BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

BAY AREA MEDICAL CENTER

and

BAY AREA MEDICAL CENTER EMPLOYEES UNION
LOCAL 3305, WISCONSIN COUNCIL 40, AFSCME, AFL-CIO

Case 18
No. 56937
A-5723
(Judy Tipler-Noel Termination)

Appearances:

von Brieson, Purtell & Roper, S.C., by **Attorney Daniel T. Dennehy**, 411 East Wisconsin Avenue, Suite 700, Milwaukee, Wisconsin 53202-4470, appearing on behalf of the Bay Area Medical Center.

Mr. David A. Campshure, Business Representative, Wisconsin Council 40, AFSCME, AFL-CIO, 1566 Lynwood Lane, Green Bay, Wisconsin 54311-6051, appearing on behalf of Local 3305.

ARBITRATION AWARD

Pursuant to the provisions of the collective bargaining agreement between the parties, Bay Area Medical Center Employes Union Local 3305, Wisconsin Council 40, AFSCME, AFL-CIO (hereinafter referred to as the Union) and Bay Area Medical Center (hereinafter referred to as the Employer) requested that the Wisconsin Employment Relations Commission designate Daniel Nielsen as arbitrator of a dispute over the termination of Judy Tipler-Noel from her position as a nurse at the Center. The undersigned was so designated. Hearings were held at the Center's facility in Menominee, Michigan, on January 21 and March 29, 1999, at which time the parties were afforded full opportunity to present such testimony, exhibits, other evidence and arguments as were relevant to the dispute. The parties submitted post-hearing briefs and reply briefs, the last of which were exchanged through the arbitrator on May 28, 1999, whereupon the record was closed.

Now, having considered the testimony, exhibits, and other evidence, the arguments of the parties, and the record as a whole, and being fully advised in the premises, the undersigned makes the following Award.

ISSUE

The issue before the arbitrator is whether the Employer had just cause under the contract to discharge Judy Tipler-Noel and, if not, what is the appropriate remedy?

RELEVANT CONTRACT LANGUAGE

The contract contains a just cause standard for discipline, as well as a provision for the final and binding arbitration of disputes.

BACKGROUND

The Bay Area Medical Center provides hospital services to citizens in the area of Marinette, Wisconsin and Menominee, Michigan, through facilities in both cities. The Union is the exclusive bargaining representative for the Center's regular full-time and regular part-time non-professional employes, including licensed practical nurses. The grievant, Judy Tipler-Noel, was employed as a LPN at the Center from 1991 through her discharge in October of 1998. She was considered a good nurse, very attentive to and popular with her patients. In 1998, she was assigned to work on the second floor, east wing (2E) on the 3:00 p.m. to 11:00 p.m. shift.

Nurses provide medication, including narcotic medications, to patients in accordance with the doctors' orders. Pain medication is often dispensed on a PRN basis, meaning that it is by patient request. Generally a narcotic medication, such as Percocet or Vicodan (a/k/a Lortab) is restricted in that a patient cannot be given more than one dose every four hours. Thus, a patient with a PRN prescription may have no pain medication, or may have as many as six doses in a twenty-four hour period.

There is a medication room on the second floor of the hospital where the various drugs are kept. Narcotics are kept in a double locked box in the med room. When a patient requests medication for pain, the nurse checks the doctor's orders to be sure the patient has been prescribed the medication and also checks the patient's MAR -- a record of what medications have been administered and when. If the patient can have the medication, the nurse takes the patient's chart to the med room and opens the narcotics box. Inside is a log, known as the Controlled Substances Record or CSR. At the beginning of each shift, a count is made of each

controlled substance and is entered at the top of the CSR. As doses are removed, the nurse notes the patient name, room number, and time that the drug was removed from the box. She also writes the number of doses remaining in the narcotic box after that dose is removed, so that if there were 30 doses of Percocet in the box, a nurse removing two pills for a patient would write "28" on the log across from the patient's name. As these notations are made at the time the drug is taken from the box, so all of the CSR entries should be in chronological order.

