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PRIVACY RIGHTS IN THE WORKPLACE: PART I — MANAGEMENT POLICIES AND PRIVACY RIGHTS

Chapter 2 — Influenza Control Policies
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Initiatives aimed at preventing and controlling the spread of infectious diseases have become a familiar part of government agendas. “Flu” campaigns have assumed increasing prominence among such initiatives. Influenza, an acute respiratory viral infection, is a serious illness with the potential for secondary infections, complications and death. Because the various strains of influenza continually evolve and mutate, immunization does not confer life-long immunity and annual vaccination is recommended. Each year, World Health Organization (WHO) members attempt to forecast what will be the prevailing strains for the upcoming year; and a vaccine cocktail of several strains is developed based on WHO predictions.

Governments are not alone in seeking to contain influenza, which is transmitted through droplets or via surfaces which have been contaminated by an infected person. Because influenza can spread rapidly, particularly in enclosed environments, more and more health care employers have adopted influenza control policies to protect their vulnerable patient/client populations.

The following arbitration case deals with one health employer’s influenza control policy and the union’s challenge to that policy. While there are other Canadian arbitration cases upholding an employer’s right to demand vaccination or exclusion from work during influenza outbreaks, there do not appear to be any other cases assessing a policy similar to the one at issue here — namely, a unilateral vaccination/masking policy. [1]

Re Health Employers Assn. of British Columbia and HSA BC (Influenza Control Program Policy) (HEABC)

Background to the Grievance

In *Re Health Employers Assn. of British Columbia and HSA BC (Influenza Control Program Policy)* (2013), 237 L.A.C. (4th) 1, 2013 CarswellBC 3189, 116 C.L.A.S. 234 (Diebolt) (*HEABC*), the employer, the Health Employers Association of British Columbia, represented six health authorities in the province and a number of affiliates. The employer provided health care in both acute care settings as well as long-term care facilities. The union, the Health Sciences Association, commenced the arbitration on behalf of a number of constituent units. The HSA was the largest unit. The union included a wide variety of job families in various bargaining units.

The employer partially implemented a version of its influenza control policy in December 2012, minus the enforcement component. The employer advised that it intended to fully implement the policy for the 2013-2014 influenza season. In July 2013, the policy underwent some amendments. Under the version before the arbitrator, apart from influenza outbreaks individuals were required either to be annually vaccinated against influenza or to wear a mask during influenza season.

The **employer** called a number of witnesses to testify about a series of voluntary campaigns which had pre-dated the **policy**. Those campaigns did not succeed in increasing rates of voluntary immunization among **health** care workers. Following the 2009 H1N1 pandemic, a **mandatory** immunization **policy** was under consideration. Representatives of government and chief executive officers of the **health** authorities formed a leadership council. After touring a number of United States facilities, the council decided to endorse a combination **vaccination**/mask **policy**. Thereafter the **employer** adopted the **policy** across the **health** authorities.

The union did not challenge the outbreaks component of the **policy**, and it strongly supported voluntary immunization. However, the union did challenge the **vaccinate**/mask requirement during influenza season, on the grounds that it was coercive, amounted to an unwarranted invasion of workers' privacy rights, was unnecessary, and ineffectual.

Three medical experts testified on behalf of the union and two medical experts testified on behalf of the **employer**. The union's experts included two occupational **health** and public **health** physicians. The other expert had a medical degree but was engaged primarily in research synthesis, *i.e.*, conducting meta-analyses of the work of other researchers. One of the **employer**'s experts was a specialist in infectious diseases and also an epidemiologist. The **employer**'s other expert was an epidemiologist and a public **health** physician. Both of the **employer**'s experts had particular experience and knowledge in the epidemiology and control of influenza.

There was a range of opinions among the experts on a variety of issues. However, all but one of the union's experts agreed that influenza **vaccination** did reduce the risk of **health** care workers becoming infected. They disagreed on the question of transmission, that is, whether **health** care worker immunization reduced the transmission of influenza to patients. Both of the **employer**'s experts strongly supported the proposition that immunization reduced the risk of transmission.

