

ARBITRATION BOARD

CANADA
PROVINCE OF QUEBEC

Date: June 7, 2011

BEFORE ARBITRATOR: Jean-Pierre Lussier

MCGILL UNIVERSITY HEALTH CENTRE,

“the Employer”

And

ASSOCIATION DES RÉSIDENTS DE MCGILL,

“the Association”

Grievance No. 4-CUSM-0809-01

ARBITRATION AWARD

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[1] On March 2, 2009, the president of the Association of Residents of McGill filed a grievance contesting the requirement placed on residents by the collective agreement to work 24 hours in a row when they have to perform call duty in an establishment. The grievance alleges that this constitutes an unacceptable condition of employment which jeopardizes the health, safety and physical integrity of patients and the residents themselves. This condition of employment, according to the grievance, violates the Quebec Charter of Human Rights and Freedoms (hereinafter called the "Quebec Charter") and the Canadian Charter of Rights and Freedoms (hereinafter called the "Canadian Charter"). The grievance seeks to have the period of work reduced from 24 to 16 hours.

1. EVIDENCE

[2] **Alain Bestawros** is a haematologist. He began his medical studies in 1998 and completed his training in haematology in 2009. He first undertook five years of study in order to obtain his MD qualification at McGill University. Then he began his residency in internal medicine at McGill in 2004.

[3] He explained that during the first year of residency, residents work four months in specialized units, three and a half months in the Coronary Care Unit (CCU) and one and a half months in the Intensive Care Unit (ICU) itself. They also have to do "selectives," that is, mandatory rotations in certain specialties, such as geriatrics, where Dr Bestawros worked one month. Finally, first-year residents also have to perform rotations in community settings. On that basis, the witness worked, for instance, for one month at the Cowansville Hospital.

[4] Second- and third-year residents do almost the same, except that the period on specialized units is not quite as long. Dr Bestawros completed his residency at the MUHC in 2007. He then chose to specialize in haematology in a French-speaking milieu at the CHUM, and finished in 2009.

[5] When asked about the tasks performed by a resident, Dr Bestawros said he arrived on the wards at about 7:30 am and took charge of a number of patients. He conducted a round, and looked after having laboratory tests taken and certain examinations carried out. He added that residents also have a social role to play toward patients and their families, particularly on admission or discharge. Depending on whether he is in first-, second- or third-year residency, his responsibilities increase. Thus, a senior resident has tasks involving supervision and even teaching of first- and second-year residents and clinical clerks (students).

[6] A resident's normal working day, whether on the wards or in units such as the ICU and CCU, ends at about 6 pm. Throughout the working day, there is only very little free time, and it is not unusual not to have time to have lunch, and to eat a sandwich on the run.

[7] As to call duty, it is performed on weekdays, after the working day, and continues until the arrival of the team the next morning at around 8 am. The resident therefore works 24 hours in a row. On Saturdays and Sundays, call duty is performed from Saturday morning 8 am to Sunday morning 8 am, or from Sunday morning to Monday morning. Once again, the total work period is 24 hours long. A resident is assigned an average of 4–6 call duty periods per month. Generally speaking, he does one Saturday, one Sunday and 2-4 call duty periods on weekdays.

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[8] When a resident is on call in the CCU or ICU, he has to watch over patients who require a great deal of attention, and the level of stress, the witness added, is very high. Some nights are easier, but there are others when the resident does not sleep in the room made available to him. When he can sleep, his sleep is fragmented and constantly interrupted with calls, either on his telephone or on his pager.

[9] Dr Bestawros admitted that at the start of the call duty, the resident does not feel too tired, even if he has worked all day. Things are going less and less well at around midnight, and get worse thereafter. The worst period is at about 4 am. He explained that the more time passes, the slower he is physically and cognitively. He sometimes has trouble taking notes. He becomes irritable, and hesitates to use techniques for fear of applying them incorrectly. He considers himself to be dangerous at around 4 am, because he is so tired. And it has happened that he has committed errors which he attributes to his state of exhaustion. He talked, for instance, of prescribing an antibiotic without previously verifying the renal function, something he considers to be a basic reflex normally. He talked of prescribing a diuretic for a patient after a nurse called him and of having no memory of it at the end of his call duty. He added that certain treatments are risky, particularly when a needle has to be inserted in the jugular vein, because that vein is so close to the carotid artery. He remembered that in 2006, he was feeling exhausted, and he asked a junior resident to perform this technique because his own movements had become unsteady owing to his state of fatigue.

[10] Dr Bestawros also talked of the cumulative effect of fatigue with the number of call duty periods. And even if the resident does not work on the day on which his call duty ends, he is still affected the following day when he resumes work.

[11] Weekend call duty, he added, is even harder, because the care team is not the same. The workload is even greater. After working 24 hours, one has to be extremely vigilant if one is driving home. One becomes irritable and has trouble concentrating.

[12] In cross-examination, Dr Bestawros acknowledged the importance of call duty for acquiring a degree of independence and increased knowledge, but he added that learning also depends on one's cognitive state. He had himself filed a grievance in May 2007 to the same effect as the grievance under review. This was the only written material he had produced contesting this practice. Also, he had talked to his staff physicians of the excessive difficulty of working 24 hours in a row. Many of his staff physicians had shared his opinion, although some others did not agree with changing anything in the current system.

[13] **Kim Anderson** is a medical resident in her third year of internal medicine at the University of Montreal. She had also performed a one-month rotation at the MUHC, specifically in cardiology at the Royal Victoria Hospital. She was at that time in her second year of residency. For two weeks, she worked in the CCU, while the other two she worked on the cardiology consultation team. This was in June 2009.

[14] She explained that the days are very busy for residents, especially in the CCU. In consultation, the work is different. The severity of the pathologies can vary, but there are more patients. During her month at the Royal Victoria, she had to perform three call duty periods when she was the only resident. Twice this was on a weekday call, the other time on a Saturday. Each time, her call duty period was very busy, and she managed to sleep only 2–4 hours per period in 30-minute stretches interrupted by telephone calls.

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[15] Like Dr Bestawros, Dr Anderson felt that the symptoms of fatigue appeared at around midnight. The worst time, she said, was between 3 am and 5 am. She talked of having experienced several physical problems (headaches, nausea, leg pain, orthostatic hypotension [seeing stars], etc.) as well as cognitive problems (diminished concentration, difficulty remembering why she was consulting a particular file, difficulty remembering common knowledge when a differential diagnosis was required). Fortunately, she said, the nurses often helped her not commit any errors. In this regard, she mentioned areas of inattention (prescribing in the wrong file, forgetting what she had prescribed, etc.). She pointed out that one night, at around 4 am, a patient should have received transvenous pacemaker. Instead of using that technique, she decided that, owing to her state of fatigue, the procedure was risky. She preferred to keep the patient under observation until the daytime care team arrived at 8 am.

[16] Dr Anderson also mentioned that it was hard driving home after working for 24 hours. She narrowly escaped a serious accident after call duty at Hôpital Maisonneuve-Rosemont in 2008, and since then she has rested before leaving the hospital. She explained that the call duty system was the same at the University of Montreal as at McGill University. She also does 4–6 call duty periods per month, most often four periods.

[17] **Roger Godbout** has a PhD in psychology and is a full professor in the Department of Psychiatry at the University of Montreal. He has been interested for a very long time in the question of sleep, and he has published numerous articles on sleep, in both humans and animals. Of these articles, 50 or so deal specifically with the effects of sleep deprivation.

[18] He explained that sleep plays an important role with respect to the work that one can perform during the day. The brain, he stated, works not only during daytime, but also at night during sleep. For instance, it is at night that the brain consolidates long-term memory. The information acquired during the day is processed once again at night, during sleep. It is also at night that the body secretes growth hormones or the immune system is activated.

[19] There are three factors to be considered with respect to sleep. The first is the sleep debt. As soon as one gets up, the human body generates a sleep debt, which increases as the hours go by. After a certain threshold (approximately 14–15 hours), the probability of falling asleep increases. The second factor is what is known as the biological clock. Each brain houses a form of clock which places a maximum and minimum on our physiological functions. Each day, this clock acts in such a way that there is a maximum and minimum moment in terms of the probability of our falling asleep. The third factor concerns external synchronizers (light, stress, noise, ambient temperature, etc.) which affect the ability to fall asleep and remain asleep.

[20] There are big sleepers and little sleepers, as each person's biological clock is different. But this clock operates 24 hours a day. And each human being is more prone to falling asleep at the moment when his body temperature begins to fall. This temperature variance exists in everybody, although its amplitude differs from one individual to another. This may perhaps explain why some people sleep longer than others, but one thing is certain: according to Dr. Godbout, it is necessary for us to sleep our regular number of hours of sleep, for our sleep not to be interrupted and for it to occur at the right time, that is to say, at night. Sleeping at a time when the other bodily functions are trying to work as if it were daytime is not very helpful. In that regard, napping for more than 20 minutes during the day is disruptive for the following night.

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[21] With regard to fragmented sleep, Dr Godbout mentioned that fragmentation generates a worse impact than being deprived totally of sleep when one measures the subject's performance the next day. Lost sleep is never totally recovered. Only part is recovered the following night.

[22] There are five stages of sleep. One cycles through all of the stages in 90 minutes, and then the cycle begins again. Stage 1 lasts 5–10 minutes, and is a transition between waking and sleep. Stage 2 is the slow, light sleep phase, where the brain cuts itself off from the world but can still receive information. About 50% of a full night is spent in Stage 2. The third and fourth stages can be grouped together, and are known as slow-wave sleep. They are more intense early in the night. And Stage 5 is the paradoxical sleep phase known as rapid eye movement (REM) sleep. It is called paradoxical because the eyes move rapidly as when awake, but the muscle tone is flat or paralysed. Paradoxical sleep appears more toward the end of the night, and is the stage when one dreams.

[23] When asked about the consequences of a bad night, whether deprived of sleep or with fragmented sleep, Dr Godbout talked of irritability, impulsivity, lack of concentration, lack of memory, difficulty planning and lack of discernment. In that regard, he pointed out that it becomes difficult to distinguish the essential from the accessory, to establish priorities or to exercise sound judgment. Attention is jeopardized by lack of sleep. Alertness (or response or reaction time) is diminished, attention is less sustained, and this is likely to lead to errors of omission or commission. Divided attention (that is, the ability to pay attention to two things at once) is also alerted [*sic*]. The same goes for selective attention, which makes it possible to target something while ignoring distraction factors. Sleep deprivation also exaggerates natural tendencies. An impulsive person becomes even more impulsive. Someone experiencing memory difficulties will feel this even more.

