02 350 071

IN THE MATTER OF AN ARBITRATION

B E T W E E N:

CHINOOK HEALTH REGION

Employer

-and-

UNITED NURSES OF ALBERTA, Local 120

Union

RE: Flu Immunization Policy

AWARD

BEFORE THE BOARD OF ARBITRATION:	Tom Jolliffe, Chairperson Donna Byrne (Union Nominee) Mark Kent (Employer Nominee)
FOR THE EMPLOYER:	William Armstrong, Q.C.
FOR THE UNION:	Patrick Nugent
DATES OF HEARING:	October 30, 31, 2002

DATE AWARD ISSUED:
November 25, 2002

In this matter the Union alleges a breach of the collective agreement, including the unilateral introduction of new terms and conditions of employment, arising out of the Employer's introduction of an influenza immunization policy. The Union views it as effectively requiring yearly immunization for its bargaining unit nurses in order for them to continue working during an outbreak, and thereby purporting to impose financial losses related to suspension without pay for those who are not immunized. The Union points out that the Employer at no time sought to renegotiate the collective agreement in order to address the issue. In seeking a remedy to include an order to require immediate rescission of the policy, the Union referenced specific provisions in the collective agreement. The parties addressed the following language during their submissions:

4.01 The Union acknowledges that it shall be the exclusive right of the Employer to operate and manage the business in all respects, unless otherwise provided by this Collective Agreement. Without limiting the generality of the foregoing, the Employer reserves all rights not specifically restricted or limited by the provisions of this Collective Agreement including the right to:

(a) maintain order, discipline and efficiency;

(b) make or alter, from time to time, rules and regulations, to be observed by Employees, which are not in conflict with any provision of this Collective Agreement;

(c) direct the working force and to create new classifications and work units and to determine the number of Employees, if any, needed from time to time in any work unit(s) or classification(s), and to determine whether or not a position will be continued or declared redundant;

(d) hire, promote, transfer, layoff, recall and to demote, discipline, suspend or discharge for just cause.

19.01 (a) Sick leave is provided by the Employer for all illness, quarantine by a Medical Office of Health or because of an accident for which compensation is not payable under the Workers' Compensation Act.

34.03 Where an Employee requires specific immunization and titre, as a result of or related to the Employee's work, it shall be provided at no cost.

The policy in question, dated January 2001, and applicable to the Employer's ten long term care facilities, is entitled **Influenza Immunization For Employees Working With Continuing Care Clients**. The policy states that "all health care workers who provide care for continuing care residents are expected to be vaccinated annually with influenza vaccine", to be made available at no cost to employees. Accordingly, in the event of an influenza outbreak having been declared by the medical officer of health (MOH) covering an area of a site/facility/unit, the policy provides that all the workers in this restricted area will have received a flu vaccination at least fourteen days prior to the outbreak or have been treated with the appropriate anti-viral prophylaxis such as amantadine in order to continue working in the restricted area during the outbreak. These vaccinated employees, or those taking amantadine, may continue to work as long as they are symptom free. Non-vaccinated employees are presented with choices regarding their work schedules. They may commence a two week preventative therapy protocol with the amantadine prophylaxis and after seventy-two hours will be allowed to return to work, or make arrangements to take the vaccination which would require them being unable to return for ten days. Otherwise, those unimmunized staff will be placed on leave of absence without pay during the influenza outbreak, although being able to utilize vacation credits or banked time to offset the financial impact. The policy also recognizes the significance of influenza having an incubation period in that unimmunized staff must wait three days from the last day they worked in the restricted area prior to working in a non-restricted area. The employees who provide acceptable medical proof in the nature of anaphylactic egg allergies or amantadine allergies, who are unable to either be vaccinated or take any antiviral therapy, will be paid for all missed scheduled shifts. Those providing satisfactory documentation showing religious grounds for failure to take the vaccine or amantadine will also be allowed to remain off work. The policy describes the "Outcome" being:

> **To ensure the clients, staff, medical staff, students, volunteers, contractors or visitors are protected from possible exposure and cross-contamination during an influenza outbreak.**

The policy makes reference to the Regional Executive Council meeting minutes of January 2001, the National Advisory Committee on Immunization (NACI)

statement on influenza vaccination, the Compendium of Pharmaceuticals and Specialties provided by the Canadian Pharmacists Association and also the Carewest influenza immunization policy of August 1999 on which this workplace policy was modeled.

At outset of hearing, counsel presented a brief of documentary materials for us to consider and also an agreed statement of facts which reads as follows:

1. **The Chinook Health Region and the United Nurses of Alberta have agreed to proceed with the arbitration of grievance #010047 as a test case to resolve all similar grievances in the Chinook Health Region. The other grievances are 010042, 010043, 010044, 010045, 010046, 010048, 010049, 010050 and 010051.**

2. **At all materials times, there was a collective agreement in force between the Chinook Health Region and various facility locals of the United Nurses of Alberta with a term of April 1, 1999 to March 31, 2001. (Exhibit 1) A virtually identical collective agreement with community locals was also in force.**

3. **Grievance 010047 was filed January 24, 2001. (Exhibit 2)**

4. **The policy in question is entitled "Influenza Immunization for Employees Working with Continuing Care Clients". (Exhibit 3)**

5. **The policy is to be enacted when an influenza outbreak has been declared by the Medical Office of Health. Only 1 outbreak has been declared by the Medical Office of Health since the policy was created. The order was issued March 10, 2002 and applied to only a portion of the Raymond facility. Some staff were reassigned. Seven took Amantadine. No staff lost any work time. Therefore, no employees have been required to remain absent from work because of not being immunized.**

6. **The National Advisory Committee on Immunization of Health Canada issues a statement on influenza immunization for each influenza season. Exhibit 4 is the 2001-2002 season. These documents detail potential adverse reactions to the vaccine.**

7. **In 1999, a coroner's jury in Ontario made recommendations related to the outbreak of influenza in a nursing home. (Exhibit 6)**

8. **In December 1999 and January 2000, there was a Type A**

influenza and parainfluenza outbreak in the Southland Nursing Home (now St. Michael's Health Care Centre). 605 of the residents became ill and 12 died (9.75%). This was the last declared outbreak in a continuing care facility in the Chinook Health Region, prior to the insurance of the policy.

