

## MEMORANDUM

<b>To</b>	Coalition of Ontario Doctors		
<b>Date</b>	May 27, 2017	<b>Our File No.</b>	92803
<b>Re</b>	Draft OMA Framework Appendix for Negotiation, Mediation, and Arbitration		

Chris G. Paliare  
Ian J. Roland  
Ken Rosenberg  
Linda R. Rothstein  
Richard P. Stephenson  
Nick Coleman  
Donald K. Eady  
Gordon D. Capern  
Lily I. Harmer  
Andrew Lokan  
John Monger  
Odette Soriano  
Andrew C. Lewis  
Megan E. Shortreed  
Massimo Starnino  
Karen Jones  
Robert A. Centa  
Nini Jones  
Jeffrey Larry  
Kristian Borg-Olivier  
Emily Lawrence  
Tina H. Lie  
Jean-Claude Killey  
Jodi Martin  
Michael Fenrick  
Ren Bucholz  
Jessica Latimer  
Debra McKenna  
Lindsay Scott  
Alysha Shore  
Denise Cooney  
Jessica H. Elders  
Lauren Pearce  
Daniel Rosenbluth

COUNSEL

Stephen Goudge, Q.C.

HONORARY COUNSEL

Ian G. Scott, Q.C., O.C.  
(1934 -2006)

This memo sets out some preliminary views on the Framework Appendix.

### The Perpetual Entrenchment of the OMA

The Framework Appendix (“FA”), in conjunction with the previous Representation Rights and Joint Negotiation and Dispute Resolution Agreement (“RRJNDRA”), has the effect of permanently entrenching the OMA as the bargaining agent for all of Ontario’s physicians.

This arrangement is unusual in the labour context, where unions/associations can typically be displaced by another union/association or decertified if the majority so wish. For most unions in Ontario, there is an “open period” during which another union can seek to be certified in place of the incumbent union, near the end of the term of the collective agreement or after 34 months, whichever is earlier.

By contrast, under the FA the OMA is given the perpetual power to bargain for all physicians in the province. There is no way to displace the OMA, or to challenge the OMA’s status as bargaining agent. The FA expressly modifies the RRJNDRA to provide that its term is perpetual. The FA entrenches the OMA as bargaining agent, and if bargaining does not produce an agreement, as the body that represents all physicians in binding arbitration, in perpetuity.

This raises a constitutional issue. Choice of bargaining representative is guaranteed under s.2(d) of the Charter. While the Supreme Court has said that choice is not absolute, it has described the “hallmarks of choice” as follows:

Hallmarks of employee choice in this context include the ability to form and join new associations, to change representatives, to set and change collective workplace goals, and to dissolve existing associations. Employee choice may lead to a diversity of associational structures and to competition between associations, but it is a form of exercise of freedom of association that is essential to the existence of employee organizations and to the maintenance of the confidence of members in them.<sup>1</sup> [emphasis added]

<sup>1</sup> *Mounted Police Ass’n of Ontario v. Canada*, 2015 SCC 1, para. 86.

The Court has recognized that there are contexts in which government designation of the bargaining association may be acceptable, citing teachers' unions, but the Court has not given any indication that it would view the OMA as falling within this category.

As a corollary, there is also no mechanism for subgroups of physicians who may not share a "community of interest" with others to establish a separate bargaining unit. In the usual labour context, a labour relations board determines which employees belong together for collective bargaining purposes, if either the employer or a union requires that this question be determined. Supervisors may be placed in a separate bargaining unit from those whom they supervise, or professionals may be in a different bargaining unit from clerical or technical employees. This allows different groups of employees to be represented by different unions, and conflicts of interest can be avoided.

The RJNDDRA recognizes that during the operation and administration of a PSA, the OMA and government "may be called upon to make decisions which may adversely affect the specific interests of a particular group of physicians represented by the OMA". That is even more true of the negotiation of a PSA, or representing physicians in binding arbitration if an agreement cannot be reached. Yet the FA does not permit particular groups to choose their own representative, to provide a voice for their own concerns which may not be shared by (or may even be opposed by) the other groups represented by the OMA. Conflicts of interest that could be resolved or ameliorated by establishing different "bargaining units"; i.e. a structure whereby different representatives speak for different groups of physicians with different interests, are instead built into the system.

Again, this may raise constitutional issues. The Ontario Superior Court has ruled that a bargaining structure that effectively forced teachers and school support staff to adopt the same position, despite their different needs and interests, was a factor in finding a violation of s.2(d) of the *Charter*.<sup>2</sup>

Some other provincial medical associations are entrenched by statute<sup>3</sup> or voluntary recognition by the provincial government,<sup>4</sup> but this does not appear to have been tested in the courts.