[24] One talks of sleep deprivation as soon as the sleep deficit takes away more than four hours from a normal night. If the deficit exceeds four hours, the deprivation effects will be even greater. As to fragmented sleep, it is not very restorative. Mood, decision-making and memory are affected. It also has an effect on team spirit and consequences on how the work team operates.

[25] A sleep-deprived brain tries to compensate for the negative effects. Other areas of the brain are then brought into play, but this does not always work, even if, subjectively, the sleep-deprived individual does not experience too many problems.

[26] When asked about recovery the following night, the witness pointed out that one generally recovers the Stage 4 minutes, but not more than half the minutes of paradoxical sleep. One can, however, during the second night, recover a little more paradoxical sleep.

[27] In cross-examination, Dr Godbout was convinced that a night worker performs less well than he could during the day in terms of attention and dexterity. The witness also acknowledged that the older one is, the less well one sustains sleep deprivation. He also admitted that there are variations in the effects of sleep deprivation from one individual to another, and that this variable is hard to discern at the outset, particularly since there are even variations in these harmful effects in the same individual over time.

[28] **Charles A. Czeisler** is an MD and a professor at Harvard Medicine [*sic*] School in Boston. He has been teaching since 1983, and in 2004 became Baldino Professor of Sleep Medicine and Director of the Division of Sleep Medicine at the Harvard Medical School. He

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has conducted a great deal of research on sleep deprivation and published a large number of scientific articles. In particular, he has studied the effects of sleep deprivation in astronauts, aeroplane pilots, police officers and firefighters, as well as medical residents.

[29] With respect to medical residents, he drew up a questionnaire in about 1985 after he realized that a large number of them had been involved in motor vehicle accidents on their way home from call duty lasting 30 hours or more. He also wanted to verify whether benefiting from four hours of sleep during such call duty would reduce this type of consequences (motor vehicle accidents). His research showed that this factor would not reduce that risk.

[30] Going 24 hours without sleep, he stated, leads to a weakening of faculties equivalent to 10 mg of alcohol per 100 mL of blood (the witness spoke of 1% blood alcohol). There are four major determinants which influence the ability to maintain one's performance. The first is the length of time one has been awake. The second is the individual's biological clock. The third is the regularity of sleep deprivation, and the fourth he named "sleep inertia," or excessively deep sleep.

[31] One of the functions of sleep is to consolidate learning, so sleep deprivation has an impact on the retention of new knowledge.

[32] Dr Czeisler then commented on the findings of his own and others' research, in particular research published in 2008 by the Institute of Medicine (IOM) of the National Academies. The IOM retained the services of several eminent American researchers at the request of the US Congress and the Agency for Healthcare Research and Quality, in order to study the question of residents' work hours. From this research work stemmed a voluminous document (exhibit S-14) entitled Resident Duty Hours: Enhancing Sleep, Supervision, and Safety.

[33] These researchers looked at the limits established in 2003 by the Accreditation Council for Graduate Medical Education (ACGME), in particular the average of 80 hours' work per week over a four-week period and the maximum duration of a shift established at 30 hours, that is, 24 hours' work with patients and 6 additional hours for performing handoff (signover) and educational activities.

[34] The researchers did not recommend changing the 80-hour period. As to the 30-hour duration, they did not recommend dropping it, but they added to it the following conditions (cf. p. 13 of S-14): work with patients should not exceed 16 hours; the 30-hour period should comprise five hours of sleep between 10 pm and 8 am, and the remainder of the 30 hours should be devoted to handoff and educational activities. If these conditions are not respected, the recommendation of the Institute of Medicine (IOM) was to limit the duration of work on a given day to 16 hours.

[35] According to Dr Czeisler, scientific research proves that the cumulative effect of sleep deprivation leads to health problems and increased risk of hypertension, diabetes, obesity, depression, cardiac problems and strokes. Among residents with family responsibilities (whose sleep for instance is more often interrupted because they have young children), the effects of sleep deprivation caused by long work hours are increased.

[36] A meta-analysis (of 60 research projects on sleep deprivation) of the comparative effects of sleep deprivation in residents and non-residents showed (cf. exhibit S-7) that on average, following 24–30 hours of being awake the subject's performance stood at the 15th percentile of all subjects for a common action and the 7th percentile for a clinical act. Other

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research conducted on 2,737 residents showed that two thirds of percutaneous injuries (cuts or sticks) were caused by a problem of concentration or fatigue. These injuries occurred much more often between midnight and 7 am than during the day. And the chance of percutaneous injury is 73% greater after 20 consecutive hours of work.

[37] Research on the risk of a motor vehicle accident on the way home from a shift of 24 hours or longer shows that there are 168% more car accidents and 468% more "near miss car crashes."

[38] A comparative study of risk of errors with respect to patients depending on whether a resident is subject to a 24-hour or 16-hour shift shows that 36% more major errors are made by the former than the latter, and 5.6 times as many diagnostic errors. On average, in Intensive Care, there are 109% more attentional errors, 36% more serious medical errors and 464% more diagnostic errors made by a resident working 30 hours in a row than another resident working 16 hours. One resident in five, according to other research, acknowledged having committed a fatigue-related error which injured a patient when he was working 24 hours or more. And one resident in 20 acknowledged having committed a fatigue-related error having led to the death of a patient (exhibit S-13).

[39] Dr Czeisler added that some residents are more vulnerable to sleep deprivation owing to their age (the younger one is, the more vulnerable one is to sleep deprivation), medical condition (for instance, pregnancy or disease), or personal or genetic characteristics.

[40] Aeroplane pilots, the witness continued, nuclear power station operators, railway operators, truckers and bus drivers are all people who, in the United States, may not work more than 16 hours a day.

[41] Residents in Canada are required to work 24 hours in a row. In Europe, since 2004, they have not be able to work more than 13 hours. In New Zealand, the limit is 16 hours. In the United States, there is no legal limit, but the ACGME sets the limit at no more than two 30-hour shifts and no more than 80 hours per week.

[42] According to Dr Czeisler, shifts extending beyond 16 hours involve higher risks for patients, the residents themselves, their families and even road users. For the witness, the imposition on residents of a work schedule of more than 24 hours violates several ethical rules: he talked of nonmaleficence toward the patient, beneficence, that is, the duty to promote health, autonomy, that is, respect for the patient's right to be informed of increased risks for his health. He also spoke of the principle of justice that requires an equitable distribution of effort and benefits. In that regard, he mentioned that no distinction whatsoever is made among residents more vulnerable to the effects of sleep deprivation.

[43] He also mentioned the principles of truthfulness and honesty in terms of the systematic falsification of files with respect to the length of shifts, which often exceed even the ACGME standards. And finally, he talked of the assault on human dignity when such a heavy work load is imposed on the resident that it generates risks for his health and that of his patients.

[44] In cross-examination, Dr Czeisler acknowledged that it is more difficult to provide service when work hours are reduced, although, he added, the resident is there first of all to be trained and not to deliver regular hospital service. He also acknowledged that work schedules vary by specialty. And the witness acknowledged that his research on sleep deprivation suffered by residents was limited to residents in the United States.

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[45] **Elisabeth Paice** is a recently retired rheumatologist. Since 1995, she had been Dean Director of Postgraduate Medical and Dental Education for junior and senior residents, first for North Thames, then from 2001 onward for London, England. In this latter assignment, she looked after residents from some 50 hospitals.

[46] She explained that during the 1980s, resident training was not well structured. Length of training was not standardized, and varied a great deal depending on the hospital and the promotions received by residents. The residents' work week was rather heavy. During the week in the 1970s, they often worked 32 hours in a row.

[47] In 1991, she stated, an agreement was reached on a "New Deal." Under this New Deal, work hours were restricted to an average of 56 hours per week. When one was on call elsewhere than in a hospital, call duty hours could go as high as 72 hours, but the actual working time could not exceed 56 hours. Rest hours at hospital were considered rest time, not work time. Shifts could not exceed 14 hours in a row. At least one complete day of rest was required per week. This was a major change, and was introduced gradually over a five-year period.

[48] In 1992, Dr Paice interviewed approximately 1,100 of the 1,500 residents in the London area. She realized that the major problems experienced by them were described as excessive work and fatigue, and sleep deprivation. She continued her investigations in 1995 and 1996. In 1996, 60% of residents said they were working more than the normal average hours, and 50% said they enjoyed on average less than five hours' continuous sleep over a 32-hour period, although the directive required a minimum of five hours' rest between 10 pm and 8 am over a 32-hour work period. The problem lay in the fact that there was no real sanction associated with this standard.

[49] In 2003, sanctions were introduced. There was said to be a breach of contract in the event of non-compliance, and a fine was associated with this. Dr Paice referred to research where it was established that only 10% of the work demanded of doctors at night was necessary. The remainder of the work could be carried out either before or after the night or be performed by personnel other than a physician. Her research also showed that a resident's medical education depended more upon supervision by an expert than the number of hours spent in the hospital.

[50] In 1998, moreover, European standards were introduced concerning length of work time that were applicable to residents in 2004. The average number of weekly hours of work was established at a maximum of 58 hours. And the European jurisprudence, applicable everywhere including the United Kingdom, determined that rest hours in hospital should be considered time worked. Thirteen hours of work had to be followed by 11 hours' rest, and in the event that work hours were exceeded in a day, then compensatory rest time had to be granted as soon as possible.

[51] These new European standards called for a major reorganization of residents' work schedules. Since the 58-hour standard was going to fall to 56 hours in 2007, a solution was sought based on the 2007 standard. In 2009, the standard was further reduced to 48 hours per week. As early as March 2008, 54% of London hospitals were complying with this standard. After August 2009, only 69 out of 10,000 residents in the United Kingdom were supposed to be working beyond the standard (less than 1%), all naturally subject to unforeseen work absences having to be filled by other doctors.