If a narcotic is removed from the box and is not actually administered to a patient, a number of entries must be made. On the MAR, the dosage and time would be shown, but would be circled to indicate it was not administered. The nurse would also have to make an entry in the CSR. Some medications, such as Percocet, come in blister packs and if the pack is not opened, the drug can be returned to the narcotics box. The nurse would make an entry, correcting the count and noting the reason. If the medication was removed from the packaging, or if it was administered to a patient, but the patient then vomited the dose up, the dose would have to be "wasted." The proper procedure for this is for the nurse to flush the dose down a sink with another nurse as a witness. The administering nurse would then note the dose as "wasted" on the original CSR entry, and she and the witnessing nurse would both sign the CSR.

At the end of each shift, a count is made by two nurses of the contents of the narcotics box to insure that it is accurate. The hospital pharmacy is responsible for a daily review of the CSR to note any errors or discrepancies.

On September 29, 1998, Charge Nurse Sharon Barnhill checked the CSR and noticed that the grievant showed a narcotic had been wasted. There was no signature in the space for a witness, so she initialed it herself. Another nurse saw her do this, and told her she should not have. She asked why, and the other nurse asked if Barnhill had not noticed that the grievant seemed to waste narcotics every single shift she worked. Barnhill was distressed by this observation, but realized that the grievant had wasted a pill the night before. She looked at the CSR entry, and saw the wasted pill had been noted as caused by a patient becoming nauseated. However, the record also showed a second dose of the medication to that patient 30 minutes later. She went to the patient's room and asked how she was feeling. The patient said she was fine. Barnhill asked if she had experienced any nausea, and the patient said she had had none. Barnhill looked at the patient's chart, which showed her consistently alert and oriented.

The next day, Barnhill went to Roberta Morton, the Director of the medical and surgical units. She told Morton she thought there might be a problem, and that the grievant was wasting a lot of medication. She reluctantly admitted that nurses on 2E had been in the habit of signing the CSR as witnesses to other nurses' wastage of narcotics without actually witnessing it. Morton interviewed three other nurses on the shift, all of whom confirmed the practice of signing without witnessing, and all of whom said they had noticed and been concerned about the grievant's high level of wasted narcotics.

Morton contacted Pharmacy head William Taccolini. Without identifying anyone, she asked him to review the CSR for the second floor, and see if he noted anything suspicious. Taccolini reviewed the records for the preceding four months, and reported back that he had found a clear pattern involving the grievant. Morton told him to review all of 1998 and subsequently told him to look at 1997 as well.

On October 2nd, Morton met with Taccolini, retired Human Resources Director Gordon Wickland, and Interim HR Director Bernie Van Court. They discussed the problem and decided to have the grievant monitored. That evening the grievant called in sick. On the evening of the 3rd and 4th, a per diem supervisor was working, and Morton did not want to have a per diem employe conducting the inquiry. On October 5th, Morton contacted Christina Kafura, the Nursing Supervisor for the 3-11 shift and asked her to observe the narcotics records and follow up on any discrepancies on her shift.

On the October 5th shift, Kafura saw that the grievant signed out a Percocet for the patient in room 228 at 3:20 p.m. She went to the patient's room and found him asleep. At 7:20 p.m., another Percocet was signed out by the grievant for that patient. A third Percocet was signed out, with no time given, but the patient's MAR showed it had been given at 11:15 p.m. The CSR showed that this pill was removed from the drug locker between 7:20 p.m. and 8:45 p.m. Kafura visited the room several times during the shift, and the patient was asleep every time she went in. She later reviewed the MAR and noted that the second Percocet was circled, indicating that it was not given. However, it was not listed as wasted on the CSR. The patient was shown as having eaten a full meal at 7:20, then having vomited bile and the Percocet immediately after that. This patient was also shown as having received 2 mg of morphine at 7:25 p.m. Kafura left an e-mail and a voice mail message for Morton advising her of this.

On October 7th, Kafura noted that the patient in room 232 was shown on the CSR as having been given two Darvocet at 4:15 p.m. She went to the room and asked the patient how she was doing with her pain. The patient was alert and talkative, and said she was fine. Kafura asked if she had needed both pain pills, and the patient said that she only had one and it was working well. Kafura checked the patient's MAR, which showed two pills had been administered. At 8:35 p.m. that same patient was shown as having gotten two more Darvocet. Kafura went to her room and found she was asleep. Kafura again advised Morton by voice mail and e-mail.