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<sup>2</sup> *OPSEU v. Ontario*, 2016 ONSC 2197, at para. 140, 146.

<sup>3</sup> For example, the Saskatchewan Medical Association has a role in bargaining compensation under the *Saskatchewan Medical Care Insurance Act*, ss.48 to 48.3.

<sup>4</sup> The Alberta Medical Association is recognized as the exclusive representation of all physicians in Alberta under its current agreement (2011-18), and this term is described as "evergreen" in the AMA Agreement.

## **The OMA's Role in Management of the Physician Services Budget**

The FA sets out a structure whereby the OMA will bargain with the government over the components of the PSB, the baseline of the PSB, changes to the PSB, and the consequences and extent to which either party should bear responsibility if expenditures on physician services exceed the PSB or a component of the PSB. All of these matters are subject to arbitration if agreement is not reached.

This degree of involvement in the management of a budget is unusual for a union or association in labour relations. Traditionally, the employer is responsible for managing the compensation budget, while the union or association advocates for enhancing (or preserving) compensation and employment opportunities. Having said that, there are many diverse situations in labour relations, including some in which unions or associations have some role in these matters. But what stands out is that the OMA is expected to take such a broad role on a permanent basis, including some assumption of responsibility when expenditures exceed the PSB.<sup>5</sup>

From what we know about demographic pressures, real or self-proclaimed fiscal pressures on the government, and the rising costs of excellence in health care associated with innovation and technological change, it seems inevitable that situations will arise in which physicians are asked to make concessions – for example, if expenditures exceed the PSB. Bargaining over concessions is among the most difficult challenges that a union or association may face, and it tends to bring conflicts of interest to the fore.

While the ability to bargain over management of the PSB (including situations in which there are calls for cutbacks) is not necessarily a bad thing, it is all the more important in this context that there be some ability for conflicting interests to be separately represented, and/or for representation to be challenged. The FA is lacking in this respect. The OMA will be permanently entrenched as the voice for all physicians, and will be in a position to make deals with the government that adversely affect the interests of specific subgroups of physicians. With its permanent and entrenched role, the OMA may be expected to take on some of the mantle of management, and the absence of any clear mechanism to challenge the OMA's representation as cutbacks are bargained (or imposed through arbitration) is concerning. Physicians should think carefully about whether they trust the OMA with this expanded role in the absence of stronger accountability mechanisms.

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<sup>5</sup> The 2011-2018 AMA Agreement, as amended in late 2016, also moves towards a risk-sharing model for certain physician-related costs in Alberta.

## **The Permanent Entrenchment of Mediation/Arbitration**

The FA provides for binding arbitration of unresolved matters. There is binding arbitration for physician compensation in one form or another in some other provinces.<sup>6</sup> The FA specifies that in Ontario it will take a particular form - mediation/arbitration (“Med/Arb”).

The FA provides that all matters that cannot be resolved through negotiation will be subject to Med/Arb. That is, the same person who is chosen or appointed to mediate between the parties, will act as the chair of the arbitration panel if resolution is not reached through mediation.

Normally, the roles of mediator and arbitrator are fundamentally different. A mediator can recommend, but cannot impose solutions. S/he attempts to assist the parties in coming to their own agreement, but if no agreement is reached, his or her role is at an end. By contrast, an arbitrator or arbitration board formally adjudicates the matter and makes a ruling that is binding on the parties.

Med/Arb is not uncommon in labour relations. It has both advantages and disadvantages. Because the same person acts as mediator and arbitrator, the dynamics of the mediation process are different. Parties are concerned about appearing to be inflexible, so are more likely to offer concessions. This may help in reaching agreement. The dynamics of arbitration, if required, are also different. The arbitrator knows all of the negotiating positions of the parties, and where they have signalled that they might be prepared to be flexible (or, potentially, where they might not object as strenuously if the arbitrator rules against them on a point, though they cannot themselves take that position for political or other reasons.) This can affect the substance of the arbitrator’s ruling.

Med/Arb is a process to be considered carefully, and in the right circumstances it can be a useful tool. However, it eliminates the possibility that the arbitration board with the power to decide an issue will see it with “fresh eyes” and in a truly unbiased manner. When mediation and arbitration are kept separate, the arbitration board can function as a “second opinion” on issues that the parties have been unable to resolve, untainted by any knowledge of the parties’ negotiation positions and the impressions of the mediator. The arbitration process is also more transparent when it is kept separate from mediation.

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<sup>6</sup> For example, under the *Saskatchewan Medical Care Insurance Act*, s.48.3; AMA Agreement, Schedule 5.