The Parties' Positions

The union characterized the **policy** as "**mandatory**, coercive, stigmatizing and shaming", emphasizing that **health** care workers desired autonomy and dignity of choice with regard to personal **health** care decisions (para. 153).

The union asserted that the **policy** violated several provisions of the collective agreement: Article 6.01, entitled "Medical Examination and Immunization", Article 4, the management rights clause, and Article 39.01, pursuant to which the parties subscribed to the principles of the **British Columbia** *Human Rights Code*[2] (the *Code*). Article 6 stated that an employee "may be required" to "take a medical examination" or "immunization" at the request of the **employer** unless the employee's physician advised that the procedure may have an adverse **health** effect.

The union argued that the **policy** was subject to a "reasonably necessary" test, a standard higher than the standard applied in *KVP*,[3] and the union asserted that this **policy** was not shown to be reasonably necessary. In the alternative, the union maintained that the **policy** did not meet *KVP* standards (para. 150).

The union also submitted that the **policy** was discriminatory and thereby contravened s. 13 of the *Human Rights Code*. Moreover, the union argued that the **policy** infringed employees' privacy rights, contrary to the *Freedom of Information and Protection of Privacy Act*[4] (*FIPPA*). Finally, the union argued that the **policy** violated ss. 2(b) and 7 of the *Canadian Charter of Rights and Freedoms* and was not saved under s. 1.

The **employer**'s first position was that it was entitled to implement the **policy** by virtue of Article 6. According to the **employer**, Article 6 represented a negotiated balance of the parties' interests: the **employer**'s interest in patient safety and employees' interest in privacy and bodily integrity. The **employer** submitted that, while Article 6 would have authorized **mandatory** immunization, instead the **employer** reasonably opted for a **policy** mandating either immunization or masking (para. 158).

The **employer** argued that, because the rule had been negotiated, *KVP* did not apply. However, in the alternative, the **policy** satisfied that standard because it was reasonable.

Finally, the **employer** contended that the **policy** did not contravene the *Human Rights Code* or *FIPPA*. The **employer** asserted that the *Charter* did not apply in the circumstances; but if it did, the **policy** did not contravene ss. 2(b) or 7. In the alternative, the **policy** was justified under s. 1 of the *Charter*.

Decision of the Arbitrator

With respect to whether the **policy** violated provisions of the collective agreement, Arbitrator Diebolt found that the **policy** could not be characterized as the exercise of a negotiated right under Article 6. That provision stated that an employee may be required by the **employer** to take **vaccination**. However, the **policy** did not mandate **vaccination**. Instead, it gave the employee a choice between **vaccination** and masking. The provision was silent regarding masking, and there was no indication that the parties contemplated masking when they negotiated the provision (para. 168).

Rather, in his view the **policy** was a unilateral rule. As such, it stood to be justified according to the principles in *KVP*. Further, since privacy rights were at stake, the **policy** had to meet the privacy tests articulated in *Irving Pulp & Paper Ltd. v. CEP, Local 30* ((2013), 231 L.A.C. (4th) 209359 D.L.R. (4th) 394, [2013] 2 S.C.R. 458, 52 Admin. L.R. (5th) 1, 77 C.H.R.R. D/304, 2013 C.L.L.C. 220-037, 285 C.R.R. (2d) 150, 1048 A.P.R. 1, 404 N.B.R. (2d) 1, 445 N.R. 1, 228 A.C.W.S. (3d) 5, 2013 CarswellNB 275, 2013 CarswellNB 276, [2013] A.C.S. No. 34, [2013] S.C.J. No. 34, D.T.E. 2013T-418, 2013 SCC 34 (S.C.C.), para. 169), the latest governing authority on unilateral rules which affect privacy interests. The arbitrator rejected the union's submission that a higher test than *KVP* applied, *i.e.*, "reasonably necessary". The cases cited by the union dealt with a demand for medical information and were distinguishable on that basis. In addition, the **mandatory** aspect in this case was not forced immunization, but rather immunization or masking.