9. **In September, 2000, the Medical Officer of Health announced immunization for the 2000-2001 flu season. (Exhibit 7)**

10. **On November 21, 2000, the Medical Officer of Health advised all directors of long term care facilities in the Chinook Health Region of his intentions to exercise certain provisions under the *Public Health Act* in the event of an outbreak. (Exhibit 8) The Medical Officer of Health reported to the Board of Directors on December 7, 2000. (Exhibit 9)**

11. **In July, 2000, Alberta Health & Wellness issued a paper entitled "Improving Influenza Vaccination Rates in Health-Care Workers: Mandatory - Choice or Education?". (Exhibit 10)**

12. **Influenza immunization rates for staff in continuing care varies from 37% to 88%. (Exhibit 11)**

13. **The parties are free to call additional evidence.**

The Union presented no evidence in addition to the agreed facts and the relevant documentary materials which included the collective agreement; grievance form; policy document; NACI statement on influenza vaccination for the 2001-2002 season and supplementary statement; Coroner's Inquest Recommendations related to an outbreak of influenza in a nursing home (Kitchener, Ontario); memorandum from MOH respecting availability of influenza vaccine for 2000/01 season; memorandum from Employer to directors of its long-term care facilities dated November 21, 2000 indicating variable acceptance of the vaccination program as amongst its facilities and requiring an exclusionary program of unimmunized staff not on any viral therapies to be put in place; follow-up report to Board of Directors issued December 7, 2000 raising issue of unimmunized staff being excluded during influenza outbreaks in long-term care facilities and referencing the high mortality and morbidity associated with influenza in collective living arrangements for frail persons; paper prepared by Rachel Foster, R.N., M.N. for Disease Control and Prevention Branch of Alberta Health and Wellness on need to improve influenza vaccination rates in health care workers; Chinook Health Region

influenza statistics compiled on February 8, 2002 setting out regional immunization rate and immunization rate for staff in rural long-term care facilities; Local Board of the Chinook Health Region MOH Order to care facility following declared outbreak.

In opening remarks, Mr. Nugent, on behalf of the Union submitted that the issue was not about the parties' concern for the health of frail elderly residents, or the efficacy of the vaccine they might receive, or whether the vaccine when provided to bargaining unit members constituted an effective tool to suppress influenza outbreaks; rather, it was about the permissible means of giving effect to these concerns given the collective agreement language, the common law cases, and statute authority. The Union contends that the policy as said by the Employer to have been implemented in 2001 is not within the scope of its authority, all things considered, and it is redundant in any event given the overriding authority vested in the MOH. In addition, any removal of bargaining unit employees from the workplace in circumstances that must be considered a "quarantine", requires the Employer to pay sick leave under article 19.01(a).

Mr. Armstrong, on behalf of the Employer, described the policy, and its choices to avoid exclusion from the area of an influenza outbreak, as a legitimate exercise of management rights in protecting the long-term care residents for those reasons to be placed in evidence. The policy, he said, did not raise any issue of "real" quarantine, albeit the choices provided could result in staff members being restricted from working to avoid spreading the influenza.

The Employer called Dr. Paul Hassleback to testify, the MOH for Chinook Health Region who was qualified as an expert in community medicine; Dr. Joel Weaver, a family physician who by reason of his practice and area of expertise was qualified as an expert in the care of the elderly; and Ms. Janet Byrne, the Employer's manager of human resources who was involved in the development and implementation of the grieved policy. Their evidence, insofar as it is considered relevant in our determination of the issue at hand, is recapitulated below. Much of it, we observe, cannot be considered materially in dispute.

According to Dr. Hassleback, the modern flu vaccine, killed viral product grown in egg cultures, encompasses three current influenza strains each year and is prepared in such quantities in Canada to cover eight to ten million doses. He said there are approximately thirty thousand vaccinations in the area of southwestern Alberta covered by the Chinook Health Region, including what he estimates to be approximately 55% of its 3,300 staff. He explained that occasionally there are medical contra-indications to being vaccinated, for example an egg allergy which could cause an anaphylatic reaction to the vaccine, a history of Guillain-Barré syndrome being a type of

neuritis condition, (three cases observed in the region over the last ten years) or ocular respiratory syndrome (two cases this year) in the nature of eye irritation, cough, or difficulty breathing. A sore arm or a feeling of malaise for up to 48 hours is more common although it is also accepted, he said, that most people have little or no reaction, no observed side effects, to a flu shot. Vaccinations have been available for at least twenty-five years to combat the yearly influenza outbreaks. Dr. Hasselback is a strong proponent.

