the Rehab unit

since the 1950s or 1960s, the UTs had done routine catheterizations as often as four times per day. Was consideration given to the older male patient population when all this stopped in 2006? The Union suggests that no such consideration was given. Instead, both female and male LPNs were instructed by Mr. Holden how to perform male catheterizations. Ms. Colbourne testified that she was one of the females trained by Mr. Holden.

The Union submitted that there is a significant difference between the acute care hospital setting at the HSC and the patient environment in *Green Bay*, which was a chronic care centre in a nursing home setting. At page 17 of the *Green Bay* arbitration award, the board states:

With respect to the objective test, we are satisfied that the employer has offered more than the mere “impressionistic” evidence offered in the Etobicoke case. While we share the same concern as the court did over what may be characterized as “scientific evidence”, we are none the less satisfied that something more than general assertions and unsubstantiated expressions that a male is desirable is required to discharge the employer’s burden of proof.

In the Union’s view, the Employer in the instant case has not offered more than general assertions and unsubstantiated expressions. Also at page 17 of *Green Bay*, the board said:

This particular grievance will turn mainly on specific local circumstances involving the needs of some, but not all, male residents. . . .

For our purposes, we are prepared to accept the direct observations and experiences of the professional people who testified at this hearing. Especially as it relates to the residents in dispute. In this regard, Ms. Rose Saunders, R.N., Director of Nursing, gave evidence of the numbers of residents and how some were gathered into male groups for the purpose of receiving care from male R.N.s and PCAs.... Ms. Saunders also established that the traditional purpose of [the male rota] was to meet *requests by certain male residents* for male intimate care. (Emphasis added.)

In other words, the male rota program there was set up to accommodate requests by some male patients. In contrast, in the urology division there was for several years a rotating schedule for all urology technicians, including the previous female technician, to provide specialized intimate care to male urology patients. Clearly, no accommodation of any kind was necessary for her. Again at page 17, the board wrote:

Teresa Short, R.N., team leader on west wing, gave detailed evidence of the names and numbers of male residents who expressed preference for male care. She also explained the intimate nature of their objections and the observable manifestations of their receiving female care instead of male care. Incidents of physical and sexual aggression were observed as were episodes of depression and emotional upset....

Dr. Frank Hicks, Medical Director, testified as to his personal observations of the residents in dispute. He generally confirmed the physical and sexual aggression mentioned by Ms. Short....

No evidence of names and numbers of residence who expressed preference for male care was offered by the Employer in the instant case. Neither was there anything but general assertions and hearsay evidence on the observable manifestations of male urology patients' objections to receiving care by the female technician. No cases of physical or sexual aggression were mentioned by anybody. In *Green Bay* these matters were supported by concrete evidence from team leader, Theresa Short, and the personal observations of the medical director, Dr. Hicks. There is no supporting concrete evidence of any kind in the instant case. In particular, the Employer's expert witness, Dr. Drover, was not able to provide any personal observations of patients who refused the female technician on nights or weekends. And he provided no evidence that he received any calls to ensure back-up for her. His direct observations were restricted solely to day surgery, and even there, no evidence was offered that somebody else had to be called in to relieve the female technician upon being requested to leave the room.

On balance, it is the Union's view that the Employer in the instant case has failed entirely to do what the board found in *Green Bay* at page 17, namely:

. . . The employer has offered specifics as well as generalities, which in total support a convincing case that a male was required to meet the needs of the male residents in these particular circumstances. . .

In *Green Bay*, weight was given to documented established patient requests. In the instant case, no such weight can be given because there are no documented established patient requests.

To assist the arbitrator's understanding of the background of how Ms. Butler's grievance had

been dealt with prior to it reaching this particular arbitration proceeding, the Union referred to *N.A.P.E. and Health Care Corporation of St. John's*, the original arbitration award regarding preliminary matters, and the decision of the court on judicial review in *Health Care Corporation of St. John's v. N.A.P.E.*.

Also, the Union confirmed that the Employer has access to the BFOQ exception under the *Human Rights Code*, subject of course to proving justification for same.

For the purpose of general background on the issue of gender discrimination in the workplace, the Union submitted *Gender Issues in Arbitration: An Academic Perspective*, which in the preamble expresses that:

. . . The author sketches the arbitral jurisprudence in a number of cases which raise explicit and implicit sex discrimination issues and in so doing identifies how the prevailing concept of arbitration fails women workers. The author concludes by suggesting that, instead of deferring to the idea of private contractual relations and contractual prerogatives, arbitrators must be prepared to invoke the public commitment to equality in order to challenge the gender hierarchies which inhere in the privacy of the workplace. Only then will it be possible to claim that our public commitment to equality is real.

*Labour Arbitration, Lancaster's Bi-Weekly E-Bulletin* (February 7, 2005) Issue No 33, refers at page 1 to one of its contents, namely:

#### **Nursing Home Residents' Rights Trump Gender Equity in Job Posting Case**

A Nova Scotia arbitrator held that a nursing home did not commit sex discrimination when it posted an orderly position as open only to male applicants. Gender was a bona fide occupational qualification., the arbitrator concluded, since requiring the employer to override the residents' explicit refusal to accept intimate personal care from women would amount to undue hardship.

The employer in that case was a nursing home which opened in 1967, had strong ties to the Roman Catholic Church, and always employed at least one male orderly to assist male residents with intimate care, particularly retired Catholic priests who objected to such care delivered by a woman. Among the comments expressed by Lancaster House at the bottom of page 4, is one which follows a review of the jurisprudence on what evidence is required in order to ground a BFOQ:

. . . In sum, an objection on the part of the patient or resident to having care provided by a member of the opposite sex appears to be a prerequisite to establishing gender as a *bona fide* occupational requirement for a personal care attendant.

Proof of such patient objections is absent in the instant case. Only hearsay evidence has been offered. In *Central Neighbourhood House*, a 2005 arbitration award, the introductory findings summary on page 1 states in part:

Discrimination – Evidence – Standard of evidence necessary to establish bona fide occupational requirement – Evidence that bona fide occupational requirement reasonably necessary must be objective and compelling.

Further at page 17, the award states:

In cases such as this there is a need to balance the rights of the employees with those of the clients. Where the very human dignity of the clients is at stake, discriminatory scheduling might amount to a BFOR. However, dignity is an elusive concept that is not determinable by a priori assumptions regarding purported social norms. People may have individual preferences for the sex, race, religion etc. of the person providing them with a service. They may see it as an affront to their dignity to be served by someone bearing a characteristic of which they do not individually approve. In order to establish that prima facie unlawful discrimination is saved because it is a BFOR, there must be compelling, objective evidence that it is reasonably necessary or else we put at risk the gains we have made in protecting people from being discriminated against in their employment. Human rights ought to be broadly defined; the exceptions to them ought to be narrowly defined. As was the case in this matters summarized above. Here we are dealing with discrimination on the basis of sex being used to deny work opportunities. That is prima facie unlawful. In order for an exception to be made, the sex of the worker must be a bona fide occupational requirement or qualification. There is no room in the analysis for a priori assumptions about purported social norms. There must be evidence that the exception is warranted. That is, that it is reasonably necessary to the performance of the job.

In the instant case, there is little or no compelling objective evidence that discriminating against females in filling urology technician positions is reasonably necessary. A female actually operated in the disputed position for an extensive period without any more incidents against her than against other male technicians. In the absence of evidence that there have been a significant or even a minimum number of male urology patients who have objected to the previous female providing intimate care procedures, it is the Union's view that denying the posted position to Ms. Butler is not

justified. There are no compelling grounds for denying her the opportunity to be placed on a regular rotation in order to provide the necessary care for the patients involved. The hearsay evidence in this case indicates that refusals have occurred for both male and female technicians alike. Therefore, no accommodation is necessary for any female applicant.

Additional support for the type of evidence that is required to establish a BFOQ may be found in *Ontario Human Rights Commission* as well as in *Sunnyside Home for the Aged*. In the former, at page 2, the court states:

. . . The McKay test provides that to be a bona fide qualification and requirement the limitation complained of must bear a reasonable relationship to the circumstances of the employment. He said: "In other words, although it is essential that a limitation be enacted or imposed honestly or with sincere intentions it must in addition be supported in fact and reason 'based on the practical reality of the work a day world and of life'."

Since the previous female technician functioned in the position without any limitations or accommodations, Ms. Butler could certainly do the same. It should also be noted that the collective agreement also provides for a trial period. In the latter case, at page 15, the arbitration board said:

On the basis of the foregoing, the board concludes and declares that the different manner in which the home schedules the work of female nursing attendants, on the one hand, and male nursing attendants on the other, constitutes discrimination on the basis of sex contrary to the collective agreement. It is a discrimination on the basis of sex for the home to schedule male nursing attendants to male residents only, and to refuse, solely on the basis of their sex, to schedule them to the care of female residents whether or not they object, while at the same time scheduling female nursing attendants to the care of all residents, subject only to specific objection by the male residents. If the home schedules female nursing attendants to the care of residents of the opposite sex, as long as consent exists and no objection is taken, it must do so for male nursing attendants as well, again, as long as consent exists and no objection is taken. The board directs that the home cease and desist from continuing its breach of the agreement and revise its scheduling practices accordingly. . . . Assignment solely on the basis of sex, however, and a policy that males cannot be scheduled to care for consenting female residents, is contrary to the collective agreement because it constitutes unjustifiable discrimination on the basis of sex.

Therefore, without clear evidence that there is even a minimal number of male patients who would reject female technician care, it is not justifiable to deny Ms. Butler the opportunity to assume that

position.

Much has been said about anxiety, privacy and right of choice in this case. But there has been little evidence demonstrating that there have been any requests of choice by patients. There is very little indication of anybody expressing that he wanted to be cared for only by a male. With respect to the issue of privacy, it must be remembered that the setting in dispute is an acute care facility, which, upon admission one normally “parks his dignity at the door.” In most situations patients are on wards or 4 bed rooms, in which the only privacy is provided by drawing a screen around a bed. In such circumstances, every other patient in the room, as well as any visitors, can hear what is happening, and in many cases, they have experienced the same procedures themselves. In the Union’s view, this lends no credence to the notion that privacy is a significant issue in the hospital. Moreover, it matters little whether a male or a female is performing the procedure behind the screen. Absolute privacy is not practised in the hospital. However, whatever their gender may be, each health care professional in a hospital endeavours to provide as much privacy as is possible. Finally, with respect to relieving anxiety, that issue comes down to the training and ability of each professional, irrespective of their gender.

The Union does not suggest that Ms. Butler, or any other LPN, could enter the technician position with the same level of confidence and competence as Mr. Holden. However, any LPN will attain that level if given the opportunity to perform the required procedures. Ms. Butler has already performed several types of male catheterization procedures as part of the scope of her LPN designation. And she is entitled to the opportunity of gaining the experience that will enable her to attain the level of confidence and competence described by Mr. Holden.

On balance, the Union’s position is that the Employer has failed to demonstrate a valid BFOQ in these particular circumstances and within the setting of the Employer’s acute care hospital facility. The Union does not question the honesty or sincerity of the Employer in seeking to establish

a BFOQ. It is simply that the Employer has not proven that a BFOQ is required. The “amassed documentation” required to support the Employer’s case has not been produced. By the Employer’s own evidence, in this acute care facility, females constitute the vast majority of staff providing care to both male and female patients. Those patients don’t have a choice to say they want a male or a female care provider. They come to the hospital with the expectation that their doctor or their nurse will be either a female or a male. Therefore, why should one very small group of patients be provided with a choice?

There has been a significant adverse effect on the grievor in these circumstances. She was an LPN at St. Clare’s Hospital when she applied for the permanent full time urology technician position. Subsequent to her being denied this position, she was repeatedly bumped out of one temporary position after another until all that was left for her after 17 or 18 years was a temporary attendant position in the emergency department. Luckily, she was able to apply for a temporary full time job in the Rehab Unit at the Miller Centre. Finally she secured her current position in the Veterans Pavilion, which, ironically, she obtained when another junior male LPN left to take a urology technician’s position. In contrast, Mr. Flight, who was awarded the position in 2000 when Ms. Butler was rejected, has never been bumped once despite being junior to her at the time of the posting.

Ms. Butler has demonstrated that she is an educated and interested LPN who has availed of any and every education opportunity provided by the Employer. She clearly can perform the procedures required of the urology technician position. Therefore, she was more than capable of performing the position for the one year trial period that will raise her competence and comfort to an experienced level. Most of the requirements for the position she has already performed or is currently doing daily for male as well as female patients. This is particularly true of male catheterizations and catheter care procedures. Nevertheless, she readily agrees that she would

have to be trained in any procedures that may be new to her. In the Union's view, she is entitled to the opportunity to prove herself via the collective agreement trial period, just as the previous female technician did. Indeed, it should be remembered that Dr. Drover said he would have no problems with Ms. Butler in the position as long as there was back-up available.

On the whole, the Union viewed the articles and (largely hearsay) evidence presented at this hearing to be nothing more than impressionistic assertions. This falls short of the specific requirement that there must be evidence of specific gender requests from patients in order to establish a BFOQ. Clear, consistent, compelling objective evidence is lacking.