The *KVP* test for the imposition of unilateral rules or **policies** comprised a number of requirements. In this case the focus was on the first two requirements: that the rule must not be inconsistent with the collective agreement, and that it must not be unreasonable.

The **policy** was not inconsistent with Article 6 because that provision did not address **mandatory** masking. There was no provision in the collective agreement specifically dealing with an influenza **policy**. Therefore the only potential source of conflict was with Article 39 in which the parties subscribed to the *Human Rights Code* (para. 183).

As to whether the immunization aspect of the **policy** was unreasonable, in assessing the medical evidence, and for a number of reasons, the arbitrator found the evidence of the **employer**'s experts more persuasive than the evidence of the union's experts, particularly on the issue of transmission. Arbitrator Diebolt noted that influenza is a serious disease with the potential for complications and death, particularly among vulnerable persons such as the elderly, the immune compromised, and those with underlying conditions. While there was a range of opinions among the union's experts, the weight of the expert evidence demonstrated that immunization (1) was efficacious — on average, the **vaccine** reduced the risk of infection by 60% — and (2) reduced the risk of transmission from **health** care workers to patients (paras. 186 and 198).

With respect to the reasonableness of the masking component of the **policy**, the arbitrator was satisfied that the purpose and effect of the **policy** was not simply to increase rates of immunization among **health** care workers. The **policy** also had a patient safety purpose and effect, as well as an accommodative purpose for **health** care workers who conscientiously objected to immunization (para. 207).

The evidence satisfied the arbitrator that wearing a surgical mask acted as a barrier to transmission and thus provided some patient protection (para. 208). In addition, in assessing the reasonableness of the **policy** it was relevant that **mandatory** immunization programs were not uncommon and the **vaccination** or masking format was not unique: many American **health** care facilities had such **policies**; a similar program was in effect in New Brunswick; and the Canadian Nurses **Association** endorsed **mandatory** immunization if voluntary **vaccination** proved unsuccessful (paras. 214-216).

Finally, the "precautionary principle", namely the principle that "it can be prudent to do a thing even though there may be scientific uncertainty" had some application in this situation and some bearing on the reasonableness of masking. The arbitrator quoted one of the **employer**'s experts on the precautionary principle:

> First the Krever commission into the tainted blood issue noted that decisions were delayed because of a lack of definitive evidence of risk from randomized controlled trials. Krever stated that reliance on high level evidence before action can be taken may be effective in guiding clinical decision making but is inappropriate for protecting public **health** safety. Justice Campbell's report on the SARS outbreak in Canada (Spring of Fear, Vol. 3:115707) echoed similar concerns when he stated: "reasonable efforts to reduce risk need not wait for scientific certainty". [5]

The union had called a number of employees, including a speech therapist and a music therapist, to testify that masking would inhibit their ability to perform their duties. However, the **employer** had committed to reviewing individual situations and making accommodations where necessary. One of the union's experts testified about potential harm to **health** care workers, such as damage to morale, stress and burnout; but this evidence fell short of establishing a significant risk of harm sufficient to render the **policy** unreasonable (paras. 223-224).

Thus the arbitrator concluded that both the immunization and the masking components of the **policy** were reasonable.

Irving required the arbitrator to balance the parties' respective interests: the **employer**'s interest in the **policy** as a patient safety measure against the harm to **health** care workers' privacy interests. One of the privacy rights at stake was employees' medical information respecting **vaccination** status. The **policy** required employees to advise their **health** authority annually of their immunization status. The arbitrator accepted that the **policy** also affected the privacy of unvaccinated employees, in that masking could have the effect of "publishing" their immunization status (para. 225). However, in his view the medical privacy right in this case was not as significant or intrusive as the right considered in *Irving*, in which the majority had cited with approval prior Supreme Court of Canada cases that characterized drug and alcohol testing as "highly intrusive" because it involves the "seizure of bodily samples" (para. 226).

