ENOUGH IS ENOUGH: RECOGNIZING AND RESPONDING TO VIOLENCE IN THE HEALTH CARE SECTOR

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1. INTRODUCTION

Violence in the health care sector is pervasive and growing at a disturbing rate. For far too many health care workers (the majority being women and many coming from immigrant and/or racialized groups), violence has become "part of the job". A recent article in the Globe and Mail newspaper reports that nearly 50 per cent of health care workers will be physically assaulted during their professional careers.[2] That makes nurses much more likely to experience violence than any other professional group.[3]

Generally speaking, violence can come from a patient, a patient's family member, or a colleague. It can take the form of acts of aggression such as hitting, kicking, grabbing, biting, sexual assault or an attack with a weapon. It can also take the form of verbal abuse, the threat of physical violence, psychological harassment and bullying.

The following paper focuses on violence in the health care sector. We begin by highlighting some of the recent and shocking statistics in this area. We then review two recent coroner's inquests to demonstrate the grave reality that results from a failure to properly address this issue. Next, we briefly discuss the role that unions play in protecting workers from such violence. In this section, we also provide examples, both contractual and statutory, whereby employers may be found liable for violent encounters in their workplaces. We also review the types of damages that may be ordered against employers as a result. Finally, we conclude by examining some of the legislative changes and employer efforts necessary to eliminate or curb similar acts from occurring in the first place.

2. THE NUMBERS ARE STAGGERING

Findings from the 2005 first-ever National Survey of the Work and Health of Nurses done by the Canadian Institute for Health Information, Health Canada and Statistics Canada are shocking.[4] Nearly 19,000 regulated nurses working in Canada between 2005 and 2006 were interviewed on a variety of topics relating to nurses' working conditions and their physical and mental health. Of those surveyed, just under one-third (29.6%) of

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2 "By the numbers: Attacks on nurses" The Globe and Mail (January 4, 2008).

3 "Violence in the Workplace: A Guide for ONA Members" (2003) online: <http://www.ona.org/publications/ona_booklets>.

4 Canadian Institute for Health Information, Health Canada and Statistics Canada, *2005 National Survey of the Work and Health of Nurses* (December 2006).

nurses working in hospitals reported being physically assaulted by a patient over the past 12 months.[5] Nurses working in long-term care facilities, such as a nursing home, fared worse with over half of those surveyed reporting experiencing physical violence by a patient within the previous year.[6]

The Survey also focused on emotional abuse at work. Nurses reported experiencing emotional abuse frequently from patients, their visitors, physicians, and even other nurses. In fact, close to 50 per cent of nurses working in hospitals and in long-term facilities reported being emotionally abused by a patient over the past 12 months.[7] Although the survey found that emotional abuse from visitors, physicians and other nurses was encountered much less often, such abuse was prevalent nonetheless.[8]

A more recent study led by York University researchers entitled "Out of Control": Violence against Personal Support Workers in Long-Term Care" tells a similar if not more troubling story.[9] Workers at 71 unionized long-term care facilities in Manitoba, Ontario and Nova Scotia were surveyed about their experiences of physical violence, unwanted sexual attention, and racial comments. The study is part of a larger project comparing Canadian long-term care facilities with those of Nordic European countries (Denmark, Finland, Norway and Sweden) who similarly have a public healthcare infrastructure. The study found that Canadian personal support workers are seven times more likely to experience violence on a daily basis than workers in Nordic countries.[10]

The study also found that almost all (89.7%) of the personal support workers surveyed indicated that they had experienced some form of physical violence from residents and their family members while at work.[11] Moreover, nearly half (43%) of these workers reported being subjected to violence every day.[12] Unwanted sexual attention was also commonly experienced with roughly one-third (30.1%) of personal support workers reporting enduring such encounters on a daily or weekly basis.[13]