Therefore, the Union requests that 1) Ms. Butler's grievance be upheld; 2) she be placed in the position of urology technician as of the date of her grievance; 3) she be compensated for the difference in salary she has lost and 4) she be compensated for all pension and other benefits lost as a result of the Employer's discriminatory action in denying her promotion to the position that was posted in February 2000.

### **Employer Rebuttal**

The Union's article *Gender Issues in Arbitration: An Academic Perspective*, is one of a number of perspectives on the issue of discrimination against women in employment (see also *Gender Issues in Arbitration: A Management Perspective*). The Employer submits that the world has changed since this particular article was written in 1991. At pages 122-23 under the heading "Explicit Discrimination," the author states:

. . . Arbitrators will construe a no-discrimination clause in a collective agreement to accord with the relevant human rights code, such that a *bona fide* occupational qualification exception will be implied. This exception has tended to benefit employers by allowing them to discriminate against employees so long as they can show a business, as opposed to an invidious, reason for the discrimination they practice.

This comment carries a rather negative connotation of a situation that is completely in accordance

with the ruling of the highest court in the land, the Supreme Court of Canada, which held in *Green Bay* that, in the absence of something extra to the contrary, reference to the relevant human rights code is the appropriate determination. While the author is entitled to her opinion, she is clearly at odds with the law. On page 124, the author states:

. . . More recently, however, arbitrators have held that employers must substantiate any arguments they make to the effect that consideration of public decency or business efficiency constitute a *bona fide* occupational qualification in order to justify a rule which discriminates on the basis of sex or which interferes with seniority clauses.

Counsel does not disagree that the Employer has to substantiate a BFOQ. What it comes down to is that, at the point where the Employer and the Union diverge, there is case law requiring evidence to substantiate its claim for a BFOQ. In the Employer's article *Gender Issues in Arbitration: A Management Perspective*, the author discusses at p. 139-40 a number of arbitration awards, one which found that "a mechanical comprehension test that women scored less well than men" did not discriminate against females and another concerning housekeeping aides and cleaners which "found that men were discriminated against in denying them housekeeping aide positions on the false premise that female residents did not want males in their rooms." Therefore, the author's conclusion was:

. . . Sometimes he wins, sometimes she wins. However, arguments over systemic discrimination will be judged on the basis of the evidence, and may in fields such as health care work to the advantage of either sex.

At the end of the day, counsel agreed that the sufficiency of evidence is one of the most complicated legal issues in every case.

With regard to the Union's Lancaster House comments concerning a Nova Scotia nursing home award, i.e., ". . . In sum, an objection on the part of the patient or resident to having care provided by a member of the opposite sex appears to be a prerequisite to establishing gender as a *bona fide* occupational requirement for a personal care attendant," the Employer's book of

authorities contains the relevant arbitration award, namely: *Ronald C. MacGillivray Guest Home*. Counsel again does not disagree with this statement. In the Employer's view, each case will turn on its own facts. In the instant case, the issue does not involve personal care attendants in a nursing home, the critical issue for consideration centres on the medical implications of anxiety in clinical circumstances where specialized intimate care is provided to a group of male urology patients by urology technicians. Anxiety was discussed by Dr. Drover, Dianne Sullivan and even Ms. Butler, all of whom agreed that not every patient who becomes anxious will refuse a procedure. Clearly the evidence is that there is a spectrum of anxiety among a patient population who are receiving medical care. Some patients who become anxious will refuse. Some other patients will say nothing, but it cannot be presumed that those patients are not equally anxious. In the particular circumstances of male urology patients, there is an extra layer on the anxiety spectrum, i.e., anxiety caused when a female caregiver is involved. The difference between those patients and other hospital patients is that this extra layer of anxiety constitutes an additional risk factor where catheterization procedures are to be performed. Anxiety is normal in a hospital. For example, people might become anxious about blood being taken, but male urology patients who become anxious are exposed to an invasive medical procedure that carries the risk of causing significant physical harm. It is not acceptable to expose those patients to a further additional risk factor caused by anxiety arising from procedures performed by a female. The only evidence regarding this extra risk factor was led by expert testimony supplied by the Employer.

In *Central Neighbourhood House*, one of the big issues on which the case turned, aside from the evidentiary issue, was community standards regarding gender identification among transgendered, transsexual, 2-spirited residents. The difference between gender and sex was considered material. For example, a transsexual may be either male or female. Those factors have nothing to do with the instant case, where the issue is discrimination on the basis of sex alone. At

the end of the day, *Central Neighbourhood House* was decided on the basis of the particular facts of that case. The instant case will be decided in the same way. *Central Neighbourhood House* said at p. 17 that “there is no room in the analysis for a priori assumptions. There must be evidence that the exception is warranted.” In other words, the question becomes whether the Employer has met the evidentiary standard. That is a matter of reasonable and compelling evidence. In *Etobicoke*, there was no clear evidence of rejection (because the case was about firefighters), but the SCC found on the evidence that was submitted that it did not discharge the Employer’s burden of proof. In the instant case, it is the Employer’s submission that, the expert testimony of Dr. Drover on the medical implications of gender-caused anxiety does provide the compelling, objective evidence that was necessary to establish that the male-only BFOQ for the urology technician position is warranted.

Although evidence of some level of refusal is needed in cases where dignity is the issue, but in the instant case, the issue of dignity is inextricably intertwined with the issue of clinical care involving an additional risk factor to patients health. That makes it a much more complex matter. Counsel for the Union has alleged that the Employer had not led one clear account of refusal. In the Employer’s view, that is not so. Mr. Rodney Flight testified that he himself saw a patient who had refused to be catheterized by the female technician all one day and had not consumed any water. That was one example. On top of that were the other patients who did not refuse despite being anxious, but had the procedure performed on them without saying anything.

The Employer cited with approval a comment by the board of arbitration in *Sunnyside Home For The Aged*, at p. 14, where they state:

. . . In our view the collected [sic] agreement should be construed in a way that balances, on the one hand, the interest of the employees not to suffer sexual discrimination against, on the other, the reasonable rights and expectations of the residents for whom they care.

Where the parties diverge, however, it is the Employer’s view that Ms. Butler’s right not to be

discriminated against must be reasonably balanced not only by the patients' rights, but also by patient care issues. In *Sunnyside*, at page 1, it states:

. . . Thus, the policy regarding the assignment of female nurse aides is that they are assigned to care for both male and female residents unless there is a specific objection from a male resident. In contrast, the policy regarding male nursing attendants is that, save for an emergency, male nursing attendants are assigned to male residents, whether or not a female resident would or has objected to being cared for by a male nursing attendant.

That situation is different from the instant case where Dr. Drover, in his expert testimony, clearly explained the differences between male and female catheterizations, i.e., male catheterizations are more difficult and are subject to more complications.

With regard to the issue of back-up, the Employer led evidence on the difference in staff make-up between males and females and the difficulty of assuring that, at any given time, there would be a male in the building able to leave his own work to provide back-up elsewhere. Where a female is asked to do something as a result of a patient expressing a preference, there is no problem finding a female to do so. However, finding a male in the hospital to respond to a urology patient's request for a male caregiver, would be considerably problematic. There are simply not sufficient males employed, if such a preference were to be articulated. And just because a preference is not articulated does not mean that it does or does not exist; rather, it means that the preference has not been articulated.

On the issue of anxiety, Dr. Drover testified that the role of the clinician was to reduce risk factors. That is what has occurred here. The evidence here is that the urology physicians at the HSC are all males. There is no evidence that any other physician group is segregated by gender as the urologists are. This recognizes the particular nature of the group of male urology patients that are involved. In many ways, the Employer's approach in directing that all urology technicians will be males, is somewhat similar. In other words, the only situation in which the Employer segregates by gender is where a clinical environment requires it.

With regard to the test in *Meiorin*, i.e., that the standard was adopted in good faith, etc., the Employer has established that this is so and the union has conceded this point. However, the process that was followed was part of adopting that standard. *Prima facie* then the process that was followed was also in good faith. Therefore, the Employer considers it a red herring that the Union complains about what might or might not have been done at an earlier time. The only issue at the end of the day is whether this (a female in the urology technician's position) is going to hurt the urology patients.

As for the Union's claim that there have been no refusals by the male patients, this should not be interpreted as meaning that there was no anxiety. The expert evidence led by the Employer established that anxiety is a risk factor. The Employer submits that the absence of a refusal does not mean that no anxiety is present.

With respect to the Union's claim that the Employer has relied entirely on hearsay regarding what occurred with the female technician during the early to mid 1990s, the Employer submits that it is an unrealistic expectation that the Employer could go back at this stage and find a patient from that era who might remember something. That kind of evidence is not a reasonable standard to which the Employer should be held. It should also be noted that hearsay evidence is admissible in the arbitration process; the only question is how much weight should be placed on it. At the end of the day, the Employer submitted that it has produced the best evidence that could have been brought forward.

On the issue of the patient populations that have been described in the jurisprudence, i.e., acute care settings vs resident care settings, the Employer reiterates that the male patients in the urology division do not reflect the normal type of patients in an acute care facility. Although the Union criticized the Employer for not calling other urologists, staff and patients from the division to testify that they did not want the previous female technician, neither did the Union call anybody to

say that they were alright with her caring for them. While the Employer does bear the onus in this case, the Employer disputes that anything would be gained by each side calling patients from the early to mid 1990s, especially given the fact that one patient might have wanted her and another patient might not. Therefore, the Employer argued that little weight should be placed on this matter.

On the matter of the articles submitted by Dr. Drover, the Employer reiterated that the principles he espoused were extrapolated from those articles and that it was very clear on the evidence that the clinical principles of human nature had not changed. On the matter of the Employer having called Dr. Drover to testify, the Employer submits that there is a standard practice for expert witnesses and even guidelines from the law society how to write the letter, and how to conduct oneself in accordance with the Medical Association, etc. The fact is that Dr. Drover was contacted as a potential witness, and in the interest that the best possible evidence could be brought forward, he wrote his reasons and brought the most recent literature available. The Employer suspects that, had he brought literature from 10 years ago, the Union would have claimed that it was dated. Instead, Dr. Drover has clearly indicated that nothing has really changed on these issues, except that people today are more informed and aware.

Dr. Drover explained that this matter has placed the Employer in a very difficult position. He said that once the link became apparent, the Employer was obligated to act. To do anything less than that would lead to liability before the court. The question of course is whether the position it has taken is legally acceptable.

With regard to distinguishing the circumstances of this case with the case law, the Employer submitted that it is not really the facility or institution that distinguishes the patient population, rather the key is the nature of care that is being provided to a particular group of people. In the instant case, there is a very small group of patients who are being provided care which is at the end of the clinical spectrum as far as intimate and invasive procedures are concerned. One cannot simply say

that dignity alone is the issue for that is not the case. Here such matters are intertwined with clinical concerns, which must be considered among all the relevant facts.

The Union has taken issue with Ms. Monaghan's reference that the "test results procured from female urology technicians were problematic." In particular, the Union argues that no evidence of such "test results" was led by the Employer. It should be noted that Ms. Monaghan testified that this expression and others in her e-mail (KM#1) was phrased in her own terminology, but that she does not have a medical or clinical background. Therefore, the wording she used to indicate her understanding of the clinical situation should not be construed as the best choice.

The Employer argued that no weight can be placed on the fact that Ms. Butler had been offered the temporary urology technician's position in August 1999. At that particular time, the Employer had not obtained sufficient information from the urologists on any clinical implications which might be relevant to the issue of a female performing the required procedures. One can only speculate how events might thereafter have transpired if Ms. Butler had accepted that position.

Although Dr. Drover was not urology chief at the time the female technician was there, he was a urologist in the division and he was knowledgeable about the various clinical procedures that occurred. It was his expert evidence that little has changed with respect to the nature of those procedures. Dianne Sullivan and Marilyn Nichols both testified as to the process of obtaining and discussing relevant information on this BFOQ issue. Therefore, it is not true that the Employer did not have witnesses to explain that process. The only issue, once again, is whether the evidence adduced has been sufficient. While counsel for the Union said that he would have liked the opportunity to cross examine Dr. Best on what written information and material was available from that period, the Employer submits that Dr. Drover's evidence and materials clearly provided the medical reasons why a male only urology technician should be sought. The Union had every opportunity to cross examine Dr. Drover on those reasons, including his extrapolations from the

articles he introduced. Dr. Best's letter did not speak to the detail of the relevant medical outcomes; he simply alluded to the fact that procedures carried out by females on adult males "does impact in their outcome and their comfort." It was Dr. Drover who clearly explained what those outcomes were and that they involved an additional physical risk factor to the patients. His evidence on that matter must be accepted.

In the Employer's view, it is something of a red herring to claim an adverse inference on the basis of whether it was the urology technicians or the urologists who made the first approach to Ms. Sullivan. The only relevant issue is whether the Employer's evidence is sufficient to establish this particular BFOQ. The only expert evidence was brought by Dr. Drover. The Union did not call competing expert evidence of its own to refute Dr. Drover's testimony. Therefore, significantly greater weight has to be given to his testimony.

With regard to Ms. Sullivan being confused about when the review process commenced, i.e., whether they occurred in June 1999 or later, it is the Employer's position that nothing turns on the timing of those events, and it is an undue expectation that she would have a precise memory of times. Clearly those matters occurred about 7 years ago and only a difference of a few months could possibly have been involved.