On the other side of the balance, the **employer** had a real and serious interest in patient safety, and the **policy** was a "helpful program to reduce patient risk" (para. 229). The **employer** had tried a number of voluntary programs over the years, without success. When the **employer** began to consider alternatives to voluntary programs, its representatives toured facilities in the United States and moved from a **mandatory** immunization model to a **vaccinate**/masking format. In other words the **employer** chose the least intrusive means of two measures that had the "capacity to achieve success" (para. 231).

In Arbitrator Diebolt's view, therefore, the **policy** satisfied the reasonableness test under *KVP* and likewise the privacy tests under *Irving*.

With respect to whether the **policy** violated the *Human Rights Code*, the union submitted that the **policy** violated s. 13(1) of the *Code* and was discriminatory because it made no provision for either workers with medical disabilities that did not permit them to be immunized or for workers who had conscientious objections to immunization (para. 238). However, the arbitrator observed that the **policy** did not require employees to immunize; rather, they had a choice to immunize or mask. With respect to masking, the fact that the **policy** did not, on its face, address accommodation was not a reason to impugn it because the duty to accommodate was a "freestanding duty imposed by law" which could be addressed in the context of an individual's request for accommodation (para. 239). Accordingly he concluded that the **policy** did not violate the *Human Rights Code*.

With respect to the *Freedom of Information and Protection of Privacy Act*, the union submitted that the requirement to report immunization and wear a mask if not immunized violated ss. 2 and 26 of *FIPPA*. Section 2, setting out the purpose of the statute, referred to preventing the "unauthorized collection, use or disclosure of personal information by public bodies". Section 26 stated:

> **26** A public body may collect personal information only if

. . . . .

> **(c)** the information relates directly to and is necessary for a program or activity of the public body . . .

The arbitrator observed that the obligation to wear a mask did not, strictly speaking, constitute collection or disclosure of personal information by the **employer**. However, he was prepared to assume, for the purpose of this legislation, that masking fell within the scope of ss. 2 and 26 to the extent that wearing a mask could signal to others that the person was not immunized and could thereby disclose the person's medical status (para. 242). Nevertheless, the collection and disclosure directly related to the **policy**; and managers had to know a person's immunization status to determine whether the employee could work without a mask. Therefore the information was necessary for the program within the meaning of s. 26 (para. 243). Accordingly the arbitrator concluded that the **policy** did not violate *FIPPA*.

With respect to the *Charter*, in the arbitrator's view, there was some question as to whether the *Charter* even applied to this **policy**. In light of prior Supreme Court of Canada decisions, the arbitrator could not conclude that the **health** care facilities were government (para. 251). The second basis for attracting *Charter* scrutiny would be if the implementation of the **policy** was a "governmental act" or program. However, each party had an arguable case on that ground. Although the facilities were not chosen by the government to be instruments for the delivery of medical services, governmental representatives did participate in the selection of the **policy**, a provincial appointee recommended it, and the government endorsed it (para. 255).

In any event, even if the *Charter* did apply, in the view of Arbitrator Diebolt the **policy** survived *Charter* scrutiny.

The union argued that the **policy** infringed s. 2(b), freedom of expression. The union characterized masking as a form of forced expression and a stigmatizing forced expression. The arbitrator accepted the characterization of forced speech as apposite in this situation, but he did not agree that masking was stigmatizing on the basis that it suggested the wearer was sick or infectious. There were many situations in which **health** care workers were required to mask. In addition, there was no reasonable factual foundation for the perception that masking was shaming and stigmatizing (para. 263).