3. CORONER'S INQUESTS: FATAL CONSEQUENCES

With statistics showing the pervasiveness of violence in the health care sector, it is hardly surprising to find recent examples of coroners' investigations and inquests into the deaths of health care workers and patients. The following two examples serve as a crude

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[5] *Ibid.* at 37.
[6] *Ibid.* at 37.
[7] *Ibid.* at 39.
[8] *Ibid.* at 38. Specifically, the survey found that within the past year, 1 in 6 nurses reported experiencing emotional abuse from a visitor, about 1 in 12 nurses reported that they had been emotionally abused by a physician, and 12% of nurses reported experiencing emotional abuse from a nurse co-worker.
[9] Albert Banerjee et al., "Out of Control": Violence against Personal Support Workers in Long-Term Care" (2008) [forthcoming].
[10] *Ibid.* at 8.
[11] *Ibid.* at 4.
[12] *Ibid.* at 2.
[13] *Ibid.* at 4.

reminder of the consequences that can result from failing to adequately address violence in the workplace.

Dupont Inquest

Lori Dupont was a Registered Nurse and member of the Ontario Nurses' Association. On November 12, 2005, she was stabbed to death while working in the recovery room at Windsor's Hotel-Dieu Grace Hospital (HDGH) by her former partner and colleague, Dr. Marc Daniel. Daniel was an anesthesiologist who later injected himself with a fatal dose of anesthetic and died several days later.

The coroner's inquest that followed Dupont's murder lasted ten weeks and over fifty witnesses were called. The jury heard testimony that Dupont and Daniel had been romantically involved since sometime in 2004, but their relationship ended in February 2005 after Daniel attempted to commit suicide as a controlling gesture over her. Daniel was subsequently involuntarily admitted to the acute psychiatric ward at HDGH. In March 2005, Daniel was discharged from the HDGH's psychiatric ward and immediately attempted to contact Dupont. As a result, Dupont sought a peace bond to limit Daniel's access to her, however, this process was repeatedly delayed and the final hearing was not scheduled until some weeks after her death.

Immediately following his release from HDGH, Daniel continued to pursue Dupont at their workplace both before and after his return to work in late May 2005. In spite of ongoing threatening and harassing behaviour which was known to a variety of individuals in their workplace, the Employer ignored the concerns raised and Daniel was allowed to continue working in the same areas as Dupont. On November 12, 2005, both Daniel and Dupont were scheduled to work together with very few other staff in the area. Dupont was in the recovery room getting equipment ready for the day when Daniel came into the room. At about 9:00 am, Daniel stabbed Dupont to death in front of one of her colleagues.

Harassment in the workplace and domestic violence were the focus of the Dupont Inquest. The Jury heard about a lengthy history of abusive conduct, both verbal and physical, on the part of Daniel that included damage to hospital equipment, a fracture of a nurse's finger, shouting and swearing and other unprofessional behaviour in front of patients, and a refusal to work with a particular nurse. These issues were not limited to Dr. Daniel however. The Jury heard generally about a culture of physician dominance at the Hospital in which nurses were reluctant to complain both because complaints were not responded to by management and for fear of reprisal.

The Jury also heard about governance issues under the *Public Hospitals Act* which make it extremely difficult for a hospital to impose consequences on a physician who fails to comply with hospital policies, including those setting out codes of conduct and zero tolerance for harassment. The criminal justice system, specifically the inadequacies of the

peace bond application process that Dupont was entwined in with Daniel at the time of her death, was also the subject of testimony.