In the circumstances of this grievance, Dr. Hassleback's concern is with the fragile population resident in the continuing care facilities, an environment which he has observed communicable illnesses to spread quickly. He is aware that the actively promoted vaccination program underway in the Employer's long-term care facilities has resulted in some 94% of residents being vaccinated for influenza this year. However, despite their cooperation there is a continuing "efficacy" issue brought about by the age and frailty of the residents. In his experience, only approximately 30-50% of them will ultimately be protected from getting ill, albeit he is confident that at least 80% will be protected against dying from the influenza. He is also satisfied that the various medical studies with which he is familiar have reached a definite conclusion that in order to reduce mortality and morbidity amongst the elderly residents of long term care facilities it is "extremely important" to increase the vaccination rate amongst staff so that in their day-to-day care of the residents they do not transmit the illness from person to person. He referred to unimmunized care givers in such a situation as "vectors", meaning that they are capable of infecting any number of residents with whom they come into contact whether by conveying the influenza from one who was ill to another who is not, or conveying their own influenza. By Dr. Hassleback's professional assessment, in an institution, it would be possible for perhaps half the infected caregivers to show no outward signs of infection by being "subclinical" or yet in an early stage by being "incubational" yet still able to transmit the strain of influenza from patient to patient. In his experience, the significance of vectoring within an institution, which can occur before an outbreak has yet been declared, is fully known and cannot be doubted. High levels of staff vaccinations have been observed to minimize the transmission issue and dramatically reduce the numbers of residents who eventually fall ill. He is confident in his expert opinion that the higher the staff immunization rate the lower the transmission rate within a long-term care facility.

Dr. Hassleback is aware that staff are not the only persons in contact with the frail and elderly residents of a continuing care facility. He has recommended that any outside person over whom the facility does not have control, such as family and friends,

should receive their yearly flu vaccination. However, he said, at least these individuals are not going from person to person performing close contact caregiver duties. Further, the facility during a known outbreak can easily curtail residents' contact with outside persons who, in any event, are realistically there to see only their own family members.

Dr. Hassleback commented briefly on the outbreak at Southland Nursing Home in Chinook Health Region prior to the issuance of the policy, occurring in December 1999 and January 2000. Initially, it was identified as a "influenza like illness" and eventually confirmed as including type A influenza. It led to 63% of the residents becoming ill, and twelve deaths, during the three weeks the outbreak took to run its course before being brought fully under control. During this past year, in March, April and May 2002 there were three outbreaks within long term care facilities, two of which were operated by Chinook Health Region. Two were understood to have "good" staff immunization levels. The other, Crowsnest, is described in the Employer's influenza statistics of February 8, 2002 as having a 46% staff immunization level.

It is not disputed that the MOH has broad powers under the *Public Health Act*, as Dr. Hassleback explained, which allows him to take whatever steps he considers necessary to suppress an outbreak of influenza once he becomes involved. Typically, at the time of an outbreak being declared in a long term care facility he issues an Order under Section 39 of the *Act* excluding all unimmunized staff members from the area of the facility where the outbreak has occurred until 48 hours after starting antiviral therapy such as amantadine, or for the duration of the outbreak, or for two weeks after receiving influenza vaccine, or for a minimum of 72 hours after developing influenza symptoms. He said that it is usual for an outbreak to be declared over within four to seven days after the last case has occurred. In distinguishing between "quarantine" and "isolation", both being statutory powers within his authority, he said, he sees the first option as a subset of the latter. He said that MOHs can use quarantine as the more dramatic intervention, which he sees as essentially calling for an individual(s) to be confined to a location, or activities restricted in order to avoid contact with any others so as to avoid the possibility of communicating a disease to which that person has been exposed or potentially even in an incubation stage. He agreed that his Order was an effective response in containing the spring 2000 outbreaks better than in some instances in the past. In his career as a MOH with over twelve years experience he has seen some thirty to fifty outbreaks and considers that the *Act* provides him with authority to do whatever he considers appropriate in the given circumstances to curtail an outbreak, normally excluding unimmunized staff from the area of the outbreak. The Order placed in evidence refers only to "the 12 bed - West Pod of the continuing care facility".

Dr. Hassleback was also clear in his testimony that he considered influenza immunization to be a significant preventative measure to avoid transmission of the disease within a long term care setting. Generally his office is notified only after two or three residents have already come down with symptoms, which is to say the outbreak is already under way. He has, over the years, provided his support in attempts to increase immunization rates in facilities and amongst staff. He is well aware of the National Advisory Committee on Immunization (NACI) recent statement on influenza epidemiology and its control contained in Canada Communicable Disease Report at vol. 27, August 1, 2001. It has concluded: "vaccination of persons at high risk each year before the influenza season is currently the most effective measure for reducing the impact of influenza", with emphasis also on immunizing people capable of transmitting the disease to others at high risk for influenza-related complications. The report specifically centres on health care workers, including employees of long term care facilities who have patient contact, while observing that some people respond inadequately to vaccination and are at high risk for infection due to low antibody response eg. the elderly. The report decries low staff immunization low rates as both a failure of the health care system to offer the vaccine and the refusal of persons to take it, having noted that studies of health care workers (HCWs) in hospitals and long term care facilities have shown vaccination rates of only 26-61%, while pointing out that the efficacy of vaccinations in preventing influenza may only be in the range of 30-40% in the elderly. The report states at pp. 14-16:

> **HCWs and their employers have a duty to actively promote, implement and comply with influenza immunization recommendations in order to decrease the risk of infection and complications in the vulnerable populations they care for.**
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> **In order to protect vulnerable patients in an outbreak situation, it is reasonable to exclude from direct patient care HCWs who develop confirmed or presumed influenza, and unvaccinated HCWs who are not on antiviral prophylaxis. Health care institutions should have policies in place to deal with this issue.**
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> **Transmission of influenza between clinically or subclinically infected HCWs and their vulnerable patients results in significant morbidity and mortality. In the absence of contra-indications, refusal of HCWs to be immunized implies failure in their duty of care to their patients. Studies have demonstrated that HCWs who are ill with influenza**

frequently continue to work. In a British study, 59% of HCWs with serologic evidence of recent influenza infection could not recall having influenza, suggesting that many HCWs experience subclinical infection. These individuals continued to work, potentially transmitting infection to their patients. In addition, absenteeism of HCWs who are sick with influenza results in excess economic costs and in some cases, potentially endangerment of health care delivery due to scarcity of replacement workers.