Arbitrator Diebolt considered *Charter* jurisprudence dealing with s. 2(b) [6] and concluded that some forms of forced expression may be justified. In the arbitrator's view it was arguable that masking under the **policy** did not rise to the level of the values protected in s. 2(b). However, even if the **policy** did infringe s. 2(b) it was justified under s. 1. Applying the analysis in *Oakes* [7] the **policy** pursued an objective, patient safety, that was sufficiently important to justify limiting the expression at issue (para. 269). There was a rational connection between the **policy** and the objective of patient safety: the extensive evidence in this case and the conclusions regarding efficacy and beneficial effects satisfied that step of the test; and the number of U.S. facilities which had adopted a **vaccination**/masking **policy** supported the rational connection (para. 270). The **policy** impaired the s. 2(b) right as little as possible: having failed to achieve success with voluntary programs, the **employer** turned to a **vaccination**/masking program, a much less intrusive **policy** because it provided choice (para. 271). The **policy** met the proportionality test. In addition, "on the basis that masking constitutes forced speech respecting immunization status, the speech is limited and the message is not factually controversial" (para. 277).

Finally, the union argued that the **policy** violated rights protected in s. 7 of the *Charter*, namely liberty and security of the person. The arbitrator disagreed:

> . . . **health** care workers do not have to immunize; they have a choice to immunize or mask during influenza season. As to the mask, I am unable to characterize it as an invasive procedure. The Union also characterized a mask as stigmatizing. I am unable to agree. I have addressed this contention in my consideration of s. 2(b) of the *Charter*, and I adopt that analysis here. Finally, **mandatory** masking does restrict one's freedom of choice, but so do many workplace rules. The **mandatory** aspect is not, in my view, in itself sufficient to trigger a violation of s. 7. [para. 282]

Having found no violation of s. 7, there was no need for the arbitrator to undertake an analysis under s. 1 of the *Charter*.

Arbitrator Diebolt concluded that the influenza **policy** was a valid exercise of management rights, and he dismissed the grievance.

Discussion

While it may be tempting to regard this case as limited in application to **health** care settings, other **employers** could conceivably impose an influenza control program on their employees. In other work sectors such a program might be more difficult to justify as reasonable unless the **employer** serves a medically vulnerable population; difficult, but not impossible. Public schools already have **mandatory** immunization **policies** for students with respect to other communicable diseases such as measles, mumps, rubella, diphtheria, tetanus, etc. If influenza were to acquire a status and a priority similar to those diseases, school board authorities, or other **employers**, might add influenza protection to their safety **policies**. Presumably the **mandatory** aspect, or degree of coerciveness, would need to be calibrated according to the work setting and the degree of safety risk.

Although the economics of an influenza control program were not at issue in *(HEABC)*, influenza activity in the community has an obvious cost in terms of lost work time. Thus there is a productivity dimension to the debate surrounding the merits of employee influenza control programs.

Apart from whether this case is directly relevant to other workplace parties, *(HEABC)* is instructive as a very thorough and thoughtful analysis and application of *Irving* and of **mandatory** **employer** **policies** that impact employee privacy rights.

Key Conclusions

- Unilaterally imposed **employer** rules will be assessed in accordance with the principles of *KVP*. In particular, an arbitrator will determine whether the rule is reasonable and whether it is consistent with the collective agreement.

- Unilateral **employer** rules that affect employee privacy interests will also be assessed in accordance with the principles articulated in *Irving*.

- The weight of case law supports an **employer**'s right to impose **mandatory** immunization or exclusion during influenza outbreaks. *(HEABC)* illustrates that an **employer** may also be justified in imposing a **mandatory** influenza control program during the entire influenza season.

- A seasonal influenza control program that offers employees a choice between **vaccination** or masking is more likely to be seen as reasonable and as reasonably balancing the **employer**'s interest in safety with the employee's interest in guarding the privacy of their medical information.