[52] All these changes, Dr Paice continued, did not lead to any modifications to the duration of doctors' training or education, except that the duration was sometimes even

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shortened because the training henceforth no longer depended on receiving a promotion. In the absence of a promotion, residents were in fact invited to seek another specialty. In addition, the basic training for all doctors went from 1 to 2 years.

[53] In cross-examination, Dr Paice stated that the average duration of training for a specialist physician is 14 years. The witness also agreed that the changes since the New Deal have led to fairly substantial additional costs, particularly because, proportionally speaking compared with most industrialized nations, the United Kingdom was short of doctors. Four new medical schools were therefore established. Also, the increase in doctors and the shorter work period led to increases in the amounts paid in salaries. On the other hand, there are fewer medical errors, since, according to Dr Paice, there is a relationship between errors committed and the length of working hours, so there is a lower cost on that front.

[54] **Frédéric Dallaire** is a pediatric cardiology resident. He also holds a PhD in epidemiology, and it was on that basis that he commented on the scientific value of certain research and reference material already produced (exhibits E-3 to E-7).

[55] Epidemiology, he pointed out, is the science that is interested in the analysis of human populations and is used to gauge the quality of research on human populations, in particular the internal and external validity of research.

[56] Concerning documents E-3 to E-7, he mentioned that E-4 is a literature review and has some shortcomings, notably because it cannot be discovered on which basis the authors decided to include the 21 research projects they mention, as well as the basis on which they eliminated other research. Exhibit E-6 is an editorial, that is, it refers solely to the authors' opinion. And while the latter refer to a survey they conducted, they mention no description standard for the methodology used. And E-3 is merely an opinion article, and E-5 is more of an economic analysis of the costs generated by different directives concerning the duration of work time. E-7, finally, is comparative research on the differences between the periods prior to and following the implementation of the new standards concerning the length of US residents' work time. But, according to the witness, many other variables than those mentioned can explain their results.

[57] **Anna Rahmani** is in her final year of residency in internal medicine. During her five years of residency, she has worked in several of the hospitals affiliated with the MUHC. She completed the first five years of her medical studies in British Columbia.

[58] After describing the work normally carried out by a junior and senior resident, she testified concerning call duty periods. There are six per month, including two on weekends.

[59] Particularly in the Intensive Care Units, the regular working day is very demanding for a resident who, most of the time, has virtually no time at all to eat except on the run. On call duty, the work, which began at about 7 am, ends at 8 am the following day and, in practice, generally at around 10 am or even later.

[60] Ms Rahmani explained that at the start of call duty, she still felt in shape for working, but that she started feeling both physically and mentally tired at around 11 pm. At about 3 am, she did not feel to be the same person, and her state of fatigue increased further an hour or two later. It had even happened that she felt inhumane, that is, she did not want to go to Emergency when called for one or more consultations. To offset her lack of concentration and avoid errors, she

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had got into the habit of writing everything down, because she did not feel secure with respect to the patients under her supervision.

[61] When cross-examined concerning her two pregnancies during her residency, she stated that after having been on preventive leave for some time, she benefited from a lighter workload, that is, she was exempted from call duty until her delivery.

[62] **Wael Hanna** is in his fifth year of residency in general surgery. He explained that, in that unit, the junior resident is the first point of contact with the patient. He then communicates with the senior resident, who reviews the case, and, ultimately, the senior resident does the same with the staff physician. In general surgery, to be eligible for the Royal College of Physicians exams and be certified, one has to have carried out 750 operations.

[63] Elective operations are scheduled in advance. They are performed during the day between 8 am and 4 pm or so, and residents also have to handle consultations in Emergency. At about 6 pm, residents who are not on call duty go home. The senior resident on call may go home, but has to be available at all times within 20 minutes, except in the trauma department, where the senior resident has to remain on site at all times. The junior resident has to remain at the hospital.

[64] According to the witness, 24-hour call duty is a unique learning experience. He performs pre-surgery planning, attends the operation and handles post-operative care. The 24-hour duration provides a comprehensive overview of the care to be delivered. Surgery, he went on, involves not only clinical training (on the diagnosis, etc.), but also technical training on procedural skills, and some of these skills are acquired at night through operations which primarily take place at that time of day (bullet or knife wounds or organ transplants).

[65] Dr Hanna then spoke of "signovers," that is, transfers of information between work teams where the following team is informed about relevant facts concerning each patient. It is often during these reports that errors of omission are committed, that is, that one forgets to pass on certain details concerning a patient. But if the duration of call duty is changed (from 24 to 16 hours), there will likely be an additional signover, and this is likely to increase errors of omission.

[66] A general surgeon also has to get used to working long hours. His training requires him to work also in hospitals in the regions, where the staff physician is on call and has to be in a position to operate at night, when necessary, even if he does office hours during the day. It is he who has to ensure that the patient is prepared before the operation, perform the surgery itself and handle post-operative care.

[67] The witness then discussed a study he had piloted jointly with other researchers. This involved a survey conducted on all surgery residents in Canada except those in Toronto. The survey concerned the effects of limiting the weekly work time to 80 hours and shortening call duty periods from 24 to 16 hours. The survey showed that, in residents' opinion, limiting weekly work hours would lead to a great improvement in burnout rates and quality of life in general. It would mean a big difference in staff physicians' lifestyles. There would be no difference in operative care, nor in residents' operating experience, but a shiftwork mentality would likely develop, to the detriment of patients.

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[68] As to reducing the call duty schedule from 24 to 16 hours, this would reduce operating experience and para-surgical activities. According to Dr Hanna, this type of change is inevitable, but their impact has to be reviewed in order to offset the disadvantages before they are introduced. Residents have to perform as many operations, and have to retain a physical ability to operate for long periods.

[69] **Jonathan Spicer** is a resident in general surgery. At the time of the grievance, he was president of the Association and a vice-president of the *Fédération des médecins résidents du Québec*. He is currently in his third year of residency, and intends to undertake a subspecialty in thoracic and oncological surgery. He signed the collective grievance.

[70] He explained that he is personally against limiting call duty to 16 hours, but he signed the grievance after an assembly of members was called and a vote was taken in favour of filing a grievance. At the assembly, only 100 or so members (out of 600) were present. An online vote was also carried out to obtain as many opinions as possible. In all, 40% of members took part, of whom 60% voted in favour of filing a collective grievance; 30–35% voted against it, and the remaining voters abstained.

[71] Dr Spicer works in the Trauma Clinic at the Montreal General Hospital. He considered that his health has never been compromised by the 24-hour call duty system. He disagreed with changing the call duty system, because the change affects all specialties and this could have disastrous consequences on some of them, notably surgery, where certain cases are rare and generally occur at night. Second, when one becomes a staff physician, he added, one often has to be on call for 24 hours, and the resident's schedule should reflect the staff physician's. Third, it is not up to the Association to decide on exposure and the training time intimately linked to doctors' competency. It is the Royal College which should be establishing training benchmarks for specialist physicians.

[72] **Ning Zi Sun** is in her fourth year of residency in internal medicine at the MUHC. She explained that the doctor responsible for internal medicine residents, Dr Thomas Maniatis, had made certain changes in call duty hours starting in July 2009. For second- and third-year residents, call duty during the week on the wards went from 24 to 16 hours. Call duty remained at 24 hours on weekends and in the Intensive Care Units. First-year residents also continued to perform 24-hour call duty.

[73] In July 2010, the same system was applied for first-year residents on the wards; 16-hour call duty was implemented on weekends, as well.

[74] Dr Sun appreciated this new system. On the one hand, she felt more awake and better able to perform her work at night. On the other hand, this new system removed the requirement to be on leave the day following call duty, so she was more familiar with the patients she was looking after.

[75] **Justin Létourneau** is in his third year of residency in anaesthesiology. He explained that an anaesthetist not only looks after surgical care, but is also a resuscitation specialist. As such, he may be called at any time to any hospital department, in particular the Trauma Clinic and Intensive Care Units.

[76] For surgical care, anaesthesia is linked to surgery and, as in this latter field, night operations take place in conditions very different from those during the day. And the experience

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acquired at night is essential, and very significant. It allows for exposure to very sick patients and critical situations where the anaesthetist has to work very autonomously.

[77] He himself had never felt physically unsafe at night. He had almost always managed to rest when he felt the need to, and had easily obtained the co-operation of the on-call anaesthetist and the respiratory therapist, as applicable. He considered that the reduction in residents' call duty in anaesthesiology from 24 to 16 hours would reduce his work hours, and therefore his experience, and lessen the quality of his training. He added that anaesthesiologists often work 24-hour periods, and residents should have to be able to work the same length of time as staff physicians, particularly since he does not believe reducing call duty hours would make residents more alert.

[78] **Pierre-Luc Bernier** is in his sixth year of residency in cardiac surgery. He intends to specialize in pediatric and congenital cardiac surgery. His first two years of residency were oriented toward surgery proper. The third was devoted to clinical enrichment, that is, research. And from the fourth year onward, he has essentially performed cardiac and vascular surgery and traumatology.

[79] In cardiac surgery, call duty is of 24 hours' duration, and is carried out at home no more than nine times a month. Such call duty allows for a comprehensive appreciation of the patient's condition and progression. It is essential, to his mind, to work at night, because it is at night that many special operations take place, for instance transplants or aortic dissections. It is therefore in residents' interest to perform 24-hour call duty.

[80] He himself has never considered his health to be jeopardized by the length of these call duty periods. One learns to manage one's fatigue and take rest time. That is quite easy to do, because one is not very busy every single night. Dr Bernier could not imagine reducing the duration of call duty in his specialty. It would be harmful for patients, because it would increase the number of reports, and information is lost each time. It would also be detrimental to the resident's training, because if he were to work a week of nights, he would learn virtually nothing that week because generally speaking, he could sleep at night. He considered that exposure to certain cases would be reduced, and the actual duration of training would likely be extended, and this could discourage some medical students from taking that route.

[81] In practice, he stated, there are only three cardiac surgery residents available for call duty. More would be needed if the duration of call duty were to go from 24 to 16 hours.

[82] **Jeffrey S. T. Barkun** has been chief of general surgery at the MUHC and McGill University since 2004. He does not directly look after residents. Dr Fata does that, but she reports to him.