Vaccination of HCWs in health care facilities has been shown to reduce total patient mortality, influenza-like illness, and serologically confirmed influenza. Influenza vaccination programs for HCWs may also result in cost savings and reduced work absenteeism, depending on factors including disincentives to take sick days, strain virulence and the match between infecting strain and vaccine.

The Chinook Health Region's information compiled February 8, 2002 indicates that its education program meant to convince staff to voluntarily immunize has been only partially successful. The statistics for last year's staff immunization levels read as follows:

Rural Long Term Care Facilities:

Cardston (Auxiliary):	**37%**
Cardston (Grandview):	**43%**
Crowsnest Pass:	**46%**
Fort Macleod:	**52%**
Magrath:	**62%**
Milk River:	**47%**
Picture Butte:	**77%**
Pincher Creek:	**55%**
Raymond:	**80%**
Taber:	**88%**

Dr. Joel Weaver, in his testimony, addressed the increased mortality and morbidity rates in the seniors' population brought about by having an age related decreased immune response as well as influenza infection tending to increase other existing cardio/respiratory symptoms. He described the fragile persons in long term care facilities as being particularly at risk to infection, sharing the same food source, living in an enclosed environment and often having respiratory problems. His concern includes

the possibility of unimmunized caregivers acting as vectors in moving from resident to resident and dealing as they do with an elderly population which may be less than 50% protected by the vaccine, even though the vaccination rates for residents are generally in the 80-90% range. He made reference to the Rachel Foster report, *Improving Influenza Vaccination Rates in Health Care Workers: Mandatory-Choice or Education?*, including the reported research in Alberta indicating a health care worker immunization rate ranging between 22-96%. In linking low staff coverages to the possibility of influenza outbreaks in long term care centres she stated at page 5 of her July 2000 report:

> **A recent personal communication with Alberta Health and Wellness regarding the 1999-2000 influenza season highlights the dilemma. Sixty-eight long-term care facilities reported a total of 72 outbreaks. In 18 outbreaks, staff coverage rates were less than 50% and in only 2 outbreaks was the coverage between 91-100%. More significantly, in 31 outbreaks staff coverage rates were not known. Conversely, resident coverage rates were reported as being 91-100% in 31 outbreaks and less than 50% in only one outbreak. Once again, in 25 outbreaks the resident coverage rate was not known. Clearly, this information suggests that the monitoring of staff and resident coverage rates across the province is inconsistent. However, the fact that 31 outbreaks occurred in facilities where resident coverage was extremely high, lends support to the work of Potter et al. (1997) who note that staff coverage rates rather than resident coverage influence influenza outcomes.**

Dr. Weaver stated he accepts that the vaccination rates for staff in long-term care facilities have more to do with outbreaks occurring than the vaccination of the elderly within the unit. He has observed that the one to three day incubation period is a significant factor in that during this time staff will move from resident to resident performing their normal caregiver duties. Also, in as many as 20% of the cases they will remain subclinical throughout although capable of infecting others. He said that he does not view outside persons visiting their family members as high risk groups, given the limited time they are in the facility and the fact of them not moving from person to person. Further, he said, it is simply not enough to focus on treatment of residents once infected and symptomatic inasmuch as there is no good treatment for the fragile elderly. He said that "the best treatment is prevention". He was able to observe at the time of the 1999 Southland Nursing Home outbreak, which resulted in twelve deaths, a high number of the symptomatic elderly patients also had complicating respiratory problems which might be expected in the age group. He acknowledged that at the same time there was an

outbreak of para-influenza which he sees as having a different and less serious epidemiology, with much less chance for morbidity in the elderly when compared to the influenza A which would have brought on the more serious outcomes.

The human resources manager, Janet Byrne, was involved in establishing the policy initially developed in 2000 for implementation in 2001. She said that the rationale behind the policy was the continuing low immunization rate amongst staff members, considered unacceptable in light of the Employer's overall responsibility for the safety of its resident population which it considered as being put at risk. Prior to the policy implementation the Employer had an education program in place which included an influenza campaign each year, videos, posters and even contests. The immunization rates amongst staff remained lower than expected, reaching only approximately 45% for staff across the region (stated in the Chinook Health Region Influenza Statistics to be 47% in 2002). She said at some point the Employer determined that it should implement a policy as a matter of protecting the safety of residents. The initial drafts were shared with managers and staff with input received and reviewed over approximately a one year period. Ms. Byrne remarked that the managers taking part in the review considered it should not be so restrictive to be mandatory in the sense of not offering any options, or "choices" to unimmunized caregivers. Hence it included preventative therapies to be made available after an outbreak in order to allow them to return to an area where the infection had occurred after 72 hours. Further, if it came down to choosing not to be immunized, and not taking the anti-viral amantadine prophylaxis, the person was still able to access their own vacation credits and any banked time. She said that certainly there was an emphasis on persuading employees to become immunized both as a safety precaution in terms of preventing infection and also in order for them to be available during an outbreak to attend to residents, some of whom would be suffering symptoms at that point. At the same time the Employer was willing to recognize religious beliefs and medical contra-indications as requiring placement elsewhere. She said she is unable to say whether the immunization issue was raised as a bargaining issue during the last round of negotiations or whether it will be raised in future. It is not disputed that there are collective agreements in at least two other provinces where unpaid leave has been negotiated as an alternative to nurses receiving flu vaccinations; see the current Hospital Central Agreement with Ontario Nurses Association.