All in all, the verdict of the Coroner's Jury made 26 recommendations targeting provincial ministries, Hotel-Dieu Grace Hospital, the Crown attorney's office and several other public organizations. Some of the key recommendations include:

- A review of the *Public Hospitals Act* to ensure that patient and staff safety, as well as patient care, be the most important factors and not be superceded by a physician's right to practice and that hospitals be able to exercise the appropriate degree of authority over physicians working within their institutions consistent with that of other regulated health professionals;

- A review of the *Occupational Health and Safety Act* (more on this below);

- A review of by-laws and policies by Hotel-Dieu Grace and all public hospitals to ensure that patient and staff safety and quality of care are the most important factors and are not superseded by a physician's right to practice. This includes adherence to clear codes of behaviour, evaluation processes, progressive discipline practices, and role definitions, i.e. For Chief of Staff and Chiefs of Departments;

- Simplification of the processes for immediate suspension, probation, or revocation of physician privileges;

- An assessment program with clear guidelines for treatment and follow-up of physicians who present with issues of mental health and/or disruptive behaviour. This shall include an independent assessment prior to the re-integration of the physician at work, consultation with the Chief Nursing Executive and advising of the nursing staff;

- Design and implementation by workplaces of policies to respond appropriately to domestic violence and abuse or harassment as it relates to the workplace, including training staff to identify signs of abuse and requiring employees to report witnessed abusive or violent behaviour. The policy at each workplace should reflect an analysis of the power differentials that exist between different groups of employees/workers/staff. Mediation should not be utilized for incidents of violence or abuse because of the power imbalance between the parties in these circumstances;

- Education for the public and professionals about the dynamics of domestic violence, including an awareness of risk factors for potential lethality;

- Development by Health and Safety Associations, in consultation with the Ontario Women's Directorate of educational materials for workplaces to train staff about the dynamics of domestic violence, abuse and harassment;

- Education of health care disciplines about the dynamics of domestic violence and risk

assessment and intervention strategies;

- A requirement that, in situations involving an allegation of drug misuse, abuse or theft, a hospital should be required to conduct a meaningful investigation and complete and file a report within 30 days;

- The establishment of domestic violence courts which focus on early intervention and vigorous prosecution;

- Availability to hospitals of the services of a "diversity officer" who can provide assistance to employee/complainants in cases of violence, abuse and harassment. The Ministry of Health and Long Term Care should consider and implement funding options for these policies.

Casa Verde Inquest

On a weekend in June 2001, Piara Singh Sandhu, a confused and physically aggressive 74-year-old man, was admitted to the Casa Verde Nursing Home in west Toronto after he became impossible for his family to manage. He was admitted before a full behavioural assessment was completed and with very little information about his dementia noted, no care plan was in place. Later that evening, Sandhu pried the metal base from a bedside table and bludgeoned to death his two elderly roommates -- Ezz-El-Dine El-Roubi, 71 and Pedro Lopez, 83. Sandhu was later charged with two counts of second-degree murder, but he died while in the Penetanguishene Mental Health Centre, where he had been sent for a psychiatric assessment.

The Casa Verde case led to an inquest to explore how to prevent similar tragedies from occurring. At its heart was an examination of how Ontario's long-term care system should deal with its most difficult residents: aggressive dementia patients. The evidence was that approximately a third of residents in long-term care facilities suffer from some form of dementia, many forms of which cause the residents to be violent as part of the disease process. The Jury heard that between 1999 and 2004, 11 long-term residents were slain by fellow residents. The Jury also heard that the number of assault cases in long-term care rose remarkably from 101 in 1999 to 864 in 2004. Reported attacks by residents against staff also increased in that same period, from 21 to 264.

The Inquest Jury reported in April 2005 after 10 weeks of testimony. Its 85 recommendations included calls for better behavioural assessments, specialized units for aggressive residents, and more nursing care, staff training and funding. The recommendations were intended to ensure that residents and staff are better protected from harm at the hands of newly admitted residents who may suffer from mental illness or cognitive impairment. Some of the key recommendations include:

- That the Ministry of Health and Long-Term Care (MOHLTC) give increased priority to the health care needs of the elderly and, in particular, the serious challenges faced in treating elderly cognitively impaired residents, by immediately developing and

implementing a plan to ensure appropriate standards, funding, tracking and accountability in Long Term Care and other facilities treating such individuals;