[83] In the first year, the MUHC currently has only 6–7 residents, not to mention four others from the Middle East (whose costs are paid by their respective countries). The residents, the witness went on, have to work in every single MUHC establishment in addition to certain other hospitals in the regions. And the way in which call duty is carried out (in an establishment or at home) varies according to the hospital and the resident's experience. For first-year residents, it is generally carried out in an establishment.

[84] When asked about the duration of call duty (24 hours rather than 16 hours), Dr Barkun mentioned that certain operations are performed essentially at night, so it is beneficial for the resident to work at night in order to be exposed to them. Second, when the resident is certified as

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a surgeon, he will often be forced to work 24 hours in a row (for instance, if he works in a regional hospital), and it is beneficial for him to get used to this as a resident. Third, he considered, having discussed this with his program chief (Doctor Fata), that the number of residents would have to be increased by 50% (moving from 6–7 to 9) in order to cover all call duty periods. Then, if the number of residents is greater and the number of operations remains the same, it will follow that residents will be exposed to a smaller number of cases during their residency, and this is likely to entail an increase in the duration of surgical residency. Finally, the increase in the number of call duty periods necessarily involves additional signovers of patients, and this is likely to lead to more frequent omissions, which can then affect the quality of care.

[85] If call duty hours are reduced, he added, quite a lengthy adjustment period would be required in order to adapt and to overcome all these difficulties.

[86] In another vein, Dr Barkun mentioned that for the past 20 years that he has been working in the same place, he has never received any complaints or ever been told of a situation where a resident has caused himself harm owing to his state of fatigue.

[87] In cross-examination, he considered that 16-hour call duty could be envisaged for first-year residents, but this would be unreasonable from their second year onward. Such an eventuality would have a negative impact on their training, their exposure to different operations and even their professionalism.

[88] **Patricia Zanelli** is chief of the internal medicine program at the Montreal General Hospital (MGH). She is responsible there for the training of some 40 internal medicine residents. Residency in internal medicine lasts five years. The first three are common to the different specialties. Residents perform call duty on the wards and in Intensive Care (ICU) and Coronary Care (CCU). At the MGH, then, residents cover three wards comprising 60 or so patients in addition to the ICU and CCU.

[89] On the wards, until July 1, 2009, for the night, there was one first-year resident, one medical student and a senior resident (second or third year) looking after all the patients. And there was one resident in the CCU and another in the ICU. Starting in July 2009, because it was anticipated that the duration of call duty would eventually have to be reduced, a pilot project was introduced, with a night team responsible for call duty from 8 pm to 8 am.

[90] The project was aimed only at senior residents (level 2 or 3) and covered only the wards, thus excluding the ICU and CCU. As the seniors assigned to the night team were assigned for two weeks at a time, five days per week, their absence (four days every two weeks) had to be made up by replacements (parachuters), who worked 24 hours in a row. The pilot project had other disadvantages, particularly in terms of communications (an additional signover carried out by a resident forced to remain on site until 8 pm, when the night-team resident arrived). Also, the staff physician and the night resident were not in direct contact for two weeks, and this led to evaluation difficulties. On top of that, the night resident received no teaching. Finally, if the resident for the two weeks of the period when he was not working at night was assigned to a subspecialty (for instance, cardiology), it could happen that he returned to cardiology only two or three months later, thus diluting his learning. On the other hand, the project generated some positive results. For instance, residents were no longer on leave following their call duty, because this no longer lasted 24 hours, so residents were present every day on the wards and could follow patients that much better. This meant patients were discharged more quickly, and improved the availability of beds. But this situation also led to more night-time admissions,

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thereby making the task of the resident working at night more burdensome, leading to questions as to whether it would not be helpful to expand the care team for that period.

[91] In July 2010, it was decided to extend the project to first-year residents. In addition, the project already in effect at the Royal Victoria and the MGH was heard [*sic*] at Montreal's Jewish General Hospital. It still did not apply to the CCU or the ICU. From that date onward, in those three hospitals, there were night teams comprising a senior and a junior resident.

[92] **Julie Goulet**, a human resources management advisor with the Ministry of Health and Social Services (MSSS) submitted a comparative table of call duty conditions in the different Canadian provinces.

[93] **Pierre Fréchette** is an emergency physician who retired in 2009. From 1986 until his retirement, he was director of professional services, assistant and co-ordinator of emergency services at Hôpital Enfant-Jésus in Quebec City, the largest tertiary trauma centre, the other two being located in Montreal (Hôpital Sacré-Coeur and Montreal General Hospital). He contributed to setting up a trauma network in Quebec starting in 1990, a challenge somewhat like the introduction of call duty schedules of limited duration. In July 2010, he was mandated by the MSSS to chair a working group that will define appropriate action for achieving a reduction in medical residents' consecutive work hours while guaranteeing patient safety, quality of teaching and safe working conditions for residents.

[94] Dr Fréchette used a PowerPoint presentation (E-23) to comment on the different testimony and scientific articles in support of the grievance submitted by the two parties. In brief, he considered that a single work schedule model would probably not suit all training programs. The issue of lack of sleep and consecutive hours of work for residents raises serious concerns, but research in that regard is only in its initial stages. Caution is needed before modifying the system in order to guarantee both patients' safety and the quality of professional training while retaining sound control over public spending.

[95] In cross-examination, Dr Fréchette acknowledged that Dr Czeisler is probably the best-known expert on sleep deprivation in medical residents. Since medical education is much the same in Canada and the United States, there is no reason to believe that Dr Czeisler's research is not relevant for Quebec. Dr Fréchette himself, he admitted, had experienced during his residency the problems described by Dr Czeisler, in particular attentional difficulties, memory loss, risk of error, extreme fatigue, etc. The current call duty system, he agreed, constitutes an increased risk for residents' and patients' health. This system must end, but a change will have a major impact. Accommodations will have to be found in disciplines where there is a shortage of residents, and generally speaking the change must not jeopardize patients' health, or doctors' training. So it will be necessary to act with circumspection. That is why Dr Fréchette felt it unlikely that it will be possible to apply a single standard in all specialties.

[96] **Heather Abrahams** is chief of the family medicine unit at Montreal's Jewish General Hospital. She is the director of the family medicine residency program, in which there are 22 first-year and 20 second-year residents. She pointed out that the residency program has to be accredited by the College of Family Physicians of Canada, which conducts a review of the program every four years.

[97] So the residency program is spread over two years and contains 26 four-week periods. For six months, residents work in family medicine units, and the rest of the time they are assigned to different relevant specialties (ICU, CCU, emergency, paediatrics, internal medicine,

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obstetrics, etc.). Residents are evaluated after each of the 26 rotation periods. A number of them (25–50%) seek an additional year of training, even after obtaining their certification.

[98] When residents are assigned to a unit like Intensive Care, for instance, they do the same type of call duty as all other residents in Intensive Care. And when they go into the regions (they have to work there two months during their training), they perform 24-hour call duty, although sometimes they do this from home.

[99] Dr Abrahams explained that there are several advantages to 24-hour call duty. In obstetrics, for instance, it is not unusual for several hours to pass between the patient's arriving at hospital and her delivering her child. For his training, it is in the interest of the resident on-site to be present for the whole duration. Similarly, there are situations which occur especially at night, and that is the time when the resident is relatively autonomous, when he will have to make decisions. She therefore considered it very helpful for call duty to stretch over 24 hours. And it has never happened to her that a resident has said he is too exhausted to complete call duty, particularly since the resident has a room where he can rest. Nor has she ever heard of residents having any health or safety problems with respect to call duty.

[100] Furthermore, she added, following the grievance, they had looked at the idea of reducing the length of call duty, and it appeared extremely complex to devise a call duty schedule where the resident would nevertheless be exposed to an equivalent clinical experience. In her view, the resident's training would be likely to suffer from this and, particularly in the event of a night team for one week each period, this resident's patients could not be followed by him during the day at the hospital.

[101] **Eric Himaya** is in his fifth year of residency in obstetrics-gynaecology at Laval University. He explained that residencies in his specialty are primarily performed in two hospitals, CHUL and Hôpital St-François d'Assise. Residents perform call duty during the five years of specialty. In oncology, call duty is performed at home; that is also the case with gynaecology at the CHUL. But for the vast majority of the time during residency, call duty takes place in an establishment.

[102] Dr Himaya performed 24-hour call duty until early July 2010. A little prior to that, the program director (Dr Jacques Mailloux) wanted a pilot project to be set up where call duty would not exceed 16 hours in length. In about May 2010, the person responsible for the rotation at St-François d'Assise asked Dr Himaya to draw up a call duty proposal himself, and he did so. This pilot project, which was in place from early July at St-François d'Assise for a six-month period, was renewed indefinitely. Dr Himaya submitted an illustration of call duty schedules for October 2010 (exhibit S-26).

[103] There are currently eight residents in gynaecology-obstetrics at Laval University. Each of them does 3–4 nights per month. On that occasion, the resident works neither on the day when he begins his call duty at 11 pm, nor on the day when he ends it at 8 am. If the number of residents is at least five, it would be possible to draw up a call duty schedule of the same type, because each resident would perform only six call duty periods at night per month.

[104] The witness added that the pilot project was drawn up for the CHUL at the same time as for St-François d'Assise. The call duty schedule for the CHUL was at the outset different from the schedule for St-François d'Assise, but the two have been built on the same model (the St-François d'Assise schedule) since September 2010, and they are working well.

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[105] According to Dr Himaya, even if there is one more signover per day (at 11 pm), there is no additional risk for patients, since the dangers associated with the loss of information during signovers are offset by the fact that the residents are more alert and less tired. There are no fewer hours of work per month, there is merely a reorganization of the hours. This harms neither the training, nor the patient follow-up.

[106] In cross-examination, Dr Himaya agreed that in other specialties, to his knowledge, they are still operating on the basis of 24-hour call schedules. It also happens, for instance on conference days where residents' attendance is mandatory, that residents cannot be assigned call duty the following night. The staff physician on call has to manage without the presence of the resident.