In argument on behalf of the Union, Mr. Nugent characterized the Employer's policy document as presenting a "mandatory choice" for bargaining unit members which, in effect, amounts to no choice at all in that ultimately it could be used to deny unimmunized, but otherwise healthy and able employees, their scheduled hours.

The Union's concern with the policy, he said, can be seen to address the importance at law of bodily integrity and privacy and also can be viewed as contravening article 19.01(a) which requires sick leave to be provided those for "quarantined by a medical officer of health...". As Mr. Nugent pointed out, the *Public Health Act* which deals with protecting the public health from the existence of a communicable disease in sec. 39-46 as "Isolation, Quarantine and Special measures", for its purposes, defines "quarantine" in section 1(v) as meaning:

(v) "quarantine" means

(i) in respect of persons or animals, the limitation of freedom of movement and contact with other persons or animals, and

(ii) in respect of premises, the prohibition against or the limitation on entering or leaving the premises,

during the incubation period of the communicable disease in respect of which the quarantine is imposed;

However, it can also be noted that sec. 43 of the *Act* deals with the effect of a person being quarantined or isolated as prescribed in the regulations under the *Act*, namely under subsection (1) that the person be "isolated or quarantined in a hospital or other place approved for the purpose by a medical officer of health" and under subsection (2) that no such person "be permitted to remain in any public place, other than a hospital or other place approved for the purpose by a medical officer of health". Sec. 44(1) requires that "the medical officer of health shall ensure that the person under quarantine is provided with all supplies and services necessary for his health and subsistence". We infer that these provisions can be taken as providing some context to the "limitation of freedom of movement and contact" contemplated as constituting a quarantine under sec. 1(v).

In his submitted caselaw, Mr. Nugent reviewed the Ontario Court of Appeal judgment in Re Fleming v. Reid (Litigation Guardian), (1991) 82 D.L.R. (4^{th}) 298, for its restatement of the deeply rooted common law principle that, with very limited exceptions, a person's body is considered inviolate and also the right to determine what or will not be done to it. The case dealt with medical treatment of mentally incompetent persons, on the issue of provincial legislation allowing a substitute consent-giver to refuse treatment on behalf of a mental incompetent patient. He tabled Glace Bay Community Hospital v. Nova Scotia Nurses' Union, [1992] N.S.J. No. 308, where, on review the Court considered that in the civil context, and without the *Charter* being

applicable as it was considered a private matter between private individuals, it should uphold the arbitration board majority decision that it could not direct the aggrieved employee to produce a sample of her blood for DNA testing. The labour relations legislation allowing the board to determine its own procedure was viewed by the Court as not including such an order which would have constituted a substantial interference with the liberty of the person. He pointed out that in R. v. Stillman, [1997] 1 S.C.R. 607, in dealing with the issue of body searches in the criminal context, the Court observed at para. 42 that it had "often been clearly and forcefully expressed that State interference with a person's bodily integrity is a breach of a person's privacy and an affront to human dignity" requiring appropriate limits on the power of search incidental to arrest. Mr. Nugent pointed out that right of privacy issues in the workplace have frequently been discussed in the context of employers' security policies, citing Canada Post and CUPW (Fingerprinting grievance), (1988) 34 L.A.C. (3rd) 392 (Bird); Canada Post and CUPW (Plant Security), (1990) 10 L.A.C. (4th) 361 (Swan), where the limits of reasonable interference with the person were recognized and commented on. He also cited Shell Canada Products Ltd. and CAIMAW, Local 12, (1990) 14 L.A.C. (4th) 75 for arbitrator Larson's discussion of the significance of protecting an employee's confidential medical information; also the learned arbitrator's decision in Re St. Mary's Hospital and HEU, (1997) 64 L.A.C. (4th) 382, where a finding that surveillance cases were analogous to cases involving search of personal effects caused one to reference the law of trespass and assault. The conclusion that there is no inherent right at common law allowing one to subject an employee to a search or physical examination without consent is also discussed in the well known Re Monarch Fine Foods Co. Ltd. and Milk and Bread Drivers Dairy Employees, Caterers and Allied Employees, Local 647, (1978) 20 L.A.C. (2nd) 419 (M.G. Picher).

Mr. Nugent submitted that the Union also recognizes that many arbitrators have seen the need for a balancing of interests to exist as between an employer's right to manage and the employee's right to individual privacy, often reviewed with respect to workplace surveillance, or drug and alcohol testing situations. He pointed out that arbitrator Picher in two railway decisions C.N.R. and C.A.W., (2000) 95 L.A.C. (4th) 341 and C.N.R. and U.T.U., (1989) 6 L.A.C. (4th) 381 had viewed such workplace testing as "a singular and limited exception to the right of freedom from physical intrusion to which employees are generally entitled by law--- (to be) used judiciously, and only with demonstrable justification, based on reasonable and probable grounds". He went on to observe that there has been widespread acceptance of reasonable cause drug and alcohol testing by Canadian arbitrators. However, Mr. Nugent said, this balancing of interests

approach is surely exceeded by what amounts to a mandatory vaccination policy where refusal constitutes no real choice as it leads to removal from the workplace without pay. It should be considered an unjustified, without consent, invasion of person, and a process which would have to be bargained as with those hospital industry collective agreements in two other provinces.