Morton spoke with this patient the next day and asked her about the medications she had received on the 7th. She said she had had some Tylenol, and had received one pain pill on the 3 to 11 shift and one on the 11 to 7 shift.

Morton called the grievant into her office at the beginning of the shift, and she, Taccolini and Van Court asked her about the discrepancies from the 5th and the 7th. The grievant denied taking the narcotics and said she was at a loss to explain why the patients would say such things. She was also asked about the incident reported by Barnhill, and gave

the same response. Van Court asked her if she wanted to participate in the hospital's Employee Assistance Program, and she said she didn't, since she didn't have a problem. Asked why she had such a high rate of wastage, she told them that patients were nauseated or vomiting, and in some cases she was just clumsy. She was placed on suspension pending further investigation. After the meeting, Morton contacted the local police, the Drug Enforcement Administration, and the professional licensing boards to advise them of the suspicions about the grievant.

Taccolini completed his analysis of the CSR for 1997 and 1998 on October 11th. Taccolini found what he felt was a troubling pattern of excessive wastage by the grievant in 1998, as compared to 1997 when she had relatively little wastage. He found that patients who received no medication on other shifts received the maximum number of pills possible on the grievant's shift, and that there were numerous alterations in the CSR, most of which had the effect of allowing the grievant to show she had given out three doses in an eight hour shift, with the required four hour interval between doses. Taccolini's analysis of the grievant's 1998 entries in the CSR showed, among other things, 32 instances of altered dispensing times, eight instances of missing dispensing times, seven cases of a patient refusing a medication then getting another medication within 15 to 30 minutes, one case of a patient refusing a Percocet and getting another Percocet at the same time, and an instance of the grievant mistakenly taking a patient the wrong medication twice on the same shift. Of 47 wastages, 21 were shown as caused by patient refusal, seven by dropping the medication, five by vomiting or nausea, three resulted from the wrong medication being taken from the drug locker, one each by the patient spitting out the medication, the medication order being changed, and the medication being administered on the wrong schedule. Nine had no reason listed. All but four of the wastages involved Percocet. The other four involved Vicodan. Taccolini advised Morton that, according to professional literature, increased wastage and alteration of records are two of the primary warning signs of narcotics diversion.

On October 15th, Morton and Van Court met with the grievant, the local Union president and AFSCME Business Representative David Campshure. Morton reviewed the data compiled by Taccolini, the altered CSR's and the statements of the patients, and asked if she could explain it. She said nothing beyond "So, I'm clumsy." Morton made another offer to enroll the grievant in the EAP, but the grievant declined. At the conclusion of the meeting, she was terminated on three charges: (1) stealing narcotic medication; (2) falsifying a patient's record and the narcotics records; and (3) unusual pattern (excess) "wasting" of narcotic medications.

The instant grievance was thereafter filed, protesting the discharge. While the grievance was pending, the district attorney undertook an investigation of the charges, but that investigation had not been completed at the time of the hearing in this case. Likewise, at the time of this hearing, the nursing board had taken no action. At the arbitration hearing, in addition to the facts set forth above, the grievant testified on her own behalf. She denied ever stealing or using narcotics, and said that she was allergic to Vicodan, Darvocet, Percocet and codeine. She explained that she was very much attuned to patients' needs for pain relief and

was very aggressive in letting them know that they had the right to pain medication if they wanted it. She made it a practice to go to each patient's room before leaving to see if they needed any medication, so she did have a pattern of giving out narcotics right at the end of her shift. She expressed the opinion that the increase in wasted narcotics from 1997 to 1998 reflected a heavier patient load and sicker patients than in the past. As for the prevalence of Percocet and Vicodan as the wasted medications, she noted that those were the two most commonly dispensed drugs on the surgical unit. She also explained that it was her practice to open the blister packs of Percocet when she got to the door of the patient's room, so she could hold the medications cup in one hand and water in the other.