- That the MOHLTC review eligibility and admissions regulations and policies to ensure that individuals exhibiting or prone to aggression be assessed prior to the eligibility decision and only be placed in specialized facilities or Long Term Care facilities with appropriate specialty units;

- That the MOHLTC and all Community Care Access Centres change their policies to ensure that in cases of potential residents with cognitive impairment, with actual or potential aggressive behaviours, that the Community Care Access Centre health professionals should ensure that a comprehensive medical assessment has been completed by a specialist in geriatric medicine and/or geriatric psychiatry;

- Where behaviours have been identified as presenting a risk to self or others, admission to any facility should be delayed until the behaviours have been appropriately assessed and a care plan has been developed. In such cases, the MOHLTC should ensure that there are interim alternatives to placement in the long-term care facility until the individual has been assessed and an appropriate plan of care has been developed such as: a) appropriate support in their homes up to 24 hours a day to assist the family; and b) beds in available at an appropriate alternative facility (hospital, mental health facility or specialized facility);

- That the MOHLTC revise the funding system to ensure that the funding model is sufficient to take into account the higher skill level of staff required for residents with dementia and other mental health problems;

- That the MOHLTC set mandatory standards and provide designated funding to ensure that all staff interacting with cognitively impaired residents in long-term care are PIECES/U-First trained. This includes those individuals who make decisions regarding admission and placement, as well as those managing the individual's care.

4. THE ROLE OF UNIONS AND THE GRIEVANCE PROCEDURE

As compared with the overall employed population, nurses are far more likely to be unionized in Canada. In fact, according to the 2005 National Survey of the Work and Health of Nurses, out of the estimated 314,900 Canadian nurses, about 8 in 10 (82%) are covered by a union contract or collective agreement.[14]

Aside from bargaining for increased wages, benefits and working conditions, unions also serve to protect workers. Unlike the non-union environment where workers are subject to the whims of management, workers in unionized workplaces have a clear set of rights which are outlined in detail in their collective agreement. If the employer breaches a

[14] *Supra* note 1 at 15.

provision of that agreement – for example, if an employee is being harassed on the job – then the worker can take defensive action through the established grievance procedure. In addition to bringing a grievance for a breach of the collective agreement, it should be noted that an employee can also grieve a breach of an employer policy, a breach of a statute, such as Ontario's *Occupational Health and Safety Act*[15], or Ontario's *Human Rights Code*[16], and/or a breach of a statutes' regulations.[17]

Rather than reviewing the arbitral jurisprudence pertaining to violence and harassment in the workplace, the following section focuses, more broadly, on several types of violations that a union might assert, as well as the types of damages that an arbitrator might order against an employer as a result.

Violations

a) Violations of a Collective Agreement

Generally speaking, trade unions negotiate with employers collective agreement clauses and letters of agreement dealing with violence in the workplace. For example, many agreements establish procedures and processes to ensure the safety of workers. Moreover, most agreements contain clauses explicitly prohibiting discrimination and harassment from the workplace. Accordingly, an employer may be found liable for breaching these clauses for failing to determine appropriate means to address the discrimination and harassment, and for failing to promote a harassment-free workplace.

Additionally, all collective agreements contain management rights clauses. These clauses are very general and give management the right to operate their business. Arbitrators have ruled that management rights clauses must be exercised in a reasonable manner.[18] Therefore, where the evidence demonstrates that management did not exercise its management rights in a reasonable manner because it did not take the necessary steps to protect its employees from violence or harassment, the employer will be in breach of this clause of the agreement.

b) Violations of the *Occupational Health and Safety Act*

Occupational Health and Safety Acts have been enacted in every province and territory. They outline various duties for employers and workers, and provide the latter with a set of rights to be free from foreseeable health or safety hazards in the workplace. In instances involving violence and harassment, an arbitrator may find that the employer was in violation of its obligations under the *Act*.