On the issue of the availability of Clyde Rice to testify, Gerard Holden is currently Mr. Rice's replacement while he is not working. Therefore, the Employer questioned the Union's claim that Mr. Rice was available to give evidence. The Employer also argued that no adverse inference may be attributed to the fact that Mr. Rice did not testify. Such an inference might apply only where no material evidence has been led. However, other urology technicians Gerard Holden, Rodney Flight and Steve Porter all testified on matters that occurred when the female technician was there. The same applies to Dr. Drover. Also Marilyn Nichols and Diane Sullivan testified on the review process. In the Employer's view, all those individuals provided relevant evidence on matters of which they

had first hand knowledge at the time they occurred. Therefore, no adverse inference can validly be claimed because every other person who might have been around at that time was not also called to testify.

One of the major issues arising out of the evidence presented is the issue of anxiety and that it is not always expressed when it does exist. Some medical procedures must be performed even though they might cause some anxiety to certain patients. In other words, the Employer cannot make the necessary procedures go away, i.e., it cannot eliminate them. And there is little the Employer can do to control individuals' fear of procedures, except apply the relaxation techniques for which technicians receive training in their LPN programs. At the end of the day, since the Employer's responsibility is to control any risk factors it can which may potentially affect patients adversely, it is obliged to eliminate the anxiety among male urology patients caused by catheterizations being performed by female caregivers.

The Union has made much of Gerard Holden's comment that he considered his wife capable of performing male catheterizations, but he felt she should not do so. In the Employer's view, counsel for the Union is in no position to speak to Mr. Holden's mind frame on what he was thinking when he made that comment. In the Employer's view, there is an important difference between the the training world and the real world with regard to a female being deemed able to perform male catheterizations. In the sense that LPNs are taught to do so in controlled situations where the artificial (dummy) patient will not feel anxiety, this illustrates how a female may demonstrate the technical ability to perform a male catheterization. However, in the real world where care is delivered to real male patients, the expert evidence is that such patients "may" exhibit anxiety. In other words, the Employer is unable to point to any particular patient and conclude with certainty that he will become anxious because of female care giving. No Employer witness testified that every male patient will experience such anxiety because they know that is not the case. The Employer's true

situation is that it is in the difficult position of not being able to control gender related anxiety until it actually happens.

As to the Union's claim that the Employer had no trouble finding a witness to provide reply evidence, the fact of the matter is that Ms. Nolan was called to correct an inconsistency in Ms. Butler's evidence. In the Employer's view, Ms. Nolan's availability had nothing to do with the availability of persons other than the particular witnesses called by the Employer who were present when events of the past occurred. The only question is whether their evidence has established the Employer's points.

Counsel for the Union has suggested that the arbitrator is being asked to make a decision based upon potential adverse patient outcomes. In the Employer's view, the arbitrator is being asked to make a determination on the basis of clinical concerns for a spectrum of anxiety that constitutes a risk factor to patients. Risk factors are not certainties. The Employer cannot state with certainty that a risk factor will occur in any given instance. However, as a hospital, the Employer is under an obligation to ensure that risk factors are eliminated.

As for whether an adverse inference could be drawn because Dr. Best was not called to testify, the fact is that Dr. Drover was called to provide expert testimony of clinical concerns for the existence of an additional risk factor. The Employer is not sure what other expert testimony Dr. Best could provide. To the Union's claim that Dr. Best was not called to give evidence of the consultation process, in the Employer's view, that process is not the issue. What is the issue is whether the Employer has provided evidence of clinical concerns that sufficiently establish a BFOQ. If Dr. Drover's credibility is at issue on the issue of clinical concerns for the existence of an additional risk factor, then the Union's responsibility is to successfully cross examine him on those points and/or lead contrary expert evidence of its own. The Union has done neither. The Employer provided the Union with advance notice that Dr. Drover would testify and supplied them with the articles he would

bring to the hearing. The Union's responsibility was to call its own witness to discredit those articles. It did not do so. It also did not request any postponement for the purpose of seeking its own expert witnesses. Therefore, Dr. Drover's testimony stands.

With regard to the Union's claim that there is a conflict between Dr. Drover and the two urology technicians who testified on what constitutes the real patient population at issue, i.e., whether the younger or the older males are included, the Employer's response is that the only thing that is important is that there is consistent evidence supported by expert testimony that a proportion of the male urology patient will become anxious where catheterization procedures are concerned.

The Union has repeatedly asked the question, "Why did the Employer only do something in 2000?" or "Why didn't the Employer do something about the situation 5 years earlier?" However, the Employer submits that Dr. Drover answered those questions. His evidence was that, once the clinical connection between procedures performed by a female caregiver and the existence of potential risk for harm to their patients was finally known by the urologists, the physicians were obliged to make their concerns known. This took time to become apparent to different physicians. While clinical procedures may well remain the same over time, new information is always arriving. Once the urologists made this connection, they did not have the option of ignoring it because to do so would not serve their patient population. For the Employer it would not have been appropriate to post for a male only earlier; it could only make that decision after the clinicians' concern was obtained.

With regard to the claim that a female provider would not increase patient anxiety, the Employer argued that this would have to be the subject of expert testimony brought by the Union, which was not done in this case.

As to the question why there are insufficient resources assigned if there is such concern for older patients, the Employer referred the arbitrator to the considerable evidence on the changes that

have occurred in the urology technicians' service to the Miller Centre. Ultimately, the evidence shows that it was routine male catheterizations that were reassigned to the staff at the Miller Centre; the more complicated patients who were more subject to the additional risk factor, continued to be serviced by the urology technicians. That was what Sharon Nolan's testimony was all about. If there is a conflict between Ms. Butler's and Ms. Nolan's testimony on that matter, then the Employer submits that Ms. Nolan's evidence should be considered more credible. The evidence clearly indicates that urology technicians perform the most difficult kind of catheterizations on male patients who are more inclined to be susceptible to the risk factor of anxiety caused by females performing their catheterizations. That risk factor must be considered by the arbitrator. It is also for the arbitrator to judge the extent to which such anxiety may be offset by a technician developing rapport with male patients over a significant period of time.

With regard to the Union's assertion that the setting in this case is an acute care hospital, the Employer's position is that such is not the case. Rather the relevant setting is a small distinguishable portion of an acute care environment, featuring a small population of male patients with specific urological problems who are subject to very intimate and very invasive medical procedures for which there is an additional unacceptable risk of adverse outcomes should a female perform those procedures.

On the issue of accommodation, the Employer's position is that, according to the jurisprudence, once we get past any disagreement whether there is a rational connection to the performance of the work, etc., it is still necessary to work out whether the individual can be accommodated.

The Employer disagreed with the Union that placement of Ms. Butler on the trial period mentioned in the collective agreement would be appropriate. The prerequisite for placement in the trial period is that the individual be the successful candidate. However, to be the successful

candidate for a position of urology technician, one would have to meet the *bona fide* occupational requirement of being male. Since Ms. Butler is female, she does not qualify for the position and, therefore, cannot be the successful candidate. In the result, she does not meet the contractual requirements for the trial period. One should also be cautious of the value of any trial period in determining the competence of an individual who is not the gender required. No amount of trial can establish such a requirement. The Employer further urged caution in assessing Dr. Drover's comment that he would not have a problem with a female technician as long as adequate back-up is available. First, Dr. Drover is not cognisant of the implications of putting someone who is not qualified on a trial period. The purpose of the trial period is not to train a person to become qualified. Second, the evidence is that there is no back-up available Monday to Friday from 4:00 p.m. to 12:00 midnight or on weekends, holidays, or on night shift. Clearly, there is no male back-up available for the vast majority of time during any week.

In the Employer's view, consideration must be given here to the evidence which describes the extremely intimate sexual nature of the procedures involved among male urology patients. The sensitive nature of those procedures is revealed in common patient comments making embarrassed excuses for the size of their penises. While the urology technicians always try to provide as much privacy as the particular room will permit, the presence of a female technician would only exacerbate the anxiety patients feel. In such circumstances, contrary to the Union's assertion that patients in an acute care facility have the expectation that they will be cared for by both females or males, male urology patients do not have the same expectation. Theirs is a different situation entirely and it distinguishes their circumstances from all other cases among the jurisprudence. Each and every time they must be catheterized, they face an intimate, invasive medical procedure which can lead to anxiety and in turn make the procedure even more difficult to perform. The potential for physical harm to patients in such circumstances is a known risk factor, one to which a further level of anxiety

would be added if a female were to perform the procedure. The elimination of the risk factor caused by that additional level of anxiety is the Employer's responsibility.

The impact that this BFOQ has had on Ms. Butler has been severe, and it is definitely not what the Employer would wish for her. But the fact is that, however unfortunate her situation may have turned out, the provisions of the collective agreement, such as bumping, have always determined Ms. Butler's options. It was not open for the Employer to depart from those contractual provisions.

Finally, with regard to the Union's claim that the grievor should be placed in the position of urology technician as of the date of her grievance and be compensated for all lost salary and benefits, the Employer pointed out that, in the event that the arbitrator were to find that Ms. Butler was the successful candidate, it could not simply award her retroactive compensation unless she successfully passed the trial period required by the collective agreement.

### **CONSIDERATIONS**

As the foregoing sections demonstrate, every attempt has been made here to reproduce as much of the parties' evidence and submissions as possible, even to the point of significant repetition, which the parties obviously considered necessary to support their respective positions. I have reviewed everything that has been said and written in this case and have thoroughly examined all the jurisprudence and authorities placed before me.

#### **The impact of the Employer's decision on the grievor – the issue of discrimination**

The Employer has conceded that, since it posted for a male only position and rejected the

grievor on that basis, a *prima facie* case for discrimination has been made out.

The impact that this decision has had on the grievor is an example of why legislation requires justification before a *prima facie* discriminatory standard may be accepted as a *bona fide* occupational requirement. By denying Ms. Butler the position of urology technician in February 2000, which I agree she would have considered to be a promotion, the Employer directly denied her the opportunity to obtain a permanent position for which she was otherwise qualified and the senior applicant. Without the relative security of this permanent position, she has been subjected to a succession of bumping exercises over the years which has drastically diminished her career opportunities. Meanwhile she has had to endure the ignominious irony of obtaining her current temporary position in the Veterans Pavilion by replacing another junior LPN who vacated his position to become a urology technician. As has been pointed out by the Employer, the provisions of the collective agreement have governed all her subsequent employment moves. Understandably, however, Ms. Butler is not consoled by this; her feelings of hurt, dismay, disbelief, disappointment, resentment, and suspicion run deep. Clearly those are all the feelings associated with a belief that one has been discriminated against. It is difficult to imagine how a person could put something like this behind her unless the legal case is clearly made on the basis of supporting compelling and objective evidence that the Employer's decision was honestly initiated and validly based on a genuine BFOQ. That is the Employer's task here and it is properly an onerous one.

#### Whether the Employer had access to the BFOQ defence under the collective agreement

The Employer addressed this issue in its submissions, claiming that it had such access. The Union did not challenge that claim. Indeed, the Union took the position that the only issue to be decided at arbitration is whether a BFOQ has been established on the basis of the facts presented. In the absence of any disagreement by the parties that the Employer has the right under the

collective agreement to attempt to establish the BFOQ exception under section 9.(1) of the *Human Rights Code* in these circumstances, I consider it unnecessary to address this matter further.

Whether a BFOQ has been established on the basis of the facts presented

*What test of appropriate evidence should be applied?*

The parties expressed very different views on the type and sufficiency of evidence that is required to establish a BFOQ for the position of urology technician. On the one hand, the Employer relied on the 3 Step test established in 1999 by the Supreme Court of Canada in *Meiorin*, viz:

- 1) that the Employer adopted the standard for a purpose rationally connected to the performance of the job;
- 2) that the Employer adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of a legitimate work-related purpose; and
- 3) that the standard was reasonably necessary to the accomplishment of that legitimate work-related purpose; and to show that the standard was reasonably necessary, the Employer has demonstrated that it was impossible to accommodate individual employees sharing the characteristics of the grievor without imposing undue hardship upon the Employer.

On the other hand, the Union's view was that the test in *Meiorin* was not appropriate because the issue there was the safety and efficient performance of the job by a firefighter, i.e., whether a woman had the ability do the task of a firefighter. The grievor in that case was subjected to different testing than the males were. In the Union's view, since the issue in the instant case is whether a woman can do the job of a urology technician in a completely different workplace setting, namely, an acute care hospital setting, *Meiorin* is not the appropriate approach. Instead the Union argued that the evidence should be subjected to the approach cited in *McKale*, at page 10, where the Alberta Court of Queen's Bench stated in 1987 that there should be evidence of the following where a claim of a hospital patient for same sex intimate care is asserted:

With regard to the claim of an auxiliary hospital patient for intimate care by a member of the same sex, there ought to be evidence on the following points:

- 1) The claim, or demand or stated preference
- 2) The manner in which it is made
- 3) Policy or systems to deal with such claims
- 4) Consequence to a patient both physically and mentally of failing to deal with the claim
- 5) Consequences to staff of failing to deal with the claim

On balance, I am satisfied that the 3 Stage test in *Meiorin* is appropriate for the purposes of determining whether a BFOQ has been established in the instant case. Although the issue revolved around forest firefighters in *Meiorin*, I am satisfied that the test that decision proposes permits application to a broad range of BFOQ issues. More to the point, I note that this test was proposed by the Supreme Court of Canada only after it determined that a new approach was required and then considered the various alternatives. At paragraph 50, the Court wrote:

Whatever may have once been the benefit of the conventional analysis of discrimination claims brought under human rights legislation, the difficulties discussed show that there is much to be said for now adopting a unified approach that (1) avoids the problematic distinction between direct and adverse effect discrimination, (2) requires employers to accommodate as much as reasonably possible the characteristics of individual employees when setting the workplace standard, and (3) takes a strict approach to exemptions from the duty not to discriminate, while permitting exemptions where they are reasonably necessary to the achievement of legitimate work-related objectives.