The grievant acknowledged that she had long had problems with her charting and had been under pressure to reduce the amount of overtime she spent on charting after the shift ended. It was her habit to do her charting at the end of the night, so she would go back through the records and make sure the CSR, the nursing notes and the MAR's were all consistent. Sometimes this required filling in blanks or making alterations in the records, including the CSR. She did not know why, in some instances, despite changes in the records, the CSR and the MAR's showed different information.

The grievant acknowledged that, on occasion if a patient said they wanted another pain pill as soon as possible, she would take the medication from the drug locker without first asking the patient, and the patient would then have changed his mind, resulting in waste. Sometimes the family would be there, and would persuade the patient to change his mind and accept medication, or the patient would change his mind of his own volition, resulting in another dose being taken from the locker.

Additional facts, as necessary, will be set forth below.

ARGUMENTS OF THE PARTIES

The Arguments of the Employer

The Employer takes the position that the grievant is guilty of serious misconduct, and that discharge is the only appropriate response. At the outset, the Employer argues that the proper standard of proof in this case is "clear and convincing evidence," a standard widely recognized by arbitrators as more appropriate in a civil proceeding than the "beyond a reasonable doubt" standard, which is drawn from the criminal law. Applying this standard, it is evident that the grievant is guilty of diverting narcotics and falsifying records.

The grievant wasted 47 doses of narcotics in the period between January and September of 1998. In that span, she worked 976 hours. The remainder of the 2E nursing staff worked 45,281 hours and wasted 22 doses. She claimed that her patients were sicker than others, but there is nothing to support that claim and it defies common sense. She claims that she is more

attentive to her patients' needs for pain relief than other nurses, but in 1997 she wasted only four doses of narcotics. She claims that patients refused medication, but that claim fails on two grounds. First, the medications are packed in blisters, so they can be put back if they are not dispensed. Second, the medication is provided at the patients' request, and it makes no sense for her patients to repeatedly request pain medication and then refuse to take it. Moreover, these same patients did not request medications at nearly the same rate on other nurses' shifts.

The grievant's entries in the Controlled Substances Record are consistently spaced at four hour intervals, with numerous time changes or entries out of order noted to make that spacing fit. This is obviously intended to make it appear that she dispensed the medication in accordance with the four-hour minimum interval. Again, since these are as needed medications, it is very unlikely that her patients were demanding the maximum doses when she was on duty, and going without medication on other nurses' shifts. It is striking that the grievant's only "errors" in the CSR concern Vicodan and Percocet, two Schedule II narcotics. She did not waste other medications, and she had no problem accurately charting other medications.

While the Union claims that there is no proof that the grievant did not waste these medications as claimed, that ignores the fact that two patients were interviewed and denied getting the medications that the grievant claimed to have administered to them. This is direct evidence of the grievant's wrongdoing, and it validates the Employer's conclusions.

The Center acknowledges that other nurses failed to follow the proper procedures for documenting the waste of narcotics, and that they were not fired. The difference is that there is no reason to think that these nurses did not actually waste the medication. Their punishment was aimed at correcting their actual behavior. Had they too been falsifying records to cover up the diversion of narcotics, they too would have been discharged.

For all of these reasons, the Center asks that the grievance be denied.

The Arguments of the Union

The Union takes the position that the grievant was not discharged for just cause. The charges against the grievant are wasting of narcotic drugs, misappropriation of narcotic drugs and falsifying records. These offenses involve questions of moral turpitude and criminal conduct. If found guilty, the grievant faces the loss of her profession and she and her family face social disgrace. Given this, clear arbitral precedent holds that the Employer is required to prove its case by proof beyond a reasonable doubt. It has utterly failed to meet that standard.