Mr. Nugent relies on arbitrator Charney's recent award in Re St. Peter's Health Systems and C.U.P.E., Local 778, (2002) 106 L.A.C. (4th)170, dealing with the employer's staff vaccination policy within a chronic care geriatric facility, being a public hospital dealing with old and frail patients. The policy in that case required in the event of a flu outbreak of two or more patients, every staff member (not just care-givers) will either have had a flu shot or, be treated with amantadine, or be suspended from work without pay until the outbreak subsided. There was said to be neither statutory nor collective agreement authority for the rule. In that case, arbitrator Charney comprehensively reviewed the same line of cases as submitted by Mr. Nugent, in addition to numerous others dealing with employers seeking to introduce mandatory searches, or testing, or disclosure of confidential health information, often said to impact the person's civil right of privacy requiring a balancing of interests. However, he viewed the flu vaccination policy as going even further, a matter of forcing medical treatment on people who had not given their consent. I note the following concluding discussion at pages 190-192:

> **In all of these cases cited by the employer, arbitrators balanced the rights as to whether the rule was reasonable or not reasonable. These cases are not comparable to mandatory medical treatment. Here, of course, we are faced with a different proposition, namely that the allegation is not whether the rule is reasonable or unreasonable but whether one can commit what the Supreme Court of Canada has said is an assault and force medical treatment on people that do not give consent.**
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> **The employer further argued in the Canada Post case, that in the Shell case, supra, and in this case here, the individuals are not being disciplined, they are merely being ordered home so that they do not work and infect perhaps other co-workers and/or patients.**
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> **In this case the employees have done nothing wrong and they are not ill with the flu, yet they are being prevented from working unless [page 191] they undergo medical treatment. There is a distinction between medical treatment and medical testing. Clearly if someone were contagious and they were sent home then the sick policy would apply**

and there would be no issue. The case here is unique in that perfectly wll employees are not being permitted to work. In all of the cases cited by the Employer, none of the cases involved medical treatment, and even when they involve merely medical reports and medical examinations, they can be conducted by the patient's own doctor which is far less invasive then mandatory medical treatment.

A number of arbitrators have drawn the line at lie detector tests or fingerprinting and this goes well beyond any of that.

The Supreme Court of Canada in Stillman, supra, set out a hierarchy of interests. They draw lines and on these facts this is the most serious. Some of the arbitrators draw lines, some do not, some would allow a balancing act on certain things. Nevertheless, the issue here is a common law right against forced medical treatment which the Supreme Court of Canada and English Court of Appeal describe as an assault without sanction of law, merely by the Employer promulgating a rule (see W. v. W.; Fleming V. Reid (Ont. C.A.); and Stillman, supra).

The Board is of the view that prior to balancing, it must look at the common law rights issues and s. 7 Chapter rights as to whether it is permissible to enforce treatment in the circumstances of this case.

For the purposes of clarity, one should point out that:

1) there is no statutory or regulatory authority for this medical treatment;

2) the Hospital could have applied to the medical office of health to promulgate a regulation under the act governing these matters that would make treatment mandatory. They did not do so and there is no such regulation in place;

3) patients and visitors do not have to be vaccinated against the flu;

4) it was never raised or bargained during collective agreements;

5) the nurses' union, ONA, has in fact bargained such a clause for its members.

It is the view of this Board that in the circumstances cited above, suspending employees (non-disciplinary) for refusing to undergo

medical treatment is a violation of their common law s. 7 Chapter [page 192] rights. Virtually all the court cases, including Supreme Court of Canada and Ontario Court of Appeal, find that enforced medical treatment, and I point out that this is not a medical examination but treatment, is an assault if there is no consent.

Though the matter is not decided except on the basis of the paragraph above, the board finds it unusual that given the seriousness of what is being demanded of the employees, the employer did not seek statutory authority through the MOH, nor was it bargained for, though the employer must have known that it was bargained for with their nurses.

While making no *Charter* argument in the current situation, presumably accepting that strictly speaking its provisions are not applicable to this collective bargaining relationship, the Union submits that the approach taken by arbitrator Charney is correct. Absent any contractual or statutory authority it does not rest with an employer to require medical treatment of people who do not give their consent. Mr. Nugent pointed out that the MOH at the time of an outbreak can always issue an order under the *Public Health Act* directing anyone to be removed from the infected area, or stay away from work, as a preventative measure to ensure that the infection goes no further. Obviously, the MOH has very broad authority under the statutory framework governing this office. Such is indicated by the Order placed in evidence whereby he directed that all unimmunized staff members from the infected area of a facility be excluded for a period of time, which in itself should be seen to invoke the "quarantine" provision of the collective agreement. Hence, the policy was not a reasonable exercise of management rights, could not be justified in that as a matter of common law principle it was inherently unjustifiable, or at the very least conflicted with the quarantine provision of the collective agreement requiring sick pay.