On balance, I accept that *Meiorin* requires sufficient and compelling evidence to establish a BFOQ. Exactly what this sufficient and compelling evidence will be will depend on the particular circumstances of each case in dispute. The case before me is no different in that respect. In adopting *Meiorin's* unified, more common sense approach, I do not in any way dismiss the approach established in *McKale* for a claim of an auxiliary hospital patient for intimate care by a member of the same sex. As is the case in all BFOQ disputes, the judgement in *McKale* was made on the basis of circumstances involving an identifiable population group. The extent to which I disagree that the test in *McKale* should be the exclusive approach for the instant case is based upon the fact that

I do not share the Union's view that the male urology patient group at Eastern Health is no different from other patients in an acute care hospital. My reasons for this are as follows.

*How should the relevant population group be characterised in this case?*

The provision of intimate care is at the root of this issue. Essentially, the question is whether intimate care for male urology patients is distinguishable from intimate care for acute care hospital patients.

It is to be expected that parties to a BFOQ dispute would canvass jurisprudence for supporting decisions, which hopefully would provide close similarities to the population group that is the subject of their particular dispute. That exercise is much more straight forward if the parties agree on the characteristics of the relevant population group. But in the instant case, the matter is made more complex because the parties disagree on its essential nature. In my view, that issue must be dealt with first.

Among the jurisprudence there are several examples of intimate personal care BFOQ issues in health care settings where the populations range from residents in critical care nursing homes (e.g., *Green Bay*) to patients in acute care hospitals (e.g., *McKale*). Neither party appears to disagree with the distinctions made in the jurisprudence with respect to intimate personal care of nursing home residents on the one hand and intimate care of patients in acute care hospitals on the other hand. However, it is abundantly clear that they very much disagree whether the patient population that is serviced by urology technicians should be considered typically as acute care hospital patients. As I see it, each party's choice of test to determine the appropriate evidence of a BFOQ in this case has been heavily influenced by their divergent views on the most accurate description of the patients involved.

It is common ground that the urology division at the HSC is the sole central provider of

specialized urology services for the entire province. On the basis of the evidence submitted, I accept that the population served by the urology physicians and the urology technicians consists almost exclusively of referred male patients who typically present with urological difficulties peculiar to their anatomy (55 and older), or with various genital problems, and also sexual dysfunction (younger men). Those between 30 and 55 do not appear to be as much of a problem. Of particular import are prostate problems and strictures which complicate catheterization procedures. Instructive and compelling information on this subject was provided by Dr. Drover's expert medical testimony explaining why male catheterizations are significantly more complex than female catheterizations. His evidence was that catheterization performed on male urology patients is not only an intimate procedure because of the significant extent of genital manipulation required, but is also an invasive medical procedure, which is complicated by the peculiarities of the male anatomy and associated "male" medical conditions involving the prostate gland. Also significant is the overwhelming evidence in this case that the requirement for catheterizations is by far the primary and most prevalent duty of urology technicians. While the physicians also perform catheterizations, the evidence suggests that they do so primarily in day surgery. The urology technicians also may catheterize patients in clinical settings, but they perform virtually all other urology catheterizations and difficult catheterizations that are required elsewhere. Although a range of other duties are performed, catheterizations constitute the highest portion of their activities and the greatest volume of their time (65% to 90% depending on the day). In my opinion, catheterizations are the *raison d'être* of a urology technician position, following the greatest need by male urology patients. This defining characteristic arises from the fact that male urology patients are almost certain to require catheterization and urology technicians are assigned this responsibility because that is their area of speciality.

In my view, the recent changes in the delivery of catheterizations at the Miller Centre, which

were made necessary because of inadequate urology technician staffing, have brought UT services in line with the type of patient population that they service elsewhere throughout Eastern Health. Essentially, routine catheterizations on non-urology patients are not performed by urology technicians. That is now the situation at the Miller centre. There was some difference between Ms. Butler and Ms. Nolan regarding who performs catheterizations on DVA patients. On balance, I do not think this raises an issue of credibility for the grievor. I accept that management has made it clear to staff that the urology technicians will continue to perform the same service to DVA patients, but not to other Miller Centre patients. To the extent that Ms. Butler says that she has not found it necessary to call the urology technicians to perform catheterizations when she is at work in the Veteran's Pavilion, it appears that she may have performed certain catheterization procedures there without the knowledge of management. If so, it is indicative of her confident personality and strong belief that she should simply do what needs to be done, and she does exactly that. If there is anything amiss here, it would seem to be a matter of ensuring adherence to management's directions and instructions, but that is not an issue for this board. It certainly does not mean that the Employer's evidence was wrong about the role urology technicians are expected to perform in the DVA Pavilion. Therefore, I do not consider this to be a matter of witness credibility.

On balance, I accept Mr. Flight's explanation of the fundamental difference between intimate personal care delivered to acute care patients and the intimate invasive medical care performed on male urology patients. Using the example of washing a patient around the genital area, Mr. Flight said that if a male patient fights (resists) being washed, the activity will be performed eventually without any physical repercussions, but if a male urology patient tenses up for a catheterization, the invasive procedure becomes more difficult, thereby causing a risk of bleeding, which is a more serious safety implication. In my view, the degree of intimacy is significantly greater and more sensitive for urology patients than for typical acute care patients. After all, the sole reason for their

referral to the urology department is to undergo treatment of genitourinary problems, which will invariably involve more genital area exposure, more sexually sensitive procedures, and more handling of patients' genitals by urology technicians with whom they have little, if any, opportunity to establish rapport. This heightened level of intimacy, particularly embarrassing for many male patients, serves to distinguish the male urology population. However, I am satisfied that the issue of patient safety, i.e., the risk of causing physical harm during an intimate care procedure is the primary feature that differentiates the population of male urology patients from typical acute care hospital patients. I would also suggest that levels of intimacy are somewhat diminished when patients have surgery under anaesthesia, and also because doctors previously would have had opportunity to establish rapport and trust. In contrast to male urology patients, acute care patients typically do not present with urology problems. Therefore, catheterizing them is more of a routine procedure which may be performed by non urology hospital staff because difficulties are far less likely to be encountered. This means that the safety of such patients is considerably less of a risk factor than it is in the case of male urology patients.

While I will consider in more detail later the overall sufficiency of Dr. Drover's testimony in establishing a BFOQ in this case, for the purpose of supporting my conclusions above, I accept his expert medical testimony that the role played by anxiety -- both anxiety related to the medical procedure itself and anxiety relating to a female performing that procedure -- further exacerbates the potential for adversely affecting patient safety.

The Union's argument is that there is no reason why male urology patients should be treated any differently from acute care hospital patients, particularly with respect to the notion that they should expect to check their dignity at the door. In other words, they should expect to receive care by either females or males and, since there are so few male RNs and LPNs employed, female care should be more anticipated. As I see it, however, dignity is not the only issue here. Whatever might

or might not be a patient's preference for a same sex care provider or what might be a patient's expectation upon entering an acute care facility, those are not the only matters to be considered in deciding who should provide the required care. Particularly relevant would be patient safety issues, which, despite the peculiar gender composition of its nursing staff, the Employer would be obliged to carefully consider. In my view, where male urology patients are concerned, the Employer is duty bound to be cognizant of potential safety implications, including potential safety consequences arising from female care giving --subject of course to establishing a male only BFOQ -- when assigning appropriate staff to their care.

In the result, I am satisfied that the existence of patient safety considerations is the key factor distinguishing intimate care given to male urology patients from intimate care given to acute care patients, or intimate care given to nursing home residents for that matter. In my opinion, that is sufficient reason to consider this group of male urology patients as a different category of patient population for the purposes of determining sufficient and compelling evidence of a BFOQ.

*Whether the Employer adopted the standard for a purpose rationally connected to the performance of the job*

This is the first step in the *Meiorin* test, which, at paragraph 57 states:

. . . is to identify the general purpose of the impugned standard . . . to determine what the impugned standard is generally designed to achieve. . .

And at paragraph 59:

The focus at the first step is not the validity of the particular standard that is at issue, but rather on the validity of its more general purpose. . . .

As a preliminary matter, the Employer pointed out that gender has been successfully argued in cases where 1) there is a negative therapeutic or clinical outcome if same gender service is not provided and, as a corollary, that brings to play negative legal outcomes and associated issues and

2) where there has been an affront to the dignity, privacy and decency of a resident.

With regard to the existence of safety issues in the analysis of the first step, the Employer cited *Meiorin* at para. 58 where the Court held that:

. . . Where the general purpose of the standard is to ensure the safe and efficient performance of the job – essential elements of all occupations – it will likely not be necessary to spend much time at this stage. Where the purpose is narrower, it may well be an important part of the analysis.

Despite claiming safety as the general purpose of the standard here, which one might ordinarily expect to be dispatched rather quickly at this stage, the Employer chose to devote considerable time and energy dealing with a large number of issues, to which the Union responded in all respects. While this might not be the appropriate point to conduct an exhausting analysis, in deference to both parties, my considerations on their submissions will be proportionately lengthy. If some aspects of this analysis prove to be equally applicable to steps 2 and/or 3, so be it. I believe it will all be relevant to ultimately determining whether a BFOQ has been established.

In the Employer's view, the general purpose of the standard here is patient safety (with some legal concerns), as well as patient dignity, privacy and ethical concerns. It is submitted that all those aspects may be found in policies and mission statements, but may also be found in the surgical care Objectives submitted in C#7, which apply to the care of urology patients. Of particular relevance are items 1, 2 and 6, namely:

1. To provide a high quality of patient care and services by educated Nurses and Urology Technicians with the necessary knowledge and skills to anticipate and contribute to the physical, psychological, emotional and spiritual needs of the patient.
2. To insure as safe an environment as possible for the patient while under our care by applying our technical knowledge and skills and the principles of asepsis.
6. To establish a rapport with the patient which will instil confidence and reduce anxiety, thus alleviating many of his fears.

In the Employer's view, the importance of patient safety cannot be overemphasized. Safety concerns were behind the 2000 job posting for a male only urology technician, which requirement was necessary in order for the Employer to meet the foregoing safety and efficiency objectives.

It was on this point and others that the Union objected strenuously and repeatedly, claiming that the Employer produced little or no evidence to prove its case on the issue of patient safety and legal concerns, or on the basis of patient dignity, privacy and ethical concerns. In particular, the Union argued that 1) no policies or mission statements were introduced; 2) the above Objectives were the same for all departments that provide services to acute care patients; 3) the Employer completely failed to adduce any concrete evidence whatsoever that there had been any patient refusals to the female technician performing catheterizations during her tenure, or that there were any documented reports of adverse outcomes caused by her; 3) Mr. Holden's and Mr. Flight's testimony on such matters was based entirely on hearsay and 4) there is no indication that there were any more problems involving the female technician than there were with the male technicians at the time. The Union also criticized the journal articles relied on by Dr. Drover on the grounds that they were compiled at Ms. Sheppard's request in December 2006 and they were not available seven years ago at the time of the grievance. Also, since the articles dealt primarily with female subject matter and did not involve urology patients, the Union argued that they were not relevant. Furthermore, the Union claimed that Dr. Best's letter of January 21, 2000 was hearsay, that no first hand evidence was called to establish its validity or to explain or support its contents. Also, the Union argued that there was no concrete evidence adduced on the "test results," "amassed material" and "lengthy consultative process" referred to in Kelly Monaghan's evidence.

It is doubtful that I will ever manage to deal with every evidentiary disagreement between the parties. However, it is critical that this issue of sufficient and compelling evidence be addressed. I have decided to do so by starting with the genesis of care provided by the urology technicians and

analysing the most relevant evidence of its progression to the present day.

I am led to understand from Dr. Drover and other witnesses that the position of urology technician has been around for a long time. There was no precise information provided when the first position was created, but whenever that was, all the positions since have been held exclusively by males despite applications being open to both females and males – the sole exception being one female who held a position for a period of two or three years (not clearly specified by the parties) somewhere around the mid 1990s (also not clearly specified).