To be more specific, an arbitrator might find an employer in breach of its duties as set out

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[15] R.S.O. 1990, c. O.1.
[16] R.S.O. 1990, c. H.19.
[17] Section 48(12)(j) of the Ontario *Labour Relations* Act, 1995, S.O. 1995, c.1, Sch. A confers the power on arbitrators to interpret statutes in the course of an arbitration hearing.
[18] *Toronto Transit Commission and Amalgamated Transit Union (Stina Grievance)* (2004), 132 L.A.C. (4th) 225 at 15 (Shime).

in the Ontario Act. This would occur where the employer failed to take "every precaution reasonable in the circumstances for the protection of the worker" in accordance with section 25(2)(h). Furthermore, an employer might also be held liable for breaching section 25(2)(c) of the Act for failing to appoint competent persons as supervisors. This would be the case, for example, where a supervisor failed to advise a worker of the existence of any potential or actual danger to the heath or safety of the worker of which the supervisor is aware, and to take every precaution reasonable in the circumstances for the protection of the worker as outlined in section 27(2).

c) Violation of Human Rights Law

Arbitrators have the authority and a responsibility to interpret and apply all applicable legislation in the course of an arbitration hearing. This includes Ontario's *Human Rights Code*. Particularly relevant are sections 5(2) and 7(3). The former section prohibits discrimination and harassment in the workplace by the employer or agent of the employer or by another employee because of sex, race and other enumerated grounds. The latter section protects employees from "sexual solicitation, advances, threats of reprisals and reprisals for rejection of sexual solicitation or advances by a person in a position to confer, grant or deny a benefit or advantage to the person". In circumstances of workplace harassment and violence, an employer may be found in breach of these provisions of the statute.

Damages

Once an arbitrator finds that an employer is in violation of the collective agreement or statute, damages are likely to follow. Damages can be awarded for contractual and tortious breaches, and for breaches of human rights law.

a) Damages for Contractual and Tortious Breaches

For contractual or tortious breaches of a collective agreement, there are a number of categories of damages that may be awarded by an arbitrator depending on the circumstances. Such damages are generally awarded to put the aggrieved party in the same position he or she would have been in had there been no breach of the collective agreement. There is no monetary cap or limit to this category of damages. In addition, in light of a recent arbitration decision, it should be noted that unions can also claim general damages for a breach of Ontario's *Occupational Health and Safety Act*.[19] In this decision, the Arbitrator found that when a supervisor exercises his or her authority under the collective agreement, it is an implied term of the agreement that the supervisor act in a manner consistent with the Act. The Arbitrator awarded $25,000 under the heading of "general damages" in this case.

Mental distress damages can also be awarded against an employer in arbitration cases. This is seen, for example, in a recent decision where a correctional officer working for the Ministry of Community and Safety Services received anonymous hate letters (several

[19] *Supra* note 18 at 14.

hate letters were received by numerous racial minority correctional officers working at this same Toronto jail).[20] The letter had a traumatic effect on the employee who suffered "mental stress" and had to go off of work on WSIB as a result.

At the Grievance Settlement Board, the arbitrator found that the employer did not "internally" investigate the hate letters in a timely manner. In spite of the fact that the employee had already received WSIB benefits, as a result of this serious incident of racial harassment related to the workplace, the arbitrator issued substantial damages against the employer. At paragraphs 14 and 15 of his decision, arbitrator Carter stated:

> In this case, the claim is for a breach of contractual guarantee of freedom from racial harassment in the workplace. What occurred here was much more than an 'accident' as defined by the *Workplace Safety and Insurance Act*, 1997. It was a vicious and hurtful racial slur that not only affected the grievor's health, but also caused substantial injury to the grievor's dignitary interests. While the workers' compensation scheme has exclusive jurisdiction over that aspect of her injury dealing with her health, exclusive jurisdiction over this one aspect of her injury does not preclude this Board from dealing with a very substantial injury to her dignitary interest. Indeed, counsel for the employer recognizes distinction, but argued that any compensation for loss of income was related only to injury to her health and so fell within the exclusive jurisdiction of the workers' compensation regime.
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> The Board does not accept the argument that, where there's been a breach of the contractual guarantee of freedom from racial harassment in the workplace, that compensation for loss of income relates only to injury to the victim's health. The jurisdiction of this Board is to compensate the grievor for damage to her dignitary interest as far as can be done by a monetary award. A monetary award that does not provide for complete compensation for the full financial loss arising from the breach of such a fundamental term of the contract would fall well short of this remedial mandate.[21]

In addition to awarding "compensatory" damages, the arbitrator relied on the Supreme Court of Canada's decision in *Fidler v. Sunlife Assurance*[22] to award mental distress damages flowing from a breach of contract. According to the arbitrator:

> The significance of the *Fidler* decision is that the Supreme Court of Canada has now made it clear that, even in the absence of bad faith, mental distress damages may flow from breach of contracts that create the expectation of a 'psychological benefit' and that this type of damage need not be based upon an independent actionable wrong...given the very substantial disruption to the grievor's life and peace of mind that was caused by the breach of the contractual guaranty of freedom from racial harassment in the workplace, the Board considers that the amount of damages for mental distress should be no less than what was considered appropriated in the *Fidler* case. Accordingly, the Board directs the

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[20] *Charlton v. Ontario (Ministry of Community, Safety and Correctional Services)*, [2007] Ontario Public Service Grievance Board (Don Carter) June 2007.
[21] *Ibid.* at paras 14 and 15.
[22] [2006] 271 D.L.R. (4th) 1.

> employer to pay the grievor forthwith the sum of $20,000 for mental distress arising from the breach of the contractual guarantee of freedom from racial harassment in the workplace.[23]

Accordingly, in light of the above, since the freedom from having to fear for one's well-being at work is arguably an expected psychological benefit, an arbitrator might award these damages against an employer after finding that an employee was denied this benefit.

Damages have also been awarded by arbitrators against employers when it was found that the employer's conduct, while not amounting to a breach of the contract per se, amounted to conduct of a tort such as the tort of intentional infliction of mental and emotional suffering, infliction of nervous shock or negligence. In a variety of arbitration decisions, arbitrators have issued substantial damage awards against employers.

Finally, while somewhat unsettled in the arbitral jurisprudence, arbitrators may also be able to award punitive and aggravated damages for contractual and tortious breaches of the collective agreement. Whereas general damages are awarded primarily for the purpose of compensating the aggrieved party, punitive damages are designed to address the purposes of retribution, deterrence and denunciation. To attract these damages, however, the impugned conduct must be found to depart markedly from ordinary standards of decency.

b) Human Rights Damages

As discussed above, arbitrators have the jurisdiction to apply and interpret human rights laws. As a corollary to that power, arbitrators also have the jurisdiction to award human rights damages. Most often, these damages form a remedial response to findings of discrimination and serve to not only place the complainant in the position he or she would have been in had the discrimination not occurred, but also to prevent future discrimination through deterrence and education.[24]

For violations of the *Human Rights Code*, arbitrators can award general damages, specific damages and damages for mental anguish. The first category is awarded for the violation of a grievor's human rights which includes damages for loss of dignity and self-respect. The second category is awarded where specific and tangible losses arise from the violation. For example, lost sick leave because of time taken off work, or any other lost salary and/or benefits would fall under this category. Finally, damages for mental anguish can be awarded if it is demonstrated that a willful or reckless infringement or violation of a grievor's human rights occurred.

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[23] *Supra* note 20 at para 20.

[24] *Toronto Transit Commission v. Amalgamated Transit Union, Local 113 (Langille Grievance)*, [2003] O.L.A.A. No. 520 at para. 35 (Chapman).