[107] In rebuttal, Dr Frédéric Dallaire commented on two of the scientific articles submitted by Dr Hanna (exhibits E-10 and E-11). For item E-11, he mentioned that it contained grossly unacceptable errors of methodology and that, moreover, the article was concerned with the total number of hours of work and not hours of continuous work. As to E-10, the study was well done, but once again, it also looked at the number of hours of work per week. Dr Dallaire also tabled an example of a call duty schedule respecting a 16-hour limit in specialties with five or six residents. This example was built by the Union Affairs Committee of the *Fédération des médecins résidents du Québec*, which he had been chairing for some time. The purpose of this example was to support the Federation in its negotiations with the Ministry of Social Affairs [sic] with respect to amendments sought to article 12 of the labour contract.

[108] **Vincent Guay-Langevin** and **Karen Woo** are, respectively, a fourth-year resident in anaesthesiology at the University of Sherbrooke and a third-year resident in gynaecology-obstetrics at McGill. They both commented on the call duty schedules in effect in their specialties in the university hospitals where they are studying. In anaesthesiology in Sherbrooke, as far as call duty in anaesthesiology is concerned, residents work on a night team for one month per year. The rest of the year, they work during the day or in the evening. In the evening, they end at 10 pm. On this schedule, residents do not work 24 hours in a row.

[109] In obstetrics-gynaecology at McGill, residents working at the Royal Victoria and the Jewish General Hospital in Montreal also work at night on 14-hour shifts. On the night shift, a resident works for a minimum of two weeks and a maximum of four weeks in a row. Residents working during the day and evening do not work more than 16 hours, except for one day per month, the Saturday when they are on call for 24 hours in a row.

[110] Drs Guay-Langevin and Woo mentioned that their schedules permitted exposure and training that was as good as a schedule with 24-hour shifts. The residents are happier and less tired, and that facilitates their learning.

2. **CLOSING ADDRESSES**

[111] Counsel abundantly and skilfully argued their respective positions. And, at the risk of offending them, I shall summarize their viewpoints extremely briefly.

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[112] The Association submitted that the grievance is aimed only at call duty in an establishment, and not call duty at home. The collective agreement to which clause 12.14 belongs was negotiated and signed by the Minister of Health and Social Services (hereinafter called the "MSSS"). The government is therefore a party to the collective agreement and, for that reason, the Canadian Charter applies to this case as much as the Quebec Charter does. But the evidence demonstrates a breach in the integrity and personal security of both residents and patients. There is therefore a violation of section 7 of the Canadian Charter and section 1 of the Quebec Charter. Furthermore, there is an infringement of section 46 of the Quebec Charter, which deals with the right to fair and reasonable conditions of employment.

[113] The Employer first reiterated its objection to the arbitrator's jurisdiction in such a case. It argued that the situation in dispute had existed since time immemorial and had never given rise to an objection. It added that there was no concrete fact placed in evidence which could provide a basis for the grievance, since there had been no demonstration of any complaint or situation, having led to injury. The evidence on the situation in the United States or England cannot be imported to the situation in Quebec, since no similar Quebec study has been carried out. Counsel emphasized the major impacts of the case in financial terms, as well as the significant differences among the specialties concerned. The duration of training and the opinion of the Royal College must also be taken into account. Finally, it mentioned that the conclusions sought violate the freedom and professional autonomy of residents who agree with extended call duty to provide them with better training.

3. DECISION AND REASONS

A. Preliminary remarks

[114] The case contests the fact that, via clause 12.14 of the collective agreement, residents can be required to work 24 hours in a row when performing call duty in an establishment. This situation, according to the wording of the grievance, violates the Canadian Charter and the Quebec Charter.

[115] *In limine litis*, the Employer raised a preliminary objection contesting the grievance arbitrator's jurisdiction over a case of this kind. Since the two parties sought an interlocutory decision on this question of jurisdiction, I agreed to provide one and, on October 16, 2009, I decided to reject the preliminary objection. This interlocutory award was the subject of an application for judicial review, which was denied by the Superior Court, and permission to appeal was not granted. The hearing continued over 15 days, and ended on April 6, 2011.

[116] During the oral hearing, counsel for the Employer reiterated his objection to the arbitrator's jurisdiction on the additional grounds that the MSSS had agreed to amend call duty schedules at the negotiating table and that the arbitrator should not become gratuitously involved in a debate whose goal, he claimed, was to obtain additional compensation. The Association strongly objected to these remarks that were not based on the evidence in the case.

[117] I report the foregoing to emphasize that I obviously do not have to discuss on that basis. A grievance was validly submitted to me, and I ruled on October 16, 2009 that the arbitrator is the

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appropriate forum for hearing the case. I reiterate, in case it should be necessary, the grounds which I presented in my interlocutory decision in support of my jurisdiction, and I intend in the following pages to provide, on the basis of the evidence adduced before me and the applicable law, my conclusions on the validity of the grievance.

[118] Before I set out my conclusions using the applicable law and jurisprudence, it is important to provide my overall assessment of the evidence.

B. Assessment of the evidence

[119] In the chapter devoted to the evidence, I provided, for the reader's benefit, a summary of the different testimony heard. This represents, and I repeat, a summary covering 1,000 pages of stenographer's notes. It is not my intention to resume each testimony one by one, but rather to mention the facts that appear to me to be the most probative and relevant. I shall begin with the testimony presented by residents and doctors responsible for certain specialties.

[120] Several residents described their personal experience with 24-hour call duty in an establishment. Some of them (for instance, Drs Bestawros, Anderson and Rahmani) emphasized the difficulties associated with lack of sleep. They talked of the great fatigue they felt from midnight onward, peaking at around 4 am. They spoke of slowing down physically and cognitively, and of medical errors owing to their state of fatigue. Dr Anderson talked of ailments (headaches, nausea, leg pain, orthostatic hypotension). Dr Rahmani spoke of sometimes feeling "inhumane," in direct contradiction with her reasons for practising medicine.

[121] Other residents, on the other hand, particularly in general surgery or anaesthesiology, mentioned that 24-hour call duty enabled them to acquire a unique pedagogical experience, providing them with extensive technical training, particularly for what happens during the night. This increased their operating experience. They sensed no health problems associated with the duration of call duty.

[122] Some residents mentioned that reducing call duty to 16 hours would mean an additional signover, and that was likely to lead to a loss of information. Others, in that regard, said that the disadvantages of the additional transfer are offset by the physical condition of the resident, who is less tired and more alert.

[123] The evidence reveals that the grievance was filed following a vote among all the residents; 40% of members cast ballots. Of that number, 60% wanted the collective grievance to be filed, 30–35% were against it, and the remainder abstained.

[124] I retain from this evidence that the majority of residents who expressed their views considered that this condition of employment (24-hour call duty in an establishment) is unreasonable and warrants the filing of a grievance. Many were against it because they considered that their training would be less complete and because they felt no major inconvenience.

[125] The preceding presentation must be examined in the light of the expert testimony, which appears to me to be of prime importance.

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[126] Dr Godbout testified primarily on the importance of the role of sleep and the impact of sleep deprivation. He explained that fragmentation of sleep generates worse effects than total deprivation which, itself, generates irritability, impulsivity, memory loss and lack of concentration and discernment. It becomes difficult, he added, to exercise sound judgment. Attention and alertness are diminished, and this is likely to lead to errors of commission and omission.

[127] As to Dr Czeisler, a well-known specialist in sleep medicine, a discipline he teaches at Harvard University, he has conducted a great deal of research on sleep deprivation in different professionals (astronauts, police officers, firefighters, etc.), including medical residents (in 2008). In his view, scientific research demonstrates that sleep deprivation leads to health problems and increased risk of hypertension, diabetes, obesity, depression, and cardiac or vascular problems.

[128] I refer the reader to the chapter on evidence for further details, but it is sufficient to remember that his research establishes that residents working 24 hours in a row make 36% more errors than those working 16 hours. The former make 5–6 times as many diagnostic errors. One resident in five acknowledged having made fatigue-related errors when working 24 hours or more. And one in 20 acknowledged, in the same circumstances, having committed an error that led to a patient's death. According to Dr Czeisler, his research proves that a work duration of more than 16 hours leads to higher risks for patients, residents, the latter's families and even road users. The witness also acknowledged that certain residents are more vulnerable than others for all kinds of reasons. And he admitted that his research is limited to residents working in the United States.

[129] In another vein, Dr Paice, formerly Dean Director of Postgraduate Education for residents in London, England, explained that it happened in the 1990s that residents often worked as much as 32 hours in a row. She interviewed 1,100 of the 1,500 residents in the London area in 1992, and realized that an excessive workload, fatigue and sleep deprivation were major problems. In 2004, to comply with the standards of the European Parliament, work schedules of a maximum of 58 hours per week were set up, with no more than 13 hours per day. These standards required some major reorganization, and more doctors had to be used (four new medical faculties were even created).

[130] I conclude the chapter on the experts' evidence by commenting on the testimony of Dr Fr chet te, even if he did not testify as an expert in sleep medicine. As a highly experienced emergency physician, he was mandated by the MSSS to chair a working group on action to be taken to reduce residents' consecutive hours of work. He acknowledged Dr Czeisler's great expertise, and stated that since medical education in Quebec was much the same as in the United States, Dr Czeisler's research was just as relevant to the situation in Quebec. He had himself experienced the problems raised by Dr Czeisler (attentional problems, memory problems, increased risk of error, extreme fatigue). And he agreed that the current call duty system represents an increased risk for residents' and patients' health. On the other hand, he considered that a single work schedule model would not adapt well to certain training programs, and that caution was needed before modifying a system, so as to ensure that patient safety and the quality of professional training were guaranteed.

[131] I therefore retain this from the evidence as a whole. It has been established to my satisfaction that the call duty schedule in an establishment of a duration of 24 hours is dangerous for resident health and leads in many of them to physical, and even mental problems. Some are less affected than others, but many of them suffer from problems of attention, concentration, memory and extreme fatigue. Not only does such a schedule jeopardize their health, but it also indirectly endangers the health of patients, who may become victims of medical errors.

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[132] Residents are also likely to be injured owing to inattention associated with fatigue, and the evidence even shows that driving home after 24-hour call duty without sleeping is dangerous (cf. Dr Czeisler's testimony on motor vehicle accidents and "near miss car crashes").

[133] Unlike counsel for the Employer, I am of the view that the evidence establishes a series of facts experienced by many residents which endangered their physical health (extreme fatigue, inattention, lack of concentration and memory) or mental health (irritable mood, feeling inhumane, etc). There may perhaps never have been any formal complaints prior to the grievance, but that does not by any means imply that call duty schedules in an establishment of a duration of more than 24 hours were not harmful to resident and patient health.