In order to prevail in this case, the Employer must prove both that the grievant is guilty of wrongdoing and that summary discharge is the appropriate penalty. It has not done so with respect to any of the charges. The allegation that the grievant wasted medication does not even raise a question of the Center's rules. The Center does have a policy on wastage, but it does

not address when a nurse should waste a medication, merely the procedures to be followed in accomplishing that act. The evidence shows that some patients refused medication, and the grievant disposed of the drugs. While some other nurses may not have removed drugs from their blister packs before entering the patients' rooms, there is no policy governing when to open the pack. The Center suggested that the unused drugs should have been placed in a drawer in the patients' rooms. That itself would have violated the drug policies requiring a double lock for storage of narcotics. The point is that these are areas of judgment, without hard and fast rules to guide employes. The Center chooses to draw sinister inferences from the degree of wastage among the grievant's patients, but it has not provided evidence to support those inferences. At best, the Center has proved that the grievant violated the procedure requiring a witness to the wastage of a narcotic. Granting that this is contrary to the rules, the record shows that many other nurses were also guilty of this, and that none of them were discharged. The Center cannot justify summary discharge on evidence such as this.

Turning to the claim that the grievant falsified records, the Union notes that there is a big difference between sloppiness and dishonesty. The grievant conceded that she would sometimes be busy with patient care, and would go back later to make entries in her charts. This resulted in some time entries being out of order. That is not unheard of. It is a fairly common practice for nurses to correct entries in the CSR and other records, and incomplete entries in these records is also commonplace. The grievant's evaluations since 1993 all contain criticism of her errors in charting, and she has been under constant pressure to reduce her overtime usage for charting. It may be that the Center needs to more carefully police these records and improve its oversight of the narcotics register. It may be that the grievant needs to be better organized and more meticulous in her charting. The Center may have many steps it wishes to take to insure the accuracy of its records, but discharging the grievant for falsifying records cannot be one of them. There is absolutely no evidence of intentional falsification here. Suspicion, even plausible suspicion, is not the same as proof and it is proof that is required under a just cause standard. The grievant provided plausible explanations for the errors in her charting, and the Center cannot simply brush those aside in its eagerness to see her discharged.

The final charge against the grievant is that she stole narcotics. There is not one shred of evidence to support this charge. No one saw her doing this, no one came forward to say she took narcotics off the Center's premises, no one says she ever used narcotics. This charge is pure conjecture, based on the Center's belief that she could not have wasted as many narcotics as she did. Verifiable evidence is the touchstone of a discharge for theft and there is none in this record. The consistent thread running through all of these charges is the Center's substitution of suspicion for proof. On close examination, there is no case because there is no proof. Accordingly, the Union asks that the grievant be reinstated and made whole for her losses.

DISCUSSION

The Standard of Proof

The parties disagree over the applicable level of proof required to sustain these charges, with the Employer arguing for "clear and convincing proof" and the Union urging "proof beyond a reasonable doubt." Certainly a discharge of a nurse for diverting narcotics and falsifying records to cover it up requires a greater degree of certainty than does a suspension for sick leave abuse. The long-term consequences for the grievant are far more severe, encompassing not only the loss of her job but the probable loss of her profession as well. Having said that, "proof beyond a reasonable doubt" is a standard drawn from the criminal law. It is a safeguard against the power of the state to imprison citizens, and with the exception of a minority of arbitrators, it is not used in civil proceedings.

Articulating a standard of proof is a somewhat artificial exercise, and the most honest answer to this question is probably to say that these charges require that, at the end of the day, the arbitrator be convinced of the grievant's guilt. To the extent that a standard can be accurately stated, I am persuaded that the appropriate balance between the compelling interests of the grievant in her job and her good name and the very strong interest of the Employer in detecting and deterring serious misconduct is best struck by requiring that the charges be proved by the clear and convincing preponderance of the evidence.

The Merits

The grievant was discharged because the Employer concluded that she had misappropriated narcotics and altered records to disguise her misconduct. There are four basic elements to the Employer's theory:

1. The grievant wasted more narcotics than all of the other nurses on the ward combined, most often with no witness;

2. The records show a much higher rate of dispensing narcotics to patients on her caseload during her shift than to those same patients during other shifts;

3. The records show a pattern of altered entries seemingly designed to justify the dispensing of the maximum doses of narcotics to her patients during her shifts;

4. Two patients who were interviewed disputed the grievant's documentation of their narcotics use. One said she got only one Darvocet, while the grievant charted four pills being administered. The other patient denied being nauseated and unable to take medication while the grievant's entries showed she refused a requested narcotic.