In argument on behalf of the Employer, Mr. Armstrong disputed what he saw to rest at the centre of the Union's argument, namely that somehow there was no choice left to employees under the policy. The Employer preferred to view the matter as "choice with consequences", namely the possible loss of a few days pay for unimmunized nurses who had been working in an infected area. He also said that one was missing the point if it were thought that the MOH alone had the ability to control the spread of influenza within a long term care facility in that the nature of his authority was to deal with outbreaks since they occurred and was not fundamentally preventative. By the time of his involvement, an unimmunized infected staff member could have already started spreading the influenza virus throughout the facility. Obviously, any unimmunized

caregiver, going from patient to patient in performing her daily nursing duties, is capable of infecting the residents under her/his care before any outbreak declaration ever occurs. Further, there was nothing about MOH authority which assisted the Employer in ensuring that there was enough immunized staff remaining and available to treat the ill residents in the infected area of the facility. The obvious purpose of the policy, he said, which admittedly depends on the Employer's view of management rights to ultimately remove employees from an area of the facility where they can be seen to pose a danger to residents by reason of their being unimmunized, is to persuade employees to be vaccinated in advance of any outbreak occurring. The choice made available to employees is no more mandatory than exercising management rights to require an ill employee to provide adequate medical documentation in order to substantiate recovery sufficient to return to work. An employee in that situation might choose to protect his/her privacy at the risk of having to remain off work, a choice with consequences.

Dealing with St. Peter's Health Systems, Mr. Armstrong would have us note that it was argued on a preliminary basis, without there being any indication that the arbitrator there had the kind of information presented in the instant case where MOH Dr. Hassleback, and Dr. Weaver practicing geriatric medicine, together with the NACI and Rachel Foster reports, provided reasonable insight into the real safety issue for residents in long term care facilities caused by their unimmunized caregivers who are capable, of spreading influenza from patient to patient without being aware of their own infectious situation. Despite it being considered a factor by arbitrator Charney, we should not view it to be relevant for our purposes that patients and visitors are not required to be vaccinated against the flu. Visitors do not present the same kind of vectoring problem. Immunization amongst patients is almost universal despite the fact that its "efficacy" is considered to be only in the 30-50% range due to the age and fragility of the residents. Mr. Armstrong disputed other of the factors set out by arbitrator Charney at page 191 of his award, including the significance of there being no statutory or regulatory authority for the medical treatment. Employers, he said, can still create rules within their management rights authority, subject to arbitral review, without specific reference to statute or regulation. While the policy clearly also has never been negotiated, although the Employer as with any workplace rule acknowledges that it must satisfy the test set out in the seminal Re Lumbar and Sawmill Workers Union, Local 2537 and KVP Co. Ltd. , (1965) 16 L.A.C. 73 (Robinson). We should consider that the arbitrator misread the role of MOHs, at least in Alberta, there being no indication that individual employers have any clout with respect to changing the *Public Health Act*.

Perhaps not in Ontario either; there was placed in evidence the jury

recommendations from a Coroner's Inquest related to a deadly outbreak of influenza in a nursing home in Kitchener, Ontario. The list of twenty five recommendations, dated September 22, 1999, included as its first item that prior to July 1, 2000 provincial legislation should be in place requiring residents of long term care facilities and all staff of those facilities to be vaccinated against influenza annually, unless there was proof of a medical contra-indication. The list indicated that it was to be circulated to all community health departments in Ontario and in the other provinces, and an attachment dated November 25, 1999 indicates that it was at that point provided to the Chief Medical Officers of Health by the Director of the Public Health Branch in Ontario. It is observed that the jury recommendations and its urging for additional statutory involvement came over two years prior to arbitrator Charney's award issued on February 7, 2002 where he considered that the hospital should be applying to the MOH to promulgate a regulation under the *Act* requiring the treatment to be made mandatory in that province.

Further, Mr. Armstrong submitted, while the Employer accepts that there is no language in the collective agreement expressly addressing the policy, which apparently differs from the Ontario Nurses Association collective agreement remarked upon by arbitrator Charney, nevertheless the applicable collective agreement in article 34.03 contemplates the possibility of an employee needing immunization for work related purposes in stating "where an employee requires specific immunization and titre, as a result of or related to the employee's work, it shall be provided at no cost". In the broader scope, he said, one might well consider that there are any number of avoidable infectious conditions dangerous to a given type of patient, rubella in pregnant women for example, which could reasonably require unimmunized employees being restricted from the area of their care, and also realistically require employees to make a choice respecting immunization in order to continue their work schedule, once again, a matter of making a choice with possible consequences. The Employer does not view the employee's choice in such circumstances to be a matter of "quarantine" under article 19.01(a), but rather it is about them complying with an immunization policy so as to avoid spreading a disease throughout their assigned area before any outbreak has yet been declared. Further, the policy does not require them to be quarantined and should not be equated under article 19.01(a) with a "quarantine by a medical officer of health". The policy ultimately could require unimmunized nurses being removed from an infected area, and hence without any work schedule for the remainder of the outbreak where that choice becomes relevant. In doing so, the Employer should be able to apply its alternative policy measures.

The Employer tabled three cases where employer policies respecting influenza vaccinations have been upheld in Canada, the first being a decision by

adjudicator Cantin under Part III of the *Canada Labour Code* in Barkley v. Mohawk Counsel of Akwesasne, [2000] C.L.A.D. No. 553, the other two being decisions by arbitrators in Ontario and Alberta respectively, in Trillium Ridge Retirement Home and Service Employees Union, Local 183, unreported, December 11, 1998, Emrich; and Carewest v. Alberta Union of Provincial Employees (Nasr Grievance), [2001] A.G.A.A. No. 76 (P.A. Smith) dealing with the Carewest influenza immunization policy on which the instant policy was modeled.