Footnotes

1 Cases upholding **policies** mandating **vaccination** or exclusion include: *Interior **Health** Authority v. B.C.N.U.* (2006), 155 L.A.C. (4th) 252, 87 C.L.A.S. 216, 2006 CarswellBC 3377, [2006] B.C.C.A.A.A. No. 167 (Burke); *North Bay General Hospital v. O.N.A.* (2008), 180 L.A.C. (4th) 52, 2008 CarswellOnt 9040, [2008] O.L.A.A. No. 669, [2009] L.V.I. 3843-1 (Chauvin); *Chinook **Health** Region v. U.N.A., Local 120* (2002), 113 L.A.C. (4th) 289, 2002 CarswellAlta 1847, [2002] A.G.A.A. No. 88 (Jolliffe); *Carewest v. A.U.P.E.* (2001), 104 L.A.C. (4th) 240, 2001 CarswellAlta 1851, [2001] A.G.A.A. No. 76 (Bartee, Graham, Smith); *Trillium Ridge Retirement Home v. S.E.I.U., Local 183*, 1998 CarswellOnt 7647, [1998] O.L.A.A. No. 1046 (Emrich). In addition, at para. 179 of *(HEABC)*, Arbitrator Diebolt cites American authorities upholding **mandatory** **vaccination**/exclusion **policies**: *Virginia Mason Hospital v. Washington State Nurses **Assn***. (2007), 511 F.3d 908 (U.S. C.A. 9th Cir.), and Rebecca Rodal, Nola M. Ries and Kumanan Wilson, "Influenza **Vaccination** for **Health** Care Workers: Towards a Workable and Effective Standard" (2009), 17 **Health** L.J. 297.

2 R.S.B.C. 1996, c. 210.

3 *Lumber & Sawmill Workers' Union, Local 2537 v. KVP Co.* (1965), 16 L.A.C. 73, 1965 CarswellOnt 618, [1965] O.L.A.A. No. 2 (Wren, Robinson, Hicks).

4 R.S.B.C. 1996, c. 165.

5 Written submission of Dr. Bonnie Henry, quoted at para. 217 of *(HEABC)*.

6 Notably *Slaight Communications Inc. v. Davidson* (1989), 59 D.L.R. (4th) 416, [1989] 1 S.C.R. 1038, 26 C.C.E.L. 85, 89 C.L.L.C. 14, 031, 40 C.R.R. 100, (*sub nom. Davidson v. Slaight Communications Inc.*) 93 N.R. 183, 1989 CarswellNat 193, 1989 CarswellNat 695, EYB 1989-67228, [1989] S.C.J. No. 1038, [1989] S.C.J. No. 45 (S.C.C.); *RJR-Macdonald Inc. c. Canada (Procureur général)* (1995), (*sub nom. RJR-MacDonald Inc. v. Canada (Attorney General)*) 100 C.C.C. (3d) 449, 127 D.L.R. (4th) 1, 62 C.P.R. (3d) 417, [1995] 3 S.C.R. 199, 31 C.R.R. (2d) 189, 187 N.R. 1, 28 W.C.B. (2d) 216, 1995 CarswellQue 119, 1995 CarswellQue 119F, EYB 1995-67815, [1995] S.C.J. No. 68 (S.C.C.); and *J.T.I. MacDonald Corp. c. Canada (Procureure générale)* (2007), 281 D.L.R. (4th) 589, [2007] 2 S.C.R. 610, (*sub nom. Canada (Attorney General) v. JTI-MacDonald Corp.*) 158 C.R.R. (2d) 127, 364 N.R. 89, 2007 CarswellQue 5573, 2007 CarswellQue 5574, [2007] S.C.J. No. 30, 2007 SCC 30 (S.C.C.).

7 *R. v. Oakes* (1986), 24 C.C.C. (3d) 321, 26 D.L.R. (4th) 200, [1986] 1 S.C.R. 103, 50 C.R. (3d) 1, 19 C.R.R. 308, 53 O.R. (2d) 719 (note), 14 O.A.C. 335, 65 N.R. 87, 1986 CarswellOnt 95, 1986 CarswellOnt 1001, EYB 1986-67556, [1986] S.C.J. No. 7 (S.C.C.).

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