The Union is correct that any one of these charges, standing alone, can be explained away. They do not stand alone, and taken as a whole they are damning. Starting with the wastage rate, in 1998, the grievant was responsible for 68% of the wasted narcotics on the ward while working 2% of the nursing hours. Put another way, on a per hour basis, the grievant experienced a wastage rate more than 99 times that of the average staff member. Wastage at this excessive rate is not, by itself, grounds for discharge. If there was no question that the grievant was actually disposing of the supposedly wasted narcotics -- if, for example, each instance was actually witnessed by another nurse as required by the procedures -- the Center might have grounds to re-orient her on procedures or caution her to avoid breaking open the blister packs of Percocet before going to the patient's room, but it could not summarily discharge her. That is not what happened here. Her wastage was not witnessed by other nurses. It was confined to narcotics, particularly Percocet. It was often attributed to refusal of the medication by patients, which is uncommon since the patient must request the medication in the first place. It is the combination of laxity among the nurses in signing off on wastage, the very high rate of wastage by the grievant, and the unlikely reasons given for the wastage that trigger a reasonable suspicion.

The very high dispensing rate of narcotics to her patients during her shift is likewise circumstantial and subject to explanation. Notwithstanding that, the explanations offered by the grievant do not make a great deal of sense. She said that her patients were sicker than other patients, but could not explain why. Nor could she explain why the patients were only sick on her shift. She said she was more aggressive than other nurses in being sure that patients knew they had pain medication available to them, but presumably they would have continued to know this during other shifts. Moreover, her philosophy of aggressive pain management does not explain why the pattern of heavy narcotics use by her patients developed in 1998, at the same time as her high wastage rate. If the patients' use of narcotics was tied to her advocacy for their comfort, one would expect that the statistics for 1997 would reflect that as well. They do not. As with the high level of narcotics wastage, the high level of narcotics use by patients is transformed from suspicious to sinister by the problems in the grievant's documentation. These narcotics can only be administered at four-hour intervals. The grievant's entries repeatedly show doses at the very beginning, exact middle and very end of her shift. Many of these entries are out of sequence with the entries before and after them, with the times written over to make them fit the four-hour interval. The writeovers and changed entries are exclusively for Percocet and Vicodan, whereas one would expect errors on other drugs if the grievant's problem was a general sloppiness in her record keeping.

The circumstantial evidence of the grievant's inexplicably high wastage rate of narcotics, the equally inexplicable usage rate of narcotics among her patients and the alteration of records to justify that usage rate are all circumstantial evidence of diversion. Saying that the evidence is circumstantial does not say it isn't persuasive. It is the nature of charges like these that the evidence is going to be circumstantial. What eliminates any doubt about where the evidence points are the interviews with patients by Barnhill, Kafura and Morton. Barnhill was prompted to bring this matter to management's attention by a discussion with a patient who,

having been recorded as rejecting a medication due to nausea but accepting the same medication 30 minutes later, said that she had not experienced any nausea. The grievant could not explain this. Kafura and Morton each spoke with a patient who was shown as getting four doses of Percocet, but said she received only one. The grievant could not explain this.

As noted above, any one piece of evidence in this record can be explained more or less plausibly. Taken as a whole, the evidence against the grievant is absolutely overwhelming. The only reasonable explanation for the altered records, the unusually high waste of narcotics, the unusually high rate of dispensing narcotics to her patients, and the contradictions between her records and the reports of the patients is that the grievant was diverting the narcotics. Whether she was using them herself or providing them to someone else is really beside the point. Theft from the Employer is customarily considered grounds for summary termination. Theft of narcotics by a nurse is fundamentally inconsistent with her job duties and her professional responsibilities. Given this, the Center was amply justified in deciding to terminate the grievant's employment.

On the basis of the foregoing, and the record as a whole, I have made the following

AWARD

The grievant was terminated for just cause under the contract. The grievance is denied.

Dated at Racine, Wisconsin, this 18th day of August, 1999.

Daniel Nielsen /s/
Daniel Nielsen, Arbitrator

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