C. Canadian Charter of Rights and Freedoms

[134] The grievance, as we know, asks the arbitration board to declare clause 12.14 of the agreement binding medical residents inoperative on the basis of the fact that it requires the latter to work up to 24 hours in a row. For the reader's benefit, I reproduce this clause 12.14 immediately:

12.14 As soon as a resident has worked for eighteen (18) hours during a twenty-four (24) hour period, he shall be released from his basic regular schedule immediately following his call duty, for a period of at least twenty-four (24) hours. In no case shall the resident work more than twenty-four (24) hours in a row.

[135] As to the Canadian Charter, its sections 1 and 7 guarantee to all the right to security of the person. These two provisions read as follows:

1. [Rights and freedoms in Canada.] The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

7. [Life, liberty and security of person.] Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

[136] Moreover, the Charter, as we know, stipulates in its section 32 that it applies to the parliament and government of Canada as well as all provincial legislatures and governments. The first question to be asked is to verify whether the collective agreement and its clause 12.14 are a matter under Quebec government responsibility.

[137] The jurisprudence tells us that the Charter applies to an activity even if it results from an act that is not performed by the government when the latter has so much control over that act that it may be deemed to be a government act. Lavigne v. Ontario Public Service Employees Union¹ saw the case of a teacher who, under his collective agreement, was subject to a mandatory dues check-off clause (Rand formula). He claimed that this provision violated his right to

¹ Reported at [1991] 2 S.C.R. 211.

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freedom of association guaranteed by section 2 of the Charter. The Supreme Court dismissed his claims, but recognized that the Charter applied in the case at hand even if the government was not party to that collective agreement, because the Council of Regents is an emanation of government and the Minister exercised full control over its activities. Pages 37 and 40 read as follows:

“What then is to be gleaned from the case law to date? It seems to me that the decisions of the Court establish that there are two ways in which the *Charter* may be invoked. First, the *Charter* applies to acts of “government”. What constitutes “government” for this purpose includes not only the legislative, executive or administrative branches of government in the sense contemplated by McIntyre J. in *Dolphin Delivery*, but also other non-traditional government bodies such as those contemplated in *Slaight Communications* and *McKinney*. In other words, the *Charter* applies to “government” entities broadly construed. Second, an activity will be subject to *Charter* review if, even although the act was not performed by “government”, it was subject to such significant government control that it may effectively be considered an act of government for *Charter* purposes.

(p. 37)

(...)

“In my view, the government controls the School of Mines and the Council of Regents so that these entities should be viewed as part of government for purposes of s. 32. I find, therefore, that the application of the control test provides a strong indication that the compelled payment of dues to the union through the joint action of the Council and OPSEU is government action for purposes of the *Charter*.”

(p. 40)

[138] In the case at issue, it is very clear that the collective agreement binding medical residents and university hospitals (establishments) is an act of government. The Health Insurance Act (RSQ, c. A-29) states this clearly. Section 19.1 reads as follows:

“19.1. With the approval of the Conseil du trésor, the Minister may make with a body representing the residents in medicine an agreement on the conditions of employment applicable to the residents in medicine in period of training in institutions having entered into a contract of affiliation or a service contract or agreement in accordance with section 110 of the Act respecting health services and social services (chapter S-4.2), or with a university within the meaning of the Act respecting health services and social services for Cree Native persons (chapter S-5).

The twelfth paragraph of section 19 applies to such an agreement.”

[139] This provision establishes the Minister's control beyond doubt, both over the negotiations of the collective agreement and over the establishments where the agreement will apply. *In fine*, the section in fact refers to the 12th paragraph of section 19, which stipulates that any agreement binds the board (*Régie*), agencies and establishments.

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[140] That being said, it remains to be decided whether the fact that article 12.14 of the agreement has the effect of requiring residents to work up to 24 hours in a row violates sections 1 and 7 of the Canadian Charter.

[141] The notion of security of the person includes that of the physical and psychological integrity of the person. Section 7 of the Canadian Charter therefore protects individuals against acts of the state which have serious or dangerous consequences for their health.

[142] Professor Christian Brunelle draws a parallel between the notions of security in the Canadian Charter and that of inviolability in the Quebec Charter. The following extract is interesting not only because of the parallel between “security” and “inviolability,” but also because it deals with the notion of “principles of fundamental justice” contained in the section 7 of the Canadian Charter, which I shall deal with later. Professor Brunelle writes as follows:²

“A- Life, freedom, security, inviolability and assistance

Section 1 of the Quebec Charter guarantees “every human being” the “right to life, and to personal security, inviolability and freedom.” Section 2 of the Charter adds that “[e]very human being whose life is in peril has a right to assistance.” The *Canadian Charter* provides, in its section 7, a similar guarantee, stating that “[e]veryone has the right to life, liberty and security of the person” as well as “the right not to be deprived thereof except in accordance with the principles of fundamental justice.” While “s. 7 of the *Charter* is not confined to the penal context,” its application is reserved first for infringements “that occur as a result of an individual’s interaction with the justice system and its administration.” But the latter requirement appears now to have been removed. For its part, section 1(a) of the *Canadian Bill of Rights* recognizes “the right of the individual to life, liberty, security of the person [...] and the right not to be deprived thereof except by due process of law.”

Whereas “the principles of fundamental justice” and “the due process of law” can to some extent restrict the right of the individual to life, liberty and security of the person enshrined in the Canadian documents, section 1 of the *Quebec Charter* has no such intrinsic restriction. The protection provided by the Quebec text could therefore be more generous.

With respect to the “principles of fundamental justice” to which section 7 of the Canadian Charter refers, the jurisprudence tells us that they “vary according to the context in which they are invoked” and are to be found “in the basic tenets and principles of our judicial system, as well as in the other components of our legal system.” One can draw in particular on common law and legislative history, Canadian legislative and judicial practice, foreign law, international law, the rights and freedoms recognized by the *Canadian Charter* or the other Canadian fundamental rights instruments to identify “the principles of fundamental justice.”

Note that the need to strike the “correct balance between individual and societal interests” is also a question of “fundamental justice” but “it is not in and of itself a freestanding principle of fundamental justice”:

“The balancing of individual and societal interests within s. 7 is only relevant when elucidating a particular principle of fundamental justice.”

² BRUNELLE, Christian, *Les droits et libertés fondamentaux*, École du Barreau du Québec, Droit public et administratif, Vol. 7, Collection de droit 2010-2011, Cowansville, Éd. Yvon Blais 2010.

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In plain language, it is “only when they are deriving or construing the content and scope of the principles of fundamental justice themselves” that the “balancing of interests” is to be “taken into consideration by courts.” (pp. 44 and 45)

(...)

3. Personal security

One can reasonably assert “that personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and psychological integrity, and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these.” Thus understood, the notion of security includes as it were the notion of physical and psychological integrity. It protects the individual from acts of the state which have “serious,” “severe” or “harmful” physical and psychological consequences for him. The Quebec legislature chose instead to provide protection specific to “integrity,” whether physical, moral or psychological, through section 1 of the Charter. (p.48)

[Unofficial translation]

[143] The Supreme Court ruled, in R. v. Morgentaler,³ that the right to security is at issue when a provision places a person's life or health in danger. Paragraphs 84 and 85 of this decision read as follows:

“84. Generally speaking, the constitutional right to security of the person must include some protection from state interference when a person's life or health is in danger. The *Charter* does not, needless to say, protect men and women from even the most serious misfortunes of nature. Section 7 cannot be invoked simply because a person's life or health is in danger. The state can obviously not be said to have violated, for example, a pregnant woman's security of the person simply on the basis that her pregnancy in and of itself represents a danger to her life or health. There must be state intervention for “security of the person” in s. 7 to be violated.

85. If a rule of criminal law precludes a person from obtaining appropriate medical treatment when his or her life or health is in danger, then the state has intervened and this intervention constitutes a violation of that man's or that woman's security of the person. “Security of the person” must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction. If an act of Parliament forces a person whose life or health is in danger to choose between, on the one hand, the commission of a crime to obtain effective and timely medical treatment and, on the other hand, inadequate treatment or no treatment at all, the right to security of the person has been violated.”

(Emphasis added)

[144] By analogy, the idea can be inferred from these passages that if complying with a contractual cause to which the government is party has the effect of jeopardizing the medical resident's physical and mental health or endangering the health care which patients are entitled to receive when they are hospitalized, the right to security of the person of the resident

³ Reported at [1988] 1 S.C.R. 30.

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and the person of the patient is placed at risk. Such a contractual provision violates section 7 of the Canadian Charter.

[145] Section 7 of the Canadian Charter stipulates that one of the rights listed there can be infringed “in accordance with the principles of fundamental justice.” The ruling handed down by the Supreme Court in Godbout v. Longueuil (City) in 1997⁴ is interesting in that regard. The City of Longueuil stipulated in its bylaws that its employees had to reside within its territorial limits. Respondent Godbout argued a deprivation of her human rights. In paragraph 74 *et seq.*, the Supreme Court wrote the following:

“74. The text of s. 7 provides that a deprivation by the state of an individual’s right to life, liberty or security of the person will not violate the Canadian *Charter* unless it contravenes the “principles of fundamental justice”. Over the years since the *Charter*’s inception, this Court has repeatedly been called upon to interpret that phrase, so as to determine in particular cases whether a *Charter* violation has, in fact, occurred. In the early days of *Charter* adjudication, questions arose as to whether the principles of fundamental justice included within their ambit a substantive element, in addition to the guarantees of natural justice or procedural fairness. That issue was conclusively settled by this Court in the *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486, where all members of the panel seized of the case agreed that the principles of fundamental justice are not limited merely to rules of procedure but include as well a substantive component. This has meant that if deprivations of the rights to life, liberty and security of the person are to survive *Charter* scrutiny, they must be “fundamentally just” not only in terms of the process by which they are carried out but also in terms of the ends they seek to achieve, as measured against basic tenets of both our judicial system and our legal system more generally; see *Re B.C. Motor Vehicle Act*, at p. 512; *Beare*, *supra*; and *Lyons*, *supra*.

(...)