Nobody seems to have disputed the general notion that there was previous wide acceptance among hospital staff that the intimate duties required of the urology technicians should be performed by males because the patients involved were almost exclusively males. General acceptance similarly prevailed that Obstetrics should be staffed by female nurses because the relevant patient group was female. Notwithstanding the pronounced gender imbalance among staff, these two areas did not appear to be the choice of opposite gender nursing providers. In other words, for the most part, opposite gender staff members appeared content to accept the provision of same gender nursing care in these two areas and, therefore, deliberately avoided applying for such positions. In my view, this general persuasion, for urology at least, appears to have been the result of a commonly held norm that the level of personal intimacy involved in performing intimate procedures on male urology patients is significantly greater and is much more sensitive than intimate care provided generally to a typical acute care hospital patient. Since the issue of the additional risk factor for male urology patients due to anxiety created by female care-giving was not identified by the physicians until more recent years, the relationship between patient safety and gender care-giving appears not to have been a contributing factor to the ongoing “maleness” of the position. Absent safety considerations, I submit that this pervasive recognition of the appropriateness of same gender nursing services for male urology patients was grounded on the perception that the

performance of extremely intimate procedures involving considerable handling of male genitalia, was considered by both staff and management alike to have significantly greater personal patient dignity, decency, privacy and ethical overtones than was the case with intimate care for typical acute care hospital patients.

On a closely related matter, the information I have been given is that, in urology, the physicians have been and still are all males. Dr. Drover spoke to the urology physician gender issue explaining that, in his experience, most female physicians who initially express interest in specializing in urology ultimately switch to obstetrics or gynaecology because of the strong preference among male urology patients for male caregivers. Although no studies or statistics were offered in support of this conclusion, and I have no idea whether such evidence exists in the literature, I am prepared to accept the foregoing as evidence supporting the reason why there are no female urologists on staff at Eastern Health. As an expert in the field of urology and as an experienced clinician, Dr. Drover's assessment of the male only specialist situation at Eastern Health enjoys a reasonable measure of credibility and, therefore, deserves to be given consideration. At the same time, I am given to wonder why same gender preference has not resulted in all female physicians in obstetrics and gynaecology at Eastern Health. Unfortunately, this issue was not explored by the parties.

In my view, the composition of the specialist physician staff in urology reflects Dr. Drover's own experience as well as his personal knowledge gleaned from discussions on the gender issue with the other five (5) urologists in the division that male urology patients prefer that male technicians perform their catheterizations and apply their penile and scrotal dressings. The weight that should be put on this evidence deserves to be carefully assessed in light of the kind of evidence that the jurisprudence has considered appropriate in the past. The unique specialty role assigned to urology technicians reflects that of the physicians in the provision of care to male urology patients

at Eastern Health. Also the experience-based notion that those male patients prefer same sex technician care has contributed naturally to the predominately male composition of the technician staff, who provide a special service to patients that is commonly performed by urology residents in other medical jurisdictions. But there are no urology residents at Eastern Health, only other speciality residents who rotate through urology as part of their programs.

I am satisfied that, in his role of urology chief, Dr. Drover would have occasion to discuss many professional issues with the other urologists, which would qualify him to represent their views and experiences. He has said that he discussed the gender issue with his peers. I believe him. I also accept his evidence that the urologists' experiences have contributed to their conviction that male urology patients generally prefer male technicians to perform their catheterizations and dressings, etc. However, conviction is one thing, proof is another. I do have some reservations about the lack of concrete evidence gathered during the previous female technician's tenure. To support the physicians' belief, a reasonable amount of evidence citing actual incidents should have been provided, and the Union, whose role here is to defend against a *prima facie* act of discrimination by the Employer (an act so serious that legislation has been enacted to prevent it), should have been able to test the Employer's evidence in cross examination and call relevant contrary evidence if it deemed necessary. Without more Employer evidence to support conviction or belief, the Union has no way to defend the grievor, except to dismiss the Employer's claim by arguing that no objective compelling evidence has been provided. That is precisely what it has done in this case. I will discuss this matter again later. In the meantime, I will continue with my analysis of Dr. Drover's evidence.

Dr. Drover further testified that all the urologists have had weekly experience with male urology patients who will not have female nurses in the room for urology procedures, especially wart removal and other procedures involving sexual dysfunction. In all such circumstances, if the

patients are apprehensive or embarrassed about opposite gender staff being in the room, the doctors ask them to leave. Similarly, he said that female patients have indicated that they do not want males to prep them and that is why male urology technicians are not assigned to any female urology patients.

The Union argued that it could only have been in day surgery that physicians would have witnessed patients requesting females to leave the room, and since there is no indication that the previous female technician was one of those asked to leave, the doctors must be referring to female nurses. Also, the Union's position was that there was no risk associated with such incidents because day surgery hours coincide with day shift hours when the UT II was available to provide back-up (also there was some UT I back-up available on day shift at the time of the grievance). On balance, I accept Dr. Drover's evidence that the urologists, on a weekly basis, have personally witnessed patients request that females leave the room during urology procedures. Once again, this evidence was not supported by concrete evidence, thereby reducing the weight that could otherwise be given to it. Based upon the fact that the urologists do not work alongside the urology technicians outside the 8 - 4 shift, I accept the Union's position that those incidents probably occurred in day surgery and probably involved nurses. I do not view the lack of evidence that the female technician was asked to leave as proof that she was not asked. I simply do not know whether or not she was involved, or the extent to which she may have been involved. Since the evidence is that not all males will object to females, her presence might not have been an issue depending on which patients were scheduled for surgery. But all that is conjecture. All we know is that no mention was made of the female technician being involved. There is not much else to discuss on this matter that would be useful at this point.

Since the evidence is that each urology technician works independently on all shifts outside of surgery and clinic hours, I accept that it would have been unlikely in those circumstances for a

urologist, or another urology technician for that matter, to witness patients refuse or object to being cared for by the previous female technician. Direct personal observation by the urology technician witnesses who testified at this hearing would have been extremely unlikely. As I understand it, Mr. Holden and Mr. Flight had very little opportunity to learn of incidents involving the female technician unless they were included in the subject matter of Report for an oncoming shift, which would have required her to disclose them if she considered it necessary, or from patients themselves who, for some reason, subsequently might have volunteered such information. Absent supporting evidence, much of this evidence is hearsay. Given the extremely sensitive and personal nature of such incidents, I have some reservations that patients, especially those who did not openly refuse the female technician although they may have been anxious about her presence, would feel comfortable raising the incidents again with another staff member, especially one whose visits are usually cold calls and not conducive to the development of rapport. Under the circumstances, I do not consider it at all surprising that the evidence of particular incidents provided by the Employer's technician witnesses was extremely limited. They were entitled to attest to the few incidents they heard about, but could not attest to their veracity. Veracity would normally be established by corroborating testimony from the relevant patient or the previous female technician. However, I can appreciate that some 10 or more years later at this arbitration, it would be rather unlikely the particular patients involved could be found and then convinced to provide supporting testimony at this arbitration, particularly since no documentation seems to exist on those matters. And as for the availability of the previous female technician to testify, I can only say that both sides were rather guarded about providing specific details of her current circumstances. While I think it might have been helpful for me to have heard her side of the story, neither party seemed inclined for that to happen. That is their right and I respect it.

Dr. Drover's letter (DD#6) at page 2, Question 1 (a) Catheterization, begins with the

following:

There is a perceived difference in patient outcomes and the gender of the person performing this procedure for catheterization. It is possible that patients' anxiety might affect the outcome of this procedure.

The Union seized on the expressions "perceived difference," "possible" and "might affect," arguing that perceptions and possibilities do not constitute appropriate compelling evidence for the purpose of determining the existence of a BFOQ. With the greatest of respect, I do not accept that the meaning of those sentences should be determined in isolation. The explanation of the link between gender and outcomes is not restricted to those sentences. Rather it continues in detail for most of that page and throughout the letter, which, in my view, provides context for the issue. As one reads further, Dr. Drover talks about medical facts, viz:

. . . These are patients that have usually been previously difficult catheterizations or had prior surgical procedures and traumatic attempts at catheterizations can lead to permanent long-term adverse event in outcomes. These are primarily manifest as immediate inability to catheterize with urinary retention and pain and bleeding and long-term with urethral stricture. The worst-case scenario would be traumatic catheterization with introduction of urosepsis and death.

In my view, this is valid medical evidence pertinent to the field of urology that is within Dr. Drover's knowledge and experience as a urology specialist. It describes the potential serious outcomes associated with catheterizations performed under conditions when patients are anxious. On balance, I am satisfied that this connection between catheterization and outcomes under circumstances of anxiety is logical and clinically supportable as determined over time by urologists' experience and examination of their respective patients. In my view, concern for patient safety cannot be ignored among this population group. It is such an inherent component of medical care that its validity does not depend on formal expression in a policy, mission statement, or statement of objectives.

The obvious question that immediately springs to mind is how could it be possible to isolate the physical implications caused by gender from those caused by anxiety associated with the

procedure? In other words, can the physical effect of gender itself be clinically witnessed? I suspect that there might be some difficulty in accomplishing that. Therefore, establishing a link between gender and outcomes by another means is critical to the Employer's case.

This raises another question: who besides the patients themselves could possibly be in a position to witness refusals, objections and adverse physical outcomes caused by opposite gender care? Clearly, if the only possible people involved at such times are the individual patient and the technician on shift, for an incident of refusal or objection to become part of a record, one of them would have to formally raise the matter with a supervisor. Frankly, I have some doubt that patients who need urgent urinary relief would always be inclined to initiate such an action in a one-on-one environment where it is known that there is nobody else on shift to provide same sex care and that the time it would take to call in another technician would further exacerbate their physical discomfort. Since patients do not call in staff, responsibility would rest initially with the technician on shift who presumably would have to contact a supervisor or a physician to authorize and conduct the call in. Since LPNs are trained to relax and reassure patients who become anxious, short of an outright refusal by a patient, which by all accounts is relatively rare or at least infrequent, one wonders what would cause the technician to stop the procedure and take steps to arrange for someone else to do it.

As I see it, regardless whether they be male or female, urology technicians are professionals who are trained to recognize and deal with patient anxiety. The objective in all cases is to apply relaxation/reassurance techniques that would ultimately permit the planned procedure to be performed without physical harm. I see no reason why either sex should not be equally capable of recognizing the point at which a patient's anxiety has sufficiently subsided to enable the procedure to be performed safely and efficiently. While a technician might or might not be told by patient what the cause of his anxiety is, the technician's focus should be on attempting to diminish

the severity of the patient's physiological response. As I understand it, anxiety over the procedure itself and anxiety over the technician's gender both manifest themselves in the same physiological condition for the patient. Nobody disputes that anxiety over the procedure can be relieved in most cases; indeed that has been the experience to date. However, I do not know what techniques might be applied to relieve anxiety over a technician's gender, or whether such relief is possible at all. If a female technician experienced more incidents of anxiety among the patients and/or increased difficulty reducing their anxiety, one might logically conclude that the reason is her gender. Essentially though, no matter what the cause of the anxiety, a technician can only proceed in accordance with his/her training unless pelvic floor tightening on the patient's part renders catheterization too risky to perform. In my view, if the previous female technician experienced such difficulties, one would expect there to be a reasonable number of actual incidents the Employer could cite in support of its position.

On balance, I am satisfied that there is no evidence that any specific cause and effect incidents due to the gender of the previous female technician have been witnessed directly. Frankly, I am at a loss to understand how such an observation could be made of any female technician unless she is observed proceeding with a catheterization despite being told by a patient that he did not want her. Indeed, I sincerely wonder how a female technician herself would always be able to recognize that her gender is or has been the cause of an adverse outcome due to catheterization. In essence, I simply cannot conceive how evidence of specific incidents of direct cause and effect based on gender could reasonably have been witnessed unless someone else had been present to witness the events. Such information would most likely have surfaced after the fact when the physicians examined their patients. Therefore, I do not find it surprising that Dr. Drover's explanation in the next paragraph does not contain the kind of "concrete" evidence, i.e., incidents where refusals have been witnessed, the Union claims should be present. That paragraph states:

The answer as to why this would be different based upon gender, outcome would be predicated upon the known effect that there is evidence of sphincteric tightening with the introduction of a catheter hitting the male pelvic floor. It is well known that relaxation is essential for male catheterization to allow the easier introduction of a catheter. It is certainly possible and quite reasonable to believe that there is a certain segment of the male population that would find a procedure performed by a female technician without any supervision or choice on behalf of the patient to enhance one's anxiety which then in turn leads to increased pelvic floor tightening which decreases the probability of a successful outcome with the potential complications as above.

In determining whether this explanation is mere impressionistic evidence, one must consider that it is given by an expert witness, i.e., an experienced urologist, based on the known effect of sphincteric tightening during catheterization, the experience of urologists -- supported by the literature that at least a significant minority of women want same gender care and extrapolating that the same proportion of males would also want same gender care -- that there is a significant proportion of the male urology patient population who do not want women to perform their catheterizations and whose anxiety in those circumstances would result in pelvic floor tightening, thereby increasing the risk of an adverse outcome. In my opinion, while these conclusions are not based on statistical research or deliberate studies, they are nonetheless acceptable because they are the considered medical conclusions of an expert in the relevant specialty area, shared by his peers. To dispel such evidence, the Union would have to call its own expert witness to provide contrary evidence or conclusions. That did not happen in this case.