5. PREVENTION OF VIOLENCE IN THE WORKPLACE

Having discussed the ramifications and consequences of violence in the workplace, the remainder of this paper focuses on some of the legislative changes and employer strategies necessary to eliminate violence from occurring in the first place.

Legislative Changes

a) *Occupational Health and Safety Act*

On December 13, 2007, Bill 29, otherwise known as "An Act to amend the Occupational Health and Safety Act to protect workers from harassment and violence in the workplace", passed its first reading in the Ontario Legislature. This Bill proposes to update Ontario's current health and safety regime which lags behind more progressive laws targeting workplace harassment and violence in other provinces. It was first filed following the release of the recommendations from the inquiry into the death of Lori Dupont.

The Bill's explanatory note aptly describes the purpose of the amendment:

> The Bill amends the Occupational Health and Safety Act to require employers to protect workers from harassment and violence in the workplace, to give workers the right to refuse to work in certain circumstances when faced with harassment or violence, to require an investigation of allegations of workplace related harassment and violence, and to require employers to take steps to prevent further occurrences of workplace related harassment or violence.

Importantly, the amendment defines harassment and violence to include psychological or non-physical acts, such as threatening or aggressive statements. The amendment also specifically defines "work-related harassment or violence" which includes:

> a) harassment or violence, whether or not the harassment or violence occurs at the workplace, by,
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> (i) a worker's employer or supervisor,
> (ii) another worker who works at the same workplace,
> (iii) a client, patient, customer or other person who receives services from the employer,
> (iv) an agent, representative or family member of a person described in subclauses (i) to (iii), or
> any other person on the employer's premises, or
>
> b) harassment or violence that has the effect of interfering with the performance or safety of any worker at the workplace or that creates an intimidating, hostile or offensive work environment for any worker.

This definition is expansive and wide enough to capture abusive behaviour between co-workers occurring offsite. The list of protected parties is also fairly extensive.

Bill 29 includes a number of duties that are triggered when an employer has reason to believe that harassment or violence has occurred or is likely to occur, including specific duties to ensure that further harassment or violence is prevented or stopped. Where necessary, the employer must take steps to remove the source of the harassment or violence from the workplace and must contact the police when appropriate.

Additionally, the Bill would also change the powers of the Ministry of Labour Inspectors so that they could investigate work refusals based on actual or threatened harassment or violence. As it currently stands, while harassment or threats of violence are considered a "hazard" according to internal policy, an employee is not permitted to refuse work based on one of these criteria under the Act. Moreover, the Ministry will not respond to complaints of emotional or psychological violence or harm.

Extending the definition of work refusals to include actual or threatened harassment or violence would be a welcomed addition. First of all, an employer is required to investigate the circumstances prompting the work refusal immediately and in the presence of witnesses. Secondly, the worker can continue to refuse to work if he or she has reasonable grounds for believing that the work continues to be unsafe, even after the employer's investigation. Third, an Inspector is mandated to come to the workplace to investigate the refusal. The Inspector would be empowered to order that the person who is the source of the violence or aggression be removed from the job, until the investigation is complete. And, at the conclusion of the investigation, the Inspector would be able to order the employer – a hospital or any other workplace in Ontario – to "make such arrangements" determined to be necessary to prevent future occurrences.

b) Ontario's Domestic Violence Law

Another piece of legislation passed its first reading on December 5, 2007, in an effort to curb the effects of violence at work. Bill 10 – An Act, in memory of Lori Dupont, to better protect victims of domestic violence – is meant to repeal and replace the current *Domestic Violence Protection Act, 2000*.[25]

As explained in a previous section, Lori Dupont applied to the courts for a peace bond against Dr. Daniel on April 11, 2005. The case was first in court on April 27 but was adjourned four weeks to allow Daniel time to review the witness statements supporting Dupont's application. When the case was next up on May 25, it was again adjourned for the same reason. At a June 22 court date, the matter was adjourned until December 22 – several weeks after Dupont was stabbed to death.