76. But just as this Court has relied on specific principles or policies to guide its analysis in particular cases, it has also acknowledged that looking to “the principles of fundamental justice” often involves the more general endeavour of balancing the constitutional right of the individual claimant against the countervailing interests of the state. In other words, deciding whether the principles of fundamental justice have been respected in a particular case has been understood not only as requiring that the infringement at issue be evaluated in light of a specific principle pertinent to the case, but also as permitting a broader inquiry into whether the right to life, liberty or security of the person asserted by the individual can, in the circumstances, justifiably be violated given the interests or purposes sought to be advanced in doing so. To my mind, performing this balancing test in considering the fundamental justice aspect of s. 7 is both eminently sensible and perfectly consistent with the aim and import of that provision, since the notion that individual rights may, in some circumstances, be subordinated to substantial and compelling collective interests is itself a basic tenet of our legal system lying at or very near the core of our most deeply rooted juridical convictions. We need look no further than the *Charter* itself to be satisfied of this. Expressed in the language of s. 7, the notion of balancing individual rights against collective interests itself reflects what may rightfully be termed a “principle of fundamental justice” which, if respected, can serve as the basis for justifying the state’s infringement of an otherwise sacrosanct constitutional right.

(...)

⁴ Reported at [1997] 3 S.C.R. 844.

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78. From the foregoing discussion, it is clear that deciding whether the infringement of a s. 7 right is fundamental just may, in certain cases, require that the right at issue be weighed against the interests pursued by the state in causing that infringement. This balancing process will necessarily be contextual, insofar as the particular right asserted, the extent of its infringement, and the state interests implicated in each particular case will depend largely on the facts. As discussed earlier, the right infringed in this case is that of the respondent to choose where to establish and maintain her home, a right which I found enures to her as an aspect of that narrow sphere of personal autonomy protected by the liberty guarantee. For its part, the appellant pointed to three “public interests” that in its view, justified the imposition of the residence requirement. I propose to deal with each of them in turn.”

[146] I retain from the foregoing that “substantial and compelling” collective interests, in the words of the Supreme Court, are a fundamental tenet of our legal system which could warrant the infringement of a fundamental right.

[147] But I have difficulty imagining how the requirement imposed on residents to work 24 hours in a row would tie in with the pursuit of a substantial and compelling collective interest, thus warranting an infringement of the right to security of residents and patients of the establishment where the former are compelled to perform 24-hour call duty.

[148] Aside from learning, duration of residents' training and budget impacts, factors I will be dealing with below with respect to section 1 of the Canadian Charter, there is no evidence of substantial and compelling collective interests warranting balancing them against the rights of residents and patients.

[149] This being stated, a rule of law, according to section 1 of the Canadian Charter (reproduced above), may nevertheless restrict a fundamental right within reasonable limits whose justification may be demonstrated. But it is up to the party claiming the restriction of a fundamental right to demonstrate that such restriction is reasonable and warranted. In Godbout,⁵ the Supreme Court reiterated the burden falling to the party wishing to justify the limitation on a fundamental right. Paragraph 104 reads as follows:

“104. First, neither issue was explicitly addressed by the parties and, consequently, the Court has not had the benefit of counsel’s submissions on the questions they raise. Putting that matter aside, however, and operating on the assumption that s. 9.1 properly applies here, I am of the opinion that it would not, in any event, avail the appellant in this case. As this Court unanimously held in *Ford v. Quebec (Attorney General)*, [1988] 2 S.C.R. 712, s. 9.1 of the Quebec *Charter* is to be interpreted and applied in the same manner as s. 1 of the Canadian *Charter*. Thus, as the Court explained in *Ford*, the party seeking to justify a limitation on a plaintiff’s Quebec *Charter* rights under s. 9.1 must bear the burden of proving both that such a limitation is imposed in furtherance of a legitimate and substantial objective and that the limitation is proportional to the end sought, inasmuch as (a) it is rationally connected to that end, and (b) the right is impaired as little as possible; see *Oakes*, supra; and *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713.”

(Emphasis added)

⁵ Supra, footnote 4.

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[150] And Oakes,⁶ which is mentioned at the end of the preceding quotation, is very specific as to the requirements for setting aside or restricting a fundamental right. Paragraphs 69 to 71 are eloquent in that regard, and read as follows:

“69. To establish that a limit is reasonable and demonstrably justified in a free and democratic society, two central criteria must be satisfied. First, the objective, which the measures responsible for a limit on a *Charter* right or freedom are designed to serve, must be “of sufficient importance to warrant overriding a constitutionally protected right or freedom”: *R. v. Big M Drug Mart Ltd.*, supra, at p. 352. The standard must be high in order to ensure that objectives which are trivial or discordant with the principles integral to a free and democratic society do not gain s. 1 protection. It is necessary, at a minimum, that an objective relate to concerns which are pressing and substantial in a free and democratic society before it can be characterized as sufficiently important.

70. Second, once a sufficiently significant objective is recognized, then the party invoking s. 1 must show that the means chosen are reasonable and demonstrably justified. This involves “a form of proportionality test”: *R. v. Big M Drug Mart Ltd.*, supra, at p. 352. Although the nature of the proportionality test will vary depending on the circumstances, in each case courts will be required to balance the interests of society with those of individuals and groups. There are, in my view, three important components of a proportionality test. First, the measures adopted must be carefully designed to achieve the objective in question. They must not be arbitrary, unfair or based on irrational considerations. In short, they must be rationally connected to the objective. Second, the means, even if rationally connected to the objective in this first sense, should impair “as little as possible” the right or freedom in question: *R. v. Big M Drug Mart Ltd.*, supra, at p. 352. Third, there must be a proportionality between the effects of the measures which are responsible for limiting the *Charter* right or freedom, and the objective which has been identified as of “sufficient importance”.

71. With respect to the third component, it is clear that the general effect of any measure impugned under s. 1 will be the infringement of a right or freedom guaranteed by the *Charter*; this is the reason why resort to s. 1 is necessary. The inquiry into effects must, however, go further. A wide range of rights and freedoms are guaranteed by the *Charter*, and an almost infinite number of factual situations may arise in respect of these. Some limits on rights and freedoms protected by the *Charter* will be more serious than others in terms of the nature of the right or freedom violated, the extent of the violation, and the degree to which the measures which impose the limit trench upon the integral principles of a free and democratic society. Even if an objective is of sufficient importance, and the first two elements of the proportionality test are satisfied, it is still possible that, because of the severity of the deleterious effects of a measure on individuals or groups, the measure will not be justified by the purposes it is intended to serve. The more severe the deleterious effects of a measure, the more important the objective must be if the measure is to be reasonable and demonstrably justified in a free and democratic society.”

(Emphasis added)

[151] In the case at hand, the only justifications demonstrated by the evidence submitted at the hearing are first of all that extended call duty favours learning, in certain surgical specialties in particular; second, that call duty of shorter duration could also extend the length of training; and third, the budgetary impact was mentioned. Finally, the fact was raised that it had always been this way in the past without leading to any complaints or particular problems.

⁶ *R. v. Oakes* [1986] 1 S.C.R. 103.

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[152] This latter argument is not at all convincing. On that basis, there would be little possibility of any change. Slavery would still exist, women would not yet have the vote, and so on. Of the other three arguments, the evidence did not demonstrate that it was the 24-hour duration of call duty, in surgery for instance, that is profitable. It is the experience acquired at night that is profitable. It would no doubt be possible to set out a schedule with shorter call duty (16 hours, for instance), some of which would take place at night. As to the fact that the resident has to get used to performing long hours because when he has become a staff physician and is working in the regions he will sometimes be required to operate for 24 hours, I emphasize that the evidence is far from having convinced me that the human organism gets used to working 24 hours in a row. It can happen that a surgeon working in the regions has to work for 24 hours, or even longer. But no evidence establishes that having experienced it while he was a resident makes him more capable of doing so. As to the extended duration of residents' training, it is for the moment nothing more than pure speculation, particularly since model call schedules in the context of pilot projects are demonstrating that residents are not working more than 16 hours in a row while accumulating, to within 1–2 hours per month, as much time at the hospital as when they are subject to 24-hour call duty.

[153] Finally, with respect to the budgetary impact, the evidence was given scant elaboration, limited to emphasizing, with supporting statistics, that in the United Kingdom health-related costs rose considerably during the period when call duty schedules were modified and new medical faculties established.

[154] This evidence is far from conclusive to my mind. The increase in health costs in the United Kingdom may be due to multiple variables, and simple statistical evidence that costs increased over a 10-year period in the United Kingdom, without further explanation, is not sufficient to establish that the change in Quebec residents' call duty schedules would lead here, also, for instance to the creation of new medical schools or a significant increase in health-related costs.

[155] To conclude that the potential budget impact would be so great as to warrant a deprivation of fundamental rights, evidence would be required of the type provided by Newfoundland when it postponed a pay equity-related increase granted to that province's civil servants.⁷ That was far from the case in the matter at issue here.

[156] At best for the Employer, it could be admitted that the limit imposed on the right to security is imposed in the pursuit of a legitimate, significant goal (excellence in training), but the evidence does not establish that schedules as they are currently structured are rationally and proportionally linked to that goal. Despite certain residents' views to the contrary, the evidence did not convince me, indeed, that working a maximum of 16 hours in a row would be less effective than working 24 straight hours. Finally, I am not of the view that current schedules constitute a minimal deprivation of the right to security. When health and indeed life itself are at issue, it is hard to talk of minimal deprivation.

[157] For all these reasons, it is my view that clause 12.14 *in fine* constitutes a violation of section 7 of the Canadian Charter. The limitation on residents' and patients' security is not warranted within the meaning of section 1 of the Charter.

⁷ Newfoundland (Treasury Board) v. N.A.P.E., [2004] 3 S.C.R. 381.

UNOFFICIAL TRANSLATION -- FOR INFORMATION PURPOSES ONLYD. Quebec Charter of Human Rights and Freedoms

[158] The Quebec Charter sets out fundamental rights, equality rights, political rights, judicial rights, and social and economic rights. The current debate involves a fundamental right provided for in section 1 and an economic and social right provided for in section 46. These two provisions read as follows:

“1. Every human being has a right to life, and to personal security, inviolability and freedom. He also possesses juridical personality.