Immediately following the forgoing explanation, Dr. Drover's letter led directly into what his conversation with Dr. Best said about the clinicians' experience with the female technician, viz:

We have had a female technician at the Health Sciences Centre previously and discussions between Dr. Best and myself affirm that there were many negative outcomes more so than we have had with male technicians.

The Union claims that this whole paragraph is hearsay because Dr. Best was not made available to be cross examined on what he might have said to Dr. Drover. On balance, I accept that there is

an element of hearsay in this evidence, but I reiterate that Dr. Drover's role as chief of urology qualifies him to speak on behalf of other urologists if he has had discussions with them. In this paragraph, he is echoing what Dr. Best apparently disclosed to him. Under the circumstances, I would assign less weight to this evidence than I would to evidence of discussions Dr. Drover had with all the urologists. It would be one thing for Dr. Drover to report Dr. Best's own experiences, particularly if they were similar to his own, but it would be quite another thing to relate Dr. Best's conclusions based on his (Dr. Best's) previous discussions with the other urologists. In my view, if discussions with other urologists occurred with Dr. Best during his own tenure as chief of urology, he, not Dr. Drover, should be the one to testify on those matters.

However, Dr. Drover's evidence on clinicians' findings regarding the previous female technician's tenure was not restricted to the foregoing paragraph. In cross examination, he testified that:

. . .while the female urology technician was on staff, more than a number of complaints occurred that were discussed at the urology division level. Some patients refused her and sometimes male technicians had to perform the procedures when she could not do so. Dr. Drover indicated that no documentation was created for those complaints.

There Dr. Drover was speaking of his own knowledge and experience of what had been discussed at the urology division level while the female technician was on staff. What is indicated in Dr. Drover's letter is that the number of incidents, including refusal incidents, involving the female technician were greater than the Union has suggested and that male technicians had to provide back-up. While he did not specify names of patients or dates of incidents, I do not consider that surprising given his admission that no documentation had been created for those complaints. In the absence of records of such incidents, he had to rely on his own recollection of events that happened a decade or more ago. The evidence is that he could not personally remember the previous female urology technician or many of the issues in which she was involved. However, he could recall the

urology division discussions regarding complaints about patients refusing her and also about male technicians having to perform the procedures when she could not do so. On balance, I accept this evidence as indication that previous complaints had been made about the female technician that were the subject of discussions among the physicians at the time, Dr. Drover being one of them. That no documentation was created on those complaints is a matter I will discuss in a moment. In the meantime, I note that Dr. Drover also recalled that a complaint had been made about a male technician as well. No details were led on that complaint either. In essence, it is clear that no documentation was created on any complaints regardless whether the technician was female or male. It is also clear to me that the female technician was the subject of more complaints than the male technicians.

It occurs to me that physicians might learn about patient refusals and objections from the supervisors or the division manager if they had such information, but I submit that could only happen if such matters had been formally complained of and recorded. On this point, however, the question must be asked: for what purpose would such documentation be recorded? Since the female technician's tenure began sometime prior to the mid 1990s, the evidence strongly suggests that at that time there was no thought among staff, managers or administration to document such incidents for the purpose of gathering information for a BFOQ. Frankly, I think an opportunity was missed here that should not have been missed. The evidence is that BFOQ matters were simply not on anybody's mind until years later, long after the female technician had departed. And there was certainly no reason to document such matters for disciplinary purposes. After all, how a patient may have felt about a technician's gender, could not possibly be remedied by disciplining the technician. Another reason for recording such information would be for clinical purposes, which would make it the initial purview of the urology physicians, not hospital administration. But that was not done. To be apprised of such information in the first place, a physician would probably have to learn about

it from individual patients during subsequent medical examinations. In my view, an unsolicited disclosure by a patient to a physician with whom he has formed a medical relationship is much more likely than with a technician who makes cold visits. Another more compelling reason for disclosing such information might occur if the physician's subsequent examination of the patient revealed that some physical damage had occurred during catheterization, which might then lead to the patient being asked about the circumstances. Since there is no issue about the female technician being equally as capable as male technicians of performing catheterizations, an individual patient's problem outcome would be unlikely to arouse any concerns about her professionalism or the quality of her performance. Dr. Drover's evidence clearly established that adverse outcomes have been attributed to male technicians as well as to the female technician. In my view, this is consistent with the medical knowledge that patient anxiety caused by aversion to catheterization can lead to pelvic floor tightening, which, in turn, can lead to physical harm, possibly even death should catheterization be attempted. Clearly, adverse outcomes are not restricted to care provided by a female technician. Indeed the Employer has made no claim whatsoever to that effect. However, Dr. Drover's evidence is that there were more complaints about the female technician than about the male technicians. I accept that evidence, but I do have some concerns about this area that I will comment on later. I also accept his explanation that it took quite some time for the urologists to realize that there was a link between adverse outcomes and the gender of the caregiver. This realization only came about after individual physician's experiences with their patients over time found their way into peer discussions, which revealed similar experiences by other urologists, thereby culminating in the identification of gender as a common thread.

I return at this belated point to what is required to establish Step 1 of the *Meiorin* test, namely, to justify the impugned standard, the Employer must establish that the standard was adopted for a purpose rationally connected to the performance of the job. The focus at this stage

is not on the validity of the particular standard, but on the validity of the general purpose. The Employer has proposed that the general purpose of the standard here is patient safety (with some legal concerns), as well as patient dignity, privacy and ethical concerns. At this point, based upon the preceding analysis, I am satisfied that the safety of male urology patients undergoing catheterization by a female has been established by the Employer as being rationally connected to the performance of the urology technician's position. Although Dr. Best did not testify on the content of his letter, I accept that the Employer relied on it at the time as support for clinical considerations. I am also satisfied on the same analysis that patient dignity, privacy and ethical concerns (all under the umbrella of patient preference for same sex care) have been established as being rationally connected to the performance of the job.

I submit that the foregoing is sufficient to satisfy Step 1 of *Meiorin*.

*Whether the Employer adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of a legitimate work-related purpose*

At this Step, the analysis shifts to the standard itself, addressing what is described in paragraph 60 of *Meiorin* as

. . .the subjective element of the test .... If the imposition of the standard was not thought to be reasonably necessary or was motivated by discriminatory animus, then it cannot be a BFOQ.

The Union approached this aspect of the case in two very different ways, which are difficult to reconcile. On the one hand, Mr. Earle freely volunteered that the Union does not question the honesty or sincerity of the Employer in seeking to establish a BFOQ, but he insisted that it simply has failed to provide compelling objective evidence to prove its case. On the other hand, the Union disputed the evidence in Kelly Monaghan's e-mail that a "lengthy consultative process" had been carried out and that "a qualification review" had been requested prior to the August 1999 job posting,

and that “test results” involving the female technician were “problematic.” It also disputed Ms. Monaghan’s testimony that “the urologists had not yet amassed the required supporting evidence” before the August 1999 temporary position was posted. In Mr. Earle’s view, there is doubt that any such evidence existed to be amassed.

As I see it, by claiming that the Employer did nothing to gather evidence for a BFOQ until late 1999 or early 2000, i.e., after the grievor might well have served in the temporary urology technician’s position had she accepted the Employer’s offer at the time, the Union is essentially saying that the Employer posted for a male urology technician in 2000 despite being aware that it did not have sufficient evidence to establish a BFOQ and then falsely claimed a lengthy consultative process to bolster its position. In my view, this is tantamount to an accusation that the Employer’s evidence on the process followed was deliberately misleading.

My reading of the evidence does not indicate any significant concerns with Ms. Nichols’ or Ms. Monaghan’s testimony, but it does reveal some inconsistency in Ms. Sullivan’s testimony concerning the time frame in which a consultative process was undertaken.

It was Ms. Nichols’ understanding that clinical concerns regarding outcomes for patients had been raised by urologists during the period the female technician was in the job. This does not indicate that concerns were raised with administration during her tenure, or whether it was a matter that was discussed solely among the urologists. It also does not indicate when administration first knew about these clinical concerns, e.g., soon after the female technician left, or in 1999 or 2000. I have been told that HR is not involved in BFOQ matters until a request is received from the division manager or program director to change a position’s gender requirement. Ms. Sullivan was the division manager who made the BFOQ request for the 2000 posting. Ms. Nichols testified that, in discussions with Ms. Sullivan and Susan Rumsey (Human Resources Officer in the area) concerning the 2000 posting, Ms. Monaghan and Ms. Nichols were informed that clinical issues

were involved that had not previously been put forward because such issues had not been fully gathered and investigated. Ms. Monaghan testified that it was her understanding that clinical concerns were raised by the urologists themselves when a female held the position. Although she did not say when, Ms. Monaghan said those concerns were then taken to the program director. However, she said that when Ms. Butler was offered the temporary position in 1999, the urologists had not yet amassed the required supporting evidence. Therefore, the request for a male only posting at that time was overruled by Employee Relations. By February 2000, the review process had been completed.

In my view, Ms. Monaghan was an honest and straightforward witness. She related her knowledge of the whole affair, which she obviously gleaned from others after being approached to post the 2000 position. She freely conceded that she was not a clinician and apologized if the terminology she chose in her e-mail to Ms. Butler was not accurate. Therefore, I do not take it literally that there were any urologist findings of actual "test results procured from female urology technicians" (there was never more than one), or, in fact, that there had been any clinical testing involving any female technician. We have it on Dr. Drover's authority that there was no such testing and there was no documentation of problems noticed with the female technician. In essence, I am satisfied that this was simply Ms. Monaghan's way of expressing her understanding that physicians' concerns were made known to the program director sometime prior to the 1999 posting and that the physicians were then advised to gather supporting clinical information. If Ms. Monaghan's understanding is correct – and I think it is -- at some point before the August 1999 posting, HR had been advised that the physicians had concerns and were made responsible for gathering supporting clinical information.

Ms. Sullivan's direct examination generally supported the timing and the sequence of events related by Ms. Monaghan. She testified that there had been a previous posting for both male and

female applicants in 1999, but she had already been discussing the matter with Dr. Best, who had come to her in support of the urology technicians' concerns that the position be open to males only. She said that she was aware at the time that Dr. Best was still in the process of canvassing his other four (4) urologist peers on the subject. This evidence suggests that the urology technicians approached Ms. Sullivan prior to the 1999 posting and Dr. Best also approached her soon afterwards to support them. Since Dr. Best was required to obtain clinical information from the other urologists, Ms. Sullivan must have known at the time that the approaches by the technicians and Dr. Best were not enough to establish a BFOQ. Since BFOQ requests are approved by the Human Resources department, one would expect that Ms. Sullivan would have had advice from someone in HR on how to proceed. That specific information simply has not been provided among Ms. Sullivan's testimony. Ms. Nichols was not asked whether she had previously discussed clinical issues with Ms. Sullivan prior to the posting of the August 1999 temporary position. And HR Officer Susan Rumsey was not called to testify. On balance, however, I am satisfied that the foregoing accounts by Ms. Monaghan and Ms. Sullivan taken together strongly indicate that a process of information gathering among the urologists had commenced in 1999 prior to August, but was not completed until January 2000 when Dr. Best's letter was written.

The one note of inconsistency on this matter is Ms. Sullivan's testimony in cross examination where, in commenting on the consultative process that led to the male only posting, she said that, sometime between September 1999 to February 2000, she was approached by the technicians, she discussed the matter with Dr. Best, and Dr. Best spoke to each of his colleagues before writing her the letter of January 21<sup>st</sup>. There is no doubt that this is what Ms. Sullivan said in cross examination for I noticed the apparent contradiction immediately, yet I quickly formed the impression that it was unintended. As I recall, when she was asked about the time frame of the consultation process, Ms. Sullivan appeared to be pensive and was rather slow to answer. In my opinion, there was no

particular pressure on her at the time which would have forced her to recant her testimony in direct examination. Indeed, I do not believe that was her intent. My distinct impression at the time was that she mistakenly uttered the wrong commencement date and was unaware that she had altered her previously testimony. Therefore, I am more inclined to accept her testimony in chief on this matter. In my view, the consultative process was not fleeting; rather it was part of the overall lengthy process of realization described by Dr. Drover.

On the basis of my analysis in Step 1, I am satisfied that Dr. Drover's evidence establishes that, during the previous female technician's tenure, the urologists were aware of and actively discussed among themselves clinical problems arising from her care-giving. Since no documentation was recorded on any of those matters, I am led to conclude that no BFOQ issues or performance concerns were considered at that time. There was never any indication at any time that the female technician deserved to be considered at fault. In my view that is still the Employer's position today. The evidence suggests to me that, as the physicians' body of information grew, it troubled them, but nobody at the time clearly understood why there were more adverse physical outcomes involving the female technician. As Dr. Drover explained, the link between gender and adverse physical outcomes took a long time to realize, but once it was realized, the physicians were duty bound to make their findings known immediately. When that happened is not exactly clear, but I am satisfied that the issue was raised with Ms. Sullivan in 1999 prior to the August posting; however, the Employer felt that it did not have sufficient clinical evidence to support a male only posting at that time. I am also satisfied that it took until January of 2000 for all the physicians to be canvassed so that a formal letter could be written to Ms. Sullivan to support their request. That letter was the supporting clinical documentation that the Employer relied upon to post a male only position.