The normal rule under the *Arbitration Act, 1991* is that the mediator and arbitrator cannot be the same person.<sup>7</sup> Likewise, for arbitrations conducted outside of that Act, it would normally be considered to raise bias issues if the arbitrator came to the process with prior involvement as a mediator. Parties can agree to waive these rules, as the OMA and government have under the FA. Sometimes, this makes sense. However, it is surprising, and perhaps concerning, that the OMA and government have agreed to do so on a permanent basis.

The mediation process is not transparent. A mediator typically meets privately with both sides, and is often told things in confidence. The mediator may lean hard on each side to change their positions, in order to bring them together, and may gain significant insight into their motivations and what they consider most (or least) important. This is deliberately kept behind closed doors. When mediation is kept separate, the parties retain ultimate control because they are not forced to agree to anything.

Under Med/Arb, however, the arbitrator decides issues with a blended knowledge of what s/he has been told in the confidential and private process of mediation, and the evidence and argument presented openly in the formal arbitration process. The arbitration award itself is public, and will set out factors that the arbitrator has taken into account, but it is impossible to say how much the arbitrator has been influenced by the knowledge s/he has gained from the mediation. A party may say one thing privately in the mediation, and another thing publicly in the arbitration. Again, physicians should carefully consider their level of trust in the OMA (and potentially, the government), in light of recent history, before endorsing this permanent commitment to Med/Arb.<sup>8</sup>

### **The Criteria for Arbitration, Including Relativity**

The FA lists various criteria for the arbitration board to consider in making a decision or award. This is not in itself unusual. The list is open, which allows the arbitration board to consider any matter that it considers to be relevant. Also, many of the criteria, such as the principle that compensation should be

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<sup>7</sup> *Arbitration Act, 1991*, s.35: "The members of an arbitral tribunal shall not conduct any part of the arbitration as a mediation or conciliation process or other similar process that might compromise or appear to compromise the arbitral tribunal's ability to decide the dispute impartially."

<sup>8</sup> Med/Arb is not used under either the *Saskatchewan Medical Care Insurance Act* or the AMA Agreement. B.C.'s 2014-19 Physician Master Agreement provides for a form of "binding conciliation" on certain issues, in which the chair of the conciliation panel (similar to a mediator) can make recommendations that may become binding, but this agreement may be terminated by either party.

fair and reasonable, consideration of relevant comparators, and the economic situation in Ontario, are well-established in interest arbitration.<sup>9</sup>

However, among the mandatory criteria that the arbitration board must consider, are “evidence-based relativity and appropriateness considerations”. Further, the arbitration board is specifically empowered to “determine an amount to be subject to distribution/allocation based on evidence-based relativity, evidence-based appropriateness” etc., and if the parties cannot agree on the distribution/allocation, to determine the distribution/allocation.

The relativity criteria are highly specific factors, of a kind that would not be typical for a list of criteria to be considered in interest arbitration. By setting these as mandatory criteria, and then spelling out a mechanism by which the arbitration board may implement any decision or award in this area, the FA has gone well beyond simply setting out general guiding principles for the arbitration board to consider. They give prominence to relativity adjustments as a mechanism by which the arbitration board could address real or claimed budgetary constraints. By specifying this mechanism, particularly at this level of detail, the FA inevitably emphasizes this potential route to the exclusion of others – for example, issues relating to managed entry into the profession. While the arbitration board is not required to implement relativity adjustments before other cost-cutting measures, the listed criteria are a strong signal to consider doing so. Whatever one might think of relativity issues on the merits, singling out relativity as a specific mandatory factor to be considered and spelling out the mechanism by which relativity adjustments may be implemented, has the potential to exacerbate the conflict of interest concerns outlined above.

### **Bargaining over CMPA Payment Subsidization**

The FA provides that payments to subsidize CMPA costs will be on the bargaining table after 2023. Again, if the parties cannot reach agreement on this matter, it will be subject to arbitration.

This is a tangible example of the kind of concession bargaining that may be expected to occur under the FA. I understand that the current subsidization payments are a long-standing and important benefit that physicians were successful in securing through the 1986 physicians’ strike. There is also a strong rationale for considering them to be a reasonable expense for the government to cover, as a necessary precondition for the publicly funded healthcare system. Putting them into the FA as a visible target for future

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<sup>9</sup> See for example, *Hospital Labour Disputes Arbitration Act*, s.9; *Police Services Act*, s.122(5), *Fire Protection and Prevention Act*, 1997, s.50.5(2), which contain criteria similar to these. These kinds of general criteria are also listed for “binding conciliation” under B.C.’s 2014-19 Physician Master Agreement, and for binding arbitration of annual increases under Alberta’s AMA Agreement.

concession bargaining after 2023 does not seem to be in the long-term interests of physicians.

Please do not hesitate to contact me if you have any questions arising from the above.

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