46. Every person who works has a right, in accordance with the law, to fair and reasonable conditions of employment which have proper regard for his health, safety and physical well-being.”

[159] Section 52 of the Quebec Charter also means that the impact of a fundamental right is not the same as that of an economic and social right. The courts have to declare void any provision which violates sections 1 to 38, barring a notwithstanding clause. Economic and social rights do not have the same scope. Indeed, section 52 reads as follows:

“52. No provision of any Act, even subsequent to the Charter, may derogate from sections 1 to 38, except so far as provided by those sections, unless such Act expressly states that it applies despite the Charter.”

[160] For these reasons, I consider it appropriate to treat medical residents' allegations separately with respect to the right to inviolability and the right to fair and reasonable conditions of employment.

- the right to inviolability

[161] Section 1 of the Quebec Charter concerns, among other things, the right to personal inviolability. The Canadian Charter, as we have just seen, deals with the right to security. These two notions are not identical, but they are very closely related. Furthermore, the jurisprudence tells us that the term “inviolability” has an even broader scope than the term “security.” This was asserted by the Supreme Court of Canada in a recent judgment,⁸ paragraphs 41 and 43 of which read as follows:

“41. The *Quebec Charter* also protects the right to personal inviolability. This is a very broad right. The meaning of “inviolability” is broader than the meaning of the word “security” used in s. 7 of the *Canadian Charter*. In civil liability cases, it has long been recognized in Quebec that personal inviolability includes both physical inviolability and mental or psychological inviolability. This was stated clearly in *Quebec (Public Curator) v. Syndicat national des employés de l'hôpital St-Ferdinand*, [1996] 3 S.C.R. 211, at para. 95:

Section 1 of the *Charter* guarantees the right to personal “inviolability”. The majority of the Court of Appeal was of the opinion, contrary to the trial judge’s interpretation, that the protection afforded by

⁸ *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791.

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s. 1 of the *Charter* extends beyond physical inviolability. I agree. The statutory amendment enacted in 1982 (see *An Act to amend the Charter of Human Rights and Freedoms*, S.Q. 1982, c. 61, in force at the time this cause of action arose) which, *inter alia*, deleted the adjective “*physique*”, in the French version, which had previously qualified the expression “*intégrité*” (inviolability), clearly indicates that s. 1 refers inclusively to physical, psychological, moral and social inviolability.

(...)

43. Canadian jurisprudence shows support for interpreting the right to security of the person generously in relation to delays. In *R. v. Morgentaler*, [1988] 1 S.C.R. 30, at p. 59, Dickson C.J. found, based on the consequences of delays, that the procedure then provided for in s. 251 of the *Criminal Code*, R.S.C. 1970, c. C-34, jeopardized the right to security of the person. Beetz J., at pp. 105-6, with Estey J. concurring, was of the opinion that the delay created an additional risk to health and constituted a violation of the right to security of the person. Likewise, in *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, at p. 589, Sopinka J. found that the suffering imposed by the state impinged on the right to security of the person. See also *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46, and *Blencoe v. British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307, 2000 SCC 44, with respect to mental suffering. If the evidence establishes that the right to security of the person has been infringed, it supports, a fortiori, the finding that the right to the inviolability of the person has been infringed.”

(Emphasis added)

[162] I have retained from the evidence the fact that the requirement to work 24 hours in a row is harmful to residents' health. Some are affected not only physically but mentally. Sleep deprivation leads to increased risk of medical accidents and percutaneous injuries in residents and patients. For instance, when a resident (cf. Kim Anderson's testimony) realizes at 4 am that a patient should be receiving transvenous pacemaker, but also deems her own state of fatigue to make the intervention too risky and, because of that, deems it preferable to wait until the care team arrives four hours later, this is, to my mind, a serious violation of that patient's physical inviolability and the resident's psychological integrity.

[163] In sum, for the same reasons I presented in support of my conclusion to the effect that clause 12.14 of the collective agreement violated section 7 of the Canadian Charter, it is my view that it is also contrary to section 1 of the Quebec Charter. I add that, even if I had considered that owing to the particularities of the right to security or because of the notion of “principles of fundamental justice” there was no violation of section 7 of the Canadian Charter, I would nevertheless have concluded that there was a violation of the right to inviolability provided for in section 1 of the Quebec Charter. Because, it should be remembered, inviolability has a broader scope than security. And this violation, once again for the reasons I presented previously, is not warranted under section 9.1 of the Quebec Charter.

- the right to fair and reasonable conditions of employment

[164] An economic and social right, particularly as contemplated in section 46 of the Quebec Charter, does not have the same scope as fundamental rights.

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[165] The Supreme Court acknowledged this explicitly in a ruling on section 45 of the Quebec Charter, which sets out the right to financial assistance measures and social measures likely to provide a decent income.⁹ Chief Justice McLachlin, writing for the majority, stated the following in paragraphs 94 to 96:

“94. For these reasons, I am unable to accept the view that s. 45 invites courts to review the adequacy of Quebec’s social assistance regime. The *Social Aid Act* provides the kind of “measures provided for by law” that satisfy s. 45. I conclude that there was no breach of s. 45 of the Quebec Charter in this case.

95. Notwithstanding my conclusion that there is no breach of s. 45, I wish to make a brief comment on the issue of remedies. I agree with much that my colleague Bastarache J. says on the question of remedies. In particular, I agree that a breach of s. 45 cannot give rise to a declaration of invalidity, since such a remedy is available only under s. 52 of the Quebec Charter, which applies exclusively to s. 1 to s. 38. I further agree that s. 49 finds no application to a case such as this. However, I must respectfully disagree with Bastarache J. that it follows from the foregoing considerations that determining whether s. 45 has been breached is superfluous.

96. While it is true that courts lack the power to strike down laws that are inconsistent with the social and economic rights provided in Chapter IV of the *Quebec Charter*, it does not follow from this that courts are excused from considering claims based upon these rights. Individuals claiming their rights have been violated under the Charter are entitled to have those claims adjudicated, in appropriate cases. The *Quebec Charter* is a legal document, purporting to create social and economic rights. These may be symbolic, in that they cannot ground the invalidation of other laws or an action in damages. But there is a remedy for breaches of the social and economic rights set out in Chapter IV of the *Quebec Charter*: where these rights are violated, a court of competent jurisdiction can declare that this is so.”

(Emphasis added)

[166] These prerequisites being stated, it is then first a question of deciding whether working 24 hours in a row is an unfair or unreasonable condition of employment.

[167] In that regard, I feel it is useful first of all to cite section 59.0.1 of the Act respecting labour standards, through which the legislature itself provides an indication of a duration beyond which an employee would be justified in refusing to work. Implicitly, it can be inferred from this provision that a refusal to work is justified because the condition of employment becomes unfair or unreasonable. The section reads as follows:

“**59.0.1** An employee may refuse to work

(1) more than four hours after regular daily working hours or more than 14 working hours per 24 hour period, whichever period is the shortest or, for an employee whose daily working hours are flexible or non-continuous, more than 12 working hours per 24 hour period;

(2) subject to section 53, more than 50 working hours per week or, for an employee working in an isolated area or carrying out work in the James Bay territory, more than 60 working hours per week.

⁹ Gosselin v. Quebec (Attorney General), [2002] 4 S.C.R. 429.

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This section does not apply where there is a danger to the life, health or safety of employees or the population, where there is a risk of destruction or serious deterioration of movable or immovable property or in any other case of superior force, or if the refusal is inconsistent with the employee's professional code of ethics.”

(Emphasis added)

[168] Secondly, and regardless of the Act respecting labour standards, it is clear to me that a condition of employment exposing a doctor to greater risk of physical or mental injury for himself, higher risk of errors, incorrect diagnoses, and even causing injury to individuals when his mission is to take care of them is an unfair, unreasonable condition of employment. And, on the basis of my appraisal of the evidence, that is precisely the case when a resident works 24 hours in a row while on call in an establishment.

[169] For these reasons, I consider that this is a violation of section 46 of the Quebec Charter.

E. Conclusions

[170] The order which follows obviously takes the preceding considerations into account. But it also takes into consideration the fact that call duty schedules cannot be changed overnight. I took note of the testimony of Dr Fréchette, who mentioned the major impact of a change in call duty schedules on certain disciplines where care has to be taken to endanger neither patients' health nor medical residents' training.

[171] Owing to these factors, I am granting the Employer a certain period of time to undertake to build call duty schedules in an establishment of a maximum duration of 16 hours. In some specialties, the change could be carried out easily. In others, on the other hand, accommodations will no doubt have to be found, and experiments will have to be implemented that will require a certain amount of time. That being said, the fact remains that the evidence reveals that these experiments have already begun and the Ministry itself wishes to undertake a significant transition with respect to the duration of call duty in an establishment.

[172] We are also in the presence of a restriction on fundamental rights. And the latent period before call duty schedules are brought into compliance with these fundamental rights must not be dragged out excessively. It is my view that a maximum period of six months following the date of this award is sufficient for modifying call duty schedules in an establishment, in respect for patients' and medical residents' rights, by adapting these schedules to the needs of each specialty.

FOR THESE REASONS, THE ARBITRATOR:

[173] **UPHOLDS** the grievance;

[174] **OBSERVES** that clause 12.14 violates section 7 of the Canadian Charter of Rights and Freedoms and section 1 of the Charter of Human Rights and Freedoms in that it requires residents performing call duty in an establishment to work 24 hours in a row and, on those grounds, declares it inoperative;

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[175] **DECLARES** that clause 12.14 violates section 46 of the Charter of Human Rights and Freedoms;

[176] **ORDERS** the Employer to amend call duty schedules in establishments so that the work period is reduced to a maximum of 16 hours per day;

[177] **GRANTS** the Employer a maximum period of six months from the date of this award to bring call duty schedules in establishments into line with this ruling.

Jean-Pierre Lussier, arbitrator

For the Employer: Jacques Laurin

For the Association: Jacques Castonguay

Hearing dates: April 26, 2010, April 28, 2010, April 29, 2010, April 30, 2010, July 7, 2010, July 8, 2010, July 9, 2010, August 16, 2010, August 17, 2010, August 18, 2010, August 19, 2010, November 9, 2010, December 2, 2010, December 6, 2010, April 6, 2011

Date of award: June 7, 2011