Although adverse physical outcomes were discussed by the urologists at the time of the

female technician's tenure, along with patient refusals and objections, I see no indication that the gender link, i.e., the patient safety/risk factor crystallized among the physicians until long after she had departed. The Union has questioned this delay arguing that, if there were problems with the female technician, they should have been addressed at the time. I have already addressed that matter. However, I do not wholly understand why it took so long for the urologists to realize the gender link and to make it known to administration. I am satisfied that there is no indication that this link was disclosed to administration until sometime prior to the temporary job posting in 1999 at the very earliest, i.e., at least two years after the female technician had departed. So the link was either realized and not communicated immediately, or it was not realized until it became known that a job posting was imminent, which could result in another female assuming the position of urology technician. In my view, the Union's suspicion about this is understandable. Although nobody has mentioned it in this case, I am led to wonder whether the departure of the female technician for reasons not disclosed at this hearing, thereby resuming an all male roster of technicians, might have diminished any pressing need to deal with female matters for as long as that condition remained. Those are the optics of the situation. They are difficult to ignore. The question of course is whether the Union's challenge, as assessed in the foregoing considerations, means that, as is stated in paragraph 60 of *Meiorin*, the Employer did not

[adopt] the standard with an honest and good faith belief that it was necessary to the accomplishment of its purpose, with no intention of discriminating against the claimant.

In my view, the discussion/consultation process which ultimately led to the identification of the gender based patient safety/risk factor took much longer than the Union has alleged. Although I wonder about the amount of time it took the physicians to realize the gender/adverse outcomes link, I am not a urology physician and, therefore, I must defer to their professional expertise. However, I am satisfied that there was no last minute invention or contrivance here that was designed to

mislead me into thinking that the Employer's evidence was more sufficient and compelling than it actually was.

Because of its overriding importance, the safety issue has dominated the Step 1 and 2 analyses. Of course, patient safety was not the only purpose claimed by the Employer. Also claimed was the non safety purpose of dignity, privacy and ethical concerns. In my view, these two purposes are not mutually exclusive; they are inextricably intertwined and cannot be considered separately for the same population group.

If the only purpose at issue here was dignity, privacy and ethical concerns, I would be satisfied that the evidence required to establish a BFOQ would revolve around manifestations of patient preference for same gender care, or perhaps more appropriately, patient objections to opposite gender care. The jurisprudence indicates that such evidence would normally include a significant number of incidents where members of the population group actually refused or objected to the provision of opposite gender care and that such refusals or objections could reasonably be expected to continue in future. In the instant case, based upon their own experiences, two urology technicians have expressed their view that most male urology patients prefer that male technicians perform their catheterizations and other intimate procedures such as applying scrotal and penile dressings and assisting in cauterizations, etc. Due to the fact that they were never present when the previous female technician cared for such patients, the only bases for their view were 1) that patients often made embarrassed comments to them about the size and condition of their penises when their genitals were being exposed for intimate procedures such as catheterizations -- the male technicians believed that such sensitive comments would be far too private to disclose to a female technician, therefore making it much more difficult for her to relax and reassure them as effectively as a male could and 2) that they had been made aware by a small number of patients, or by the female technician herself during report, that some objections to her care had occurred.

In my view, the first basis above has been honestly advanced by Mr. Holden and Mr. Flight, but it is impressionistic and a general assertion on their part, which would require more evidence to establish their point. This matter is mentioned in *Etobicoke, supra*, at page 6:

In dealing with the evidence Professor Dunlop remarked that it was largely "impressionistic". He considered that something more was required to discharge the burden of proof and noted the insufficiency of general assertions and expressions of witnesses. . .

And again at page 7:

. . . While the evidence given and the views expressed were, I am sure, honestly advanced, they were, in my view, properly described as "impressionistic" and were of insufficient weight.

I ascribe little weight to the testimony of Mr. Holden and Mr. Flight as far as the first basis above is concerned. What would support their belief would be evidence that patients who made such comments to male technicians did not do so to female technicians. In the instant case, there was only one period when a female technician was on staff and the nature of individual work schedules made it almost impossible for the male technicians to make such observations. Under the circumstances, I cannot with any certainty say that their belief is either correct or incorrect. I simply do not know because no reasonable supporting evidence is available.

As for the second basis, while I accept the evidence as valid, I consider it sparse and insufficient -- not through any fault of the witnesses In hasten to add, but because they were simply unable to offer more. Whatever the reason, however, in the absence of significantly more provable incidents or reasonable supporting testimony by or on behalf of members of the population group, I find insufficient proof in the testimony of these two witnesses of actual refusals or objections that would reasonably indicate a significant expectation of same sex care on the part of the population group in future.

The notion that male urology patients prefer that their intimate care be provided by male professionals was also strongly asserted by Dr. Drover on behalf of himself and the other urologists.

He relied primarily on physicians' experiences in day surgery. I accept Dr. Drover's evidence on this point just as I accept the evidence of Mr. Holden and Mr. Flight. While no specifics were provided on patient names, whether the incidents involved the female technician or other female nurses, or whether the incidents occurred post grievance, I am inclined to place a little more weight on his evidence due to the fact that the "weekly experience" he described would necessarily mean at least 52 occurrences (presuming that day surgery was scheduled all 52 weeks in a year). However, I do not consider Dr. Drover's evidence to be sufficient to establish a BFOQ on this point. In my view, it falls short of the kind of compelling objective evidence that should be available from such a large medical institution possessing such significant administrative and technical resources.

There is no doubt that, for a long time, intimate care for male urology patients had been generally accepted by staff as the appropriate role of male urology technicians. That notion was itself impressionistic and those who advocated it essentially were generally asserting or expressing their own views. Of course, commonly held impressions sometimes have a way of changing over time. I submit that the successful application by the first female technician clearly was an exception to the general impression on two levels. First, her willingness to apply for the job signalled at least some measure of change within the ranks of the nursing staff. Second, since there is no indication of any objection or concerns by the Employer to her being awarded the position, or completing the trial period, or performing the various required duties completely on her own on the regular shift rotation until she vacated the position, it suggests to me that the Employer had no reservations about this departure from the accepted norm. While Ms. Nichols testified that the issue of accommodation was newly emerging at the time of Ms. Butler's grievance, I am satisfied that the issue of BFOQs in general was not new at the time the female technician was employed and that jurisprudence on the subject had been available since at least the late 1980s. Within the Newfoundland jurisdiction, the *Green Bay* arbitration award was rendered on April 1, 1989 and was

reported in 6 L.A.C. (4<sup>th</sup>). Predating *Green Bay* in 1989 was *Etobicoke*, a Supreme Court of Canada decision in 1982 and *McKale* and *Stanley* in 1987. In the early 1990s came *St. Boniface General Hospital v. Manitoba Association of Health Care Professionals* in 1992 (32 L.A.C. (4<sup>th</sup>)); *Board of School Trustees* in 1993 (33 L.A.C. (4<sup>th</sup>)); *Boniface General Hospital v. U.F.C.W. in 1995*. Then in 1996 came the Supreme Court of Canada decision in *N.A.P.E. v. Green Bay*.

In my opinion, for its own protection and planning, an employer with a large number of employees such as Eastern Health's predecessor, the Health Care Corporation of St. John's, should be responsible for keeping abreast of current issues in human rights legislation as well as emerging jurisprudence on important employment matters. One would presume that the Human Resources department of the Health Care Corporation of St. John's was aware of current BFOQ issues at least by 1990. If it was not, it should have been. I consider this important because all of the jurisprudence in one way or another indicates what was considered objective compelling evidence for each case. As far as medical institutions and long term care facilities were concerned, there was ample indication prior to and during the female technician's tenure what kind of practical evidence would be required to establish a male only BFOQ for the position of urology technician. Although no request for such a BFOQ had been made up to that time, one would think it prudent and advisable for the Employer to pay reasonable attention to any gender related issues associated with the hiring and working experiences of the first ever female technician in the event that such evidence might later be of value in determining the merits of a BFOQ request. I would not consider such attention as unwarranted suspicion or as something that should be placed on the employee's personal file; rather I would consider it honest and reasonable management preparedness in case the information gathered might subsequently serve as supporting practical evidence before a tribunal.

Clearly, however, no administrative initiatives were put in place to gather such information, and no request was made of the physicians to pay attention to or record any clinical issues involving

the female technician. The sole opportunity to gather potentially relevant gender information during the female technician's tenure passed without benefit to anyone. Therefore, by the time the gender issue was raised by the technicians and the urologists in 1999, the Employer had very little practical evidence to offer in support of its purpose of dignity, privacy and ethical concerns. Frankly, I believe short sightedness contributed significantly to that situation. The patient safety/gender link had never been an issue until it was raised in 1999. Therefore, at any earlier time, if a BFOQ request had been made solely on the basis of dignity, privacy and ethical concerns, it would have to be established on its own merits with reasonable supporting evidence of actual incidents where patients refused or objected to female care, or by having some patients themselves testify as to their preference for same gender care. I realize that the population group of male urology patients consisted of people who were not long term patients as were the residents in *Green Bay*, but I do not accept that the observation and/or recording of actual gender related refusals or objections was impossible to attain. For example, I see no indication that patients who received technician care on the floor during night shifts were ever asked, for example in exit interviews, to share their relevant individual experiences or to express their opinions on preference for same gender care. As for the patients in day surgery who purportedly refused to have females in the room, names, dates and other relevant details could easily have been recorded in those circumstances. I see no reason why such records could not have been required to be kept during the female technician's tenure. And I also see no reason why post grievance day surgery incidents should not have been recorded to support Dr. Drover's testimony. Surely, if preference among male urology patients for same gender care has been and still is as prevalent as the Employer asserts, a reasonable amount of actual evidence should be made available to support that assertion. As I understand it, no effort has ever been made to gather such information. While it might be perfectly correct that most male urology patients do prefer that male urology technicians perform their catheterizations, I am satisfied that

the Employer has failed to provide sufficient proof of this claim.

However, the Employer's claim for a BFOQ cannot entirely be dismissed on the basis of the foregoing finding. In this case the safety purpose is intertwined with the non safety purpose due to the fact that gender based anxiety cannot arise unless same sex preference exists among some patients. In my view, the link between opposite sex care and the risk to patient safety has been made satisfactorily by the expert evidence of Dr. Drover. This link is the result of a medical conclusion based upon the urology physicians' pooled knowledge of adverse patient outcomes during the tenure of the female technician. As such I do not consider their conclusion as a mere impression or general assertion. In the absence of any expert evidence called by the Union to refute this medical conclusion, Dr. Drover's evidence stands. I am satisfied that, to the extent that anxiety arising from opposite gender care may contribute to physical reactions that would make attempted catheterization on some male urology patients more difficult, an unacceptable risk factor would be created. In my opinion, it would be unacceptable to expose male urology patients to this risk factor.

The evidence in this case is that not all male urology patients will become anxious about the procedures to be performed by urology technicians, or about the prospect of a female technician performing them. The evidence also indicates that, among those who become anxious because of the caregiver's gender, not all patients will refuse a female. As I understand it, the group of patients most at risk are those who won't refuse but will accept the procedure without objection despite their anxiety. The difficulty, I am told, is that the Employer has no way of knowing beforehand which patients will or will not have a preference for same sex care, or which patients will become anxious and refuse, or which patients will suffer through the procedures without objection.

Of course, if a patient refuses a female technician, she should not continue with a procedure. If a patient does become anxious but does not object to her care, a female technician would have

to contend with that extra level of anxiety and thereafter make a professional decision whether to proceed with or discontinue a procedure. One would hope that her professional judgement would always result in the correct decision being made. But there appears to be no denying the fact that the complications and implications of gender related anxiety would always be a potential safety risk for male urology patients. This factor would result in a greater professional burden for female technicians than their male counterparts. And it may well be of significant liability concern for the Employer if it did not take appropriate steps to eliminate the risk in the first place.

However, before total elimination of the risk factor may be decided upon, the third Step in *Meiorin* would require the Employer to accommodate the grievor to the point of undue hardship. If a patient refuses or the technician decides to discontinue a procedure, the issue would then be whether adequate back-up could be found to complete the procedure. However, if she were to proceed with a catheterization in those circumstances and cause some harm to a patient, there might be potential for both her and the Employer to be exposed to liability. That would also be a matter of "undue hardship" to be considered under Step 3.

On balance, even though the proportion of patients most susceptible to a gender related risk is not specifically known, I am satisfied that the implications are of considerable importance for at least a minority of patients whose safety would be at risk, and also for any female technician and the Employer who may be exposed to greater potential for liability under the law. Therefore, I find that, subject to determining whether it was impossible for the Employer to accommodate the grievor to the point of undue hardship, the Employer has established that a male only standard is reasonably necessary to eliminate the safety risk factor to some male urology patients arising from a female performing the duties of urology technician.

On the basis of the foregoing considerations, for the purposes of Step 2, I find that the Employer adopted the male only standard with an honest and good faith belief that it was necessary

to do so in order to accomplish its purpose, with no intention of improperly discriminating against the grievor or any other female applicant. I find no evidence that the Employer's decision was motivated by discriminatory animus and I am satisfied that the Employer honestly believed that the male only requirement was reasonably necessary in all the circumstances. In the result, I submit that the Employer has established on the balance of probabilities that it has met the requirements of Step 2.