Most notably, Bill 10 re-introduces the "intervention order" and the "emergency intervention order". Where the application for the milder peace bond failed Lori Dupont, the intervention order would be granted provided that the court is satisfied that domestic

[25] S.O. 2000 c. 33.

violence has occurred and that a person applying may be at risk of harm. An intervention order would be tailored to specific circumstances and could, among other features, restrain the named party from attending or entering any place regularly attended by the person making the application, including a *place of employment*. The named respondent could also be ordered to stay a certain specified distance from the applicant.

An intervention order could also be granted on an emergency basis by the court, a designated judge or a justice. The key factor here, in addition to the factors that the court would weigh in a regular order, is that the person at risk requires the order on an urgent and temporary basis. Breaches of either order would result in charges under the *Criminal Code*.

Bill 10 contemplates a future date when emergency intervention orders would be available 24 hours a day, and seven days a week throughout Ontario. The Bill imposes stricter timelines throughout, so that these applications for protection do not get clogged in the system.

Employer Strategies

Employers have a general duty to take every precaution reasonable in the circumstances to protect the health and safety of their workers in the workforce. This includes protecting them against the risk of workplace violence. Preventative measures, including the adoption of clear policies, training and education are the best strategies to realize this goal. Policies alone, however, are not enough. Many workplaces have been found to have good policies on paper, but no implementation or half-hearted untimely implementation that does not address the problem.

Adopting these measures in the health care sector is vitally important. This is especially so since health care workers have the highest injury and illness rate and are at the highest risk of violence in the workforce. Not surprisingly, working short-staffed, under strict time-constraints, and in a high stress environment places workers in dangerous situations. As the Casa Verde inquest uncovered, this is particularly true when dealing with patients or long-term care residents suffering from Alzheimer's disease or other forms of dementia.

Accordingly, appropriate training that recognizes the complete medical, mental, emotional and social needs of patients is necessary. On-going training must be provided to increase worker awareness of potential hazards and how to spot and diffuse problem situations or prevent injury if violence does take place. Proper training must be offered to all new employees, and re-training must be provided on a regular basis with backfilling of employees to ensure that there is support staff on at all times.

The design and implementation of policies to respond appropriately to domestic violence and abuse or harassment as it relates to the workplace must also be adopted. All staff should be trained to identify signs of abuse, and mandatory reporting should be implemented for witnessed incidents of abusive or violent behaviour. Most importantly,

employers must follow up on these concerns. Ultimately, it is the employer who will be held responsible for a safe workplace.

Finally, as recommended by the Dupont Jury, all public hospitals should ensure that patient and staff safety and quality of care are the most important factors and are not superseded by a physician's right to practice. Hospitals must ensure that their policies and codes of behaviour are adhered to. They must also simplify their processes for immediate suspension, probation, or revocation of physician privileges.

6. CONCLUSION: ENOUGH IS ENOUGH

Violence in health care is a growing concern as health care workers are at a heightened risk of violence in the workforce. The fact that most health care workers are women, many of whom are from immigrant and/or racialized groups is particularly troubling. Even more troubling is the notion that violence in the health care sector is simply "part of the job".

The consequences of violence are devastating. Its effects can range in intensity and include minor and serious physical injuries, temporary and permanent physical disability, psychological trauma and even death. Violence can also have negative organizational outcomes, such as low worker morale, increased job stress, increased worker turnover, reduced trust of management and coworkers and a hostile working environment.

The recognition of the magnitude of workplace violence in the health care sector is a crucial first step. However, industry players must also work diligently to implement policies and procedures to adequately respond to these issues. For that to occur though, attitudes need to change. Violence can no longer be accepted as being "part of the job". More importantly, the concern for the safety of patients and staff must be the fundamental consideration behind each and every decision made. Without these changes, it is only a matter of time before the next coroner's inquest makes all too familiar recommendations.