In Barkley, a registered practical nurse (RPN), working as a non-unionized employee on a fixed term employment contract at an adult care facility handling frail and elderly patients, refused to comply with the facility's mandatory influenza immunization policy on the basis that she had never been sick with the flu, had faith in her own immune system and did not want to tamper with it in any way. The employer had previously issued a bulletin describing the immunizations as a condition of continued employment and requiring that anyone refusing would be dismissed, unless contra-indicated by certain medical conditions or allergic reactions. There was medical evidence adduced concerning the importance of ensuring that staff having frequent contact with the residents be immunized given the high risk of contracting influenza and the underlying chronic cardiac and pulmonary conditions of their residents. Adjudicator Cantin applied the KVP approach in considering that a unilaterally introduced rule must satisfy a number of prerequisites including that it cannot be unreasonable, must be brought to the attention of the employee affected, with notification of breach, and relying upon such cases as City of Calgary, (1990), 12 L.A.C. (4th) 57 (Beattie) that it must also establish a substantial connection with the employer's legitimate interest. The adjudicator succinctly stated his view in remarking at page 7 of the award:

> **There is no doubt in the present instance, on the basis of the evidence which was adduced, that the residents' health was involved and that the risks were serious. There was on the part of the Council a legitimate interest which was the residents' health and well-being. It affected the employment relationship itself. The Council was justified to rely on its Community Medical Officer of Health. Its resolution to impose vaccination was not unreasonable. The other requisites have been met.**
>
> **I am satisfied that the complainant did not quit her job but was terminated and terminated with cause. Such cause was not that she was incompetent or that her conduct was improper. She was and still is highly recommended. The only reason for her dismissal is that she did not comply with a resolution asking that she receives influenza**

vaccination.

In the Trillium Ridge case, arbitrator Emrich dealt with a policy imposed at a nursing home and retirement home in Kingston requiring staff to have been vaccinated for influenza, or in the event of an outbreak to be vaccinated and wait two weeks for acquisition of immunity, or to take the antiviral medication to be able to report for work within 48 hours, and if neither option was chosen staff could take time off work without pay until the influenza outbreak was declared over in the facility. Those with medical contra-indications were exempted. The employer's argument was based on it having the right and duty to safeguard the frail and elderly residents. The evidence before the arbitrator indicated that previously the facility had promoted flu awareness and the importance of vaccination, had made available brochures, put up posters and had held an annual staff flu shot clinic, following which thirty five staff members were contacted who had not yet been immunized, despite influenza A having been confirmed elsewhere in the community. Eventually, sixteen staff still remained unimmunized at which point the policy was implemented, which the employer saw as providing choices. Failing those choices being accepted, however, the employer was not willing to allow the remaining non-immunized staff to work during any influenza outbreak declared at the facility, which eventually occurred. In her award, arbitrator Emrich observed that management had taken a variety of reasonable steps to give advance notice to the aggrieved employees of the importance of early vaccination, including making available a vaccination clinic. Reasonable steps were taken to advise all staff of the options and the implications of non-immunization in the event of an outbreak occurring, without any real possibility for misunderstanding. She saw the issue as being whether the policy constituted an arbitrary, disciplinary and unreasonable exercise in management rights, or even an unlawful assault and battery at law as a matter of invasion of bodily integrity. It raised also the overall question of the extent of management's rights to safeguard frail residents from potential sources of influenza infection. She reviewed arbitration awards dealing with protection of privacy issues including arbitrator Larson's award in St. Mary's Hospital, and the recognition that management actions involving bodily intrusion were considered at the top of the list in protecting the right to privacy. She also reviewed the policy according to the tests set out in KVP, being the same approach taken in Re Air Canada and CALEA, (1982), 8 L.A.C. (3rd) 83 (Simmons) which involved an employee having to submit to a medical examination by an employer appointed physician or face being removed from the employer's payroll, an action found by arbitrator Simmons to have been unreasonable in all the circumstances of that case. Arbitrator Emrich in Trillium Ridge provided the

following reasoning on pp. 25-28 for determining the matter in the employer's favour:

> **In the case before me there is ample evidence to show that vaccination of staff and residents at a long-term care facility such as Trillium Ridge, which provides care to the frail elderly, is an effective means to prevent transmission of influenza A. The vaccination is also effective to reduce the severity of symptoms and the incidence of complications arising from infection with the virus. Although vaccination is not perfectly effective, this may have to do with the compromised immunity of the elderly patient population and the similarity between the vaccine virus strains and the circulating strain of virus during an outbreak. The preponderance of the evidence favours the beneficial effect of vaccination to prevent transmission of the infection and reduce the severity of infections and complications. Furthermore, the evidence substantiates that amantadine is an effective antiviral medication which can be taken instead of or in addition to vaccination to prevent transmission or reduce the severity of infection for those unable or unwilling to take the vaccination. I find that the Employer's policy was rationally connected to the legitimate objective of protecting the health and safety of residents and staff at the facility.**
>
> **Furthermore, the evidence substantiates that the period of contagion begins before the display of respiratory symptoms associated with influenza. Thus, a policy simply to require staff to stay home when they display such symptoms would not be as effective to reduce transmission of the virus. The serious consequences for the frail elderly population of infection include the likelihood of serious complications developing such as infection with opportunistic bacteria, pneumonia, and death. These serious consequences for the resident population warrant measures being taken that will be effective in preventing the transmission of infection. On the other hand, the law cherishes the right of the individual to freedom from intentional infliction of harmful or offensive physical contact. Respect for individual autonomy and the right to control one's body is at the heart of the law pertaining to consent to medical treatment. Deliberate infliction of harmful or offensive contact, without consent, is a battery at law and has been actionable since ancient times.**
>
> **On the whole of the evidence, I must conclude that the Employer's policy was not mandatory in requiring employees to accept vaccination or amantadine. Ultimately the employee was permitted to refuse either measure, but there was a cost to such refusal. Such an employee would not be allowed to attend at work and be paid during the period of an outbreak. Did the imposition of such a cost render the policy arbitrary**

and unreasonable? Did the imposition of