*Whether the standard was reasonably necessary to the accomplishment of that legitimate work-related purpose; and to show that the standard was reasonably necessary, the Employer has demonstrated that it was impossible to accommodate individual employees sharing the characteristics of the grievor without imposing undue hardship upon the Employer.*

The Step 2 analysis above concludes that the Employer has failed to establish a BFOQ based upon patient same gender preference issues such as dignity, privacy, and ethical concerns. However, subject to the Employer demonstrating that it was impossible to accommodate a female in the position of urology technician to the point of undue hardship, the analysis initially determines that the Employer has established that the male only standard was reasonably necessary to protect the safety of male urology patients.

To explain that the standard was reasonably necessary in these particular circumstances, the Employer led evidence that it considered and rejected several accommodation scenarios involving the provision of male back-up care. Ms. Nichols explained that, since the addition of a female UT would require another UT to be available for back-up should a male patient refuse her, scheduling and staffing issues were of particular significance. Dr. Drover also commented on the issue of back-up, readily agreeing that he would have no reservations about a female urology technician being hired as long as there was male back-up available for refusals while she was on shift. He also testified that the urology technicians make the urology physicians' lives bearable because they are able to perform all procedures required in the evenings, at night and on weekends

and holidays, thereby, relieving the physicians from that responsibility. Dr. Drover made it quite clear that, if increased back-up is needed for urology technicians' work (which would ordinarily be performed by urology Residents if there were any), the physicians will not provide it.

In my view, refusals are clearly a manifestation of same gender preference. Dr. Best's letter of January 21, 2000, which the Employer heavily relied on to justify a male only posting, states that "Most adult males are reluctant to have [catheterizations, change of genital area dressings, scrotal supports, etc.] carried out by females." This is a gender preference view that was also expressed by Mr. Holden and Mr. Flight. I will not speculate how Dr. Best would have supported this assertion with specific practical evidence had he testified, but it is noteworthy that Dr. Drover has made quite a different claim some seven years later. Indeed he states at page 4 of his own letter that "While the majority of patients, presumably, do not profess a significant difference in gender selection for health care provider, the incidence of such a request is significant enough and increasing to the point that ethically one has to be able to provide such care." In my view, this suggests a professional difference of opinion between Dr. Drover and Dr. Best's letter, which somewhat erodes the scope of gender preference that was presumed to exist at the time of the posting in February 2000. On balance, I am inclined to accept that the bases for Dr. Drover's comment above were the Journal Articles he submitted, from which, in my view, he reasonably extrapolated that a significant minority of males do prefer same gender care. Dr. Drover had an advantage here as those Articles were not available in 2000. On the one hand, I think it is to his credit that he would rely on trends expressed in the literature rather than espouse the long held impression contained in Dr. Best's letter. On the other hand, I think the Employer should have been able to support Dr. Drover's extrapolation of the literature by producing specific practical evidence that such requests are also growing among male urology patients at the HSC. It is not as if the Employer was brand new and had no prior staffing history or experiences to support a gender based BFOQ decision. This

Employer has existed for many years and has had experience with a female in the very position that is in dispute. Administratively and clinically, specific incidents involving her could have been noted and recorded, but that did not happen. Instead, Dr. Drover relied largely on unsubstantiated occurrences. He also relied on an ethical argument for same sex care, namely, the apparent inconsistency of prohibiting male UTs from catheterizing female urology patients while allowing female UTs to catheterize male urology patients. In my view, however, establishing a consistent practice would still leave open the question whether a BFOQ exists. And that is the issue before me.

I note that counsel for the Employer fully adopts Dr. Drover's position that the proportion of same gender preference is at the lesser level of a significant minority. On examination of the evidence as a whole, I am prepared to accept that position. In other words, I accept that a majority of male urology patients do not prefer care by any particular gender. If individual patients within that group could be easily identified as those without a gender preference, one would expect that a female technician would have little difficulty performing her duties among that grouping. After all, the gender/safety link would not be a factor. Unfortunately, however, the evidence is that the Employer has no way of knowing who those patients will be on any given day. Essentially, the majority would be intermixed with the minority such that no homogenous group could be identified in advance. Therefore, there would be no reasonable way to assign the grievor exclusively to those patients whose safety would not be at risk.

It should be noted that it is in these particular circumstances only that I have decided that sufficient objective and compelling evidence has not been provided to establish a BFOQ on the basis of patient preference for same sex care, i.e., dignity, privacy and ethical concerns. I make no judgement whether the Employer would be successful in defending a future BFOQ attempt after gathering additional supporting evidence.

Counsel also argues that, among the minority who do prefer same sex care, only a very few male patients can be expected to actually refuse a female. Indeed the Employer's claim is that there is a larger sub group who become anxious yet do not refuse, rather they grin and bear the procedure so to speak. It is this group who are most at risk. It would seem, however, that Dr. Drover has not specifically commented on when back-up would be required for patients in this group. I did consider this matter earlier in my considerations and I reiterate here my view that, ideally, a female technician should be able to perform the duties of a urology technician until the point patients refuse her, or if no refusal occurs, to the point that she professionally determines that she should not continue with a procedure due to physical difficulties arising from patient anxiety, i.e., to the point of unacceptable risk. Unfortunately however, there appears to be no way to determine how much work a female technician will be able to perform on an average shift before she is obliged to call for back-up. Put another way, there appears to be no way to determine what proportion of her overall job she will actually be able to perform on a daily basis before accommodation in the form of back-up becomes an issue. By all accounts, the Employer has no way of knowing in advance which patients on the list might become anxious when faced with opposite gender care. Therefore, there is no way to create a homogenous "non risk" group for a female technician.

The foregoing is the current situation. I have no way of knowing whether a system of determining individual patient's preference could be developed.

At this juncture, I am satisfied that the patient safety issue strongly supports the Employer's case for a BFOQ to the extent that the case will turn on whether accommodation to the point of undue hardship is possible. In my view, undue hardship would result if male back-up could not be readily available whenever it is needed, regardless how many times per shift it might occur. After all, catheterizations cannot be put off for too long where patients are unable to urinate on their own.

With a view to ultimately determining whether their implementation would result in undue

hardship for the Employer, I have tentatively considered all of the following scenarios:

- 1) Placing the grievor in the position of UT II. I agree that Ms. Butler is not qualified for that position.
- 2) Placing the grievor on the same 8 - 4 day shift as the UT II, so that he could provide back-up during that period. This would require the other technicians to absorb a greater proportion of night shifts, weekends and call-ins, situations which the Employer claims would cause a disruption to the rights of other employees under the collective agreement -- see Article 19.03 -- Rotation of Shifts:

The rotation of shifts shall be carried out in an equitable manner. Each employee receive at least seven (7) days of day shift in a month, provided he/she may waive this right.

And also Article 17.03(a)(ii) – Twelve Hour Shift:

Employees shall receive a minimum of two (2) weekends off out of every four (4) weekends and the Employer shall endeavour to grant every second (2<sup>nd</sup>) weekend off, unless otherwise agreed by mutual consent.

The Employer also expressed concern that these changes would make the positions of the other UT Is less attractive to them, thereby causing retention problems -- losing people who have taken a long period of time to become comfortable and proficient in their duties -- as well as recruitment problems, i.e., applicants would also consider extra night shifts as being unattractive.

- 3) Placing the grievor on a regular 12 hour shift, working independently as the other technicians do. No back-up would be available between 4 p.m. and 8 p.m. on day shift and from 8 p.m. to 8 a.m. night shift, or on week ends or holidays. The Employer's concern is that compelling the other technicians to share a greater burden of stand by would also make the position unattractive to them because of the disruption to their lives. Also the same concerns about retention and recruitment would apply.
- 4) Requiring the two casual technicians to be available on stand by. Since those individuals are free to accept work in other departments when not assigned to relieve other urology technicians, they could not be relied upon to be available for back-up as needed. The Employer's concern is that, if they were required to be on stand by, it would cost them money and make their positions unattractive to them, thereby creating retention and recruitment problems.
- 5) Relying on back-up availability among male LPNs already employed by the Employer. The evidence is that there are too few males among hospital staff and they are all employed in other areas where they could not be released to perform back-up elsewhere. In addition, it would require training all the males to the significantly greater level of competency held by urology technicians and maintaining that competency on a long term basis.

- 6) Employing another male urology technician to work side by side with the grievor. This would effectively double the cost and result in the inefficiency of two people essentially performing the same job.
- 7) Assigning the grievor exclusively to the non risk group who have no gender preference for their care. This scenario has been examined previously in this section.
- 8) Placing the grievor on a trial period. The trial period mentioned in Article 15.05 is for successful applicants only. The parties disagree whether a BFOQ is established that precludes the grievor from being the successful applicant. For reasons that follow below, I am satisfied that consideration of this scenario should be temporarily postponed.

While I am satisfied that each of the above scenarios contain relevant points that deserve serious consideration in determining whether their implementation would cause undue hardship to the Employer, I choose not to render final decisions on all of them at this juncture. Since those scenarios were developed solely by a small number of Employer officials, I am not convinced that a full and complete assessment of accommodation alternatives has been placed before me.

In her submissions, counsel for the Employer pointed out that there is support among the case law that the search for accommodation is a multi-party inquiry, in which there is no requirement for the grievor to generate options, but there is a requirement that the Employer, the Union and the grievor be involved in the process. In the instant case, the evidence is that there was no discussion about accommodation among the Employer, the Union and the grievor because the Employer did its own analysis and concluded that it could not accommodate the grievor without incurring undue hardship. Counsel cited *Queen Alexandria Hospital* as authority for the proposition that, in cases where there is no evidence that accommodation possibilities have been canvassed, it is appropriate to send the matter back to have it happen and for the arbitrator to remain seized. Since there was no evidence in that case that management had approached other managers or other employees to canvass accommodation possibilities, the grievance succeeded in part, but the arbitrator sent the matter back to the employer for re-determination to consider reasonable attempts at accommodation. Also in *Re Board of School Trustees*, some evidentiary deficiencies were noted

and because the evidence fell short of enabling the board to fully assess or quantify the foregone opportunities of one of the grievors for other work, the board decided to refer the matter back to the parties for further discussion and an effort at accommodation.

On balance, I agree that a reasonably full and complete search for accommodation was not done in the circumstances of the instant case. It is my understanding that the list of accommodation scenarios introduced at this hearing was developed by Ms. Nichols, Ms. Rumsey, Ms. Monaghan – all Human Resources officials – and by Ms. Sullivan and the program director. There appears to have been no attempt to widen the canvassing process to other managers, supervisors and employees. I do not know how many other managers and supervisors would be appropriate to canvass in a search for accommodation alternatives, but they should reasonably be included in the process. As for canvassing employees, a reasonable number of them should also be included. Articles 17.03(a)(ii) and 19.03 were highlighted by the Employer as employee rights that would be violated if the grievor were to be accommodated. I note with interest that a departure from minimum weekend work in 17.03(a)(ii) may be made by mutual consent, yet no employees were canvassed for such consent. Similarly, the right to at least seven (7) days of day shift in a month in 19.03 may be waived by the employees concerned, yet none were asked in this case. To those who might think that canvassing employees on these matters would be a futile academic exercise, I would point out that, by providing for employee consent or waiver in these articles, the parties themselves have contractually recognized that some employees, for reasons of their own, might wish or be willing to have other schedule arrangements than those stated in those articles. At the very least, the employees concerned deserve to be canvassed on those matters. They should also be asked for suggestions on other accommodation alternatives.

Since the Union is a party to the collective agreement whose provisions might possibly be compromised by a particular accommodation suggestion, I am satisfied that it should be a part of

honest and sincere accommodation discussions so that it may offer its own options, suggestions and views on how compromises might be achieved.

Although the grievor is not required to generate options, she is entitled to participate in the discussions and to offer her own suggestions if she wishes to do so.

In essence, a reasonable attempt at accommodation is required before a final Step 3 decision may be made. I am referring the matter back to the Employer to complete the accommodation process and I will remain seized of that matter. I do not know whether an acceptable accommodation resolution will result from this process, but the participants to the exercise do have the advantage of knowing the results of my deliberations to date. If an accommodation is found, whether it be a new scenario or a combination of several scenarios, it would be all the better for everybody concerned and I would be prepared to simply confirm it in the final award. If one is not found, then I will make a final decision on the matter after hearing the results of the canvassing, the multi-party discussions, and the parties' submissions on them. If necessary and appropriate, I will deal with the issue of compensation after the next hearing.

Under normal circumstances, I would consider a month to be sufficient time for the Employer to canvass relevant individuals for accommodation options, to discuss them with the Union and the grievor, and to schedule another arbitration hearing date on the matter. However, since the summer vacation season is almost upon us with the inevitable problem of people's availability, I think that the parties should be able to make a September 14<sup>th</sup> hearing. If the parties agree to an alternate deadline, I will accept it. If there are valid reasons why one side or the other would not be able to appear on September 14<sup>th</sup>, I will set another date.

Respectfully submitted as the preliminary ruling of the arbitrator.

**Dated at Mount Pearl, Newfoundland and Labrador, this 14<sup>th</sup> day of June, 2007.**

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David L. Alcock, Sole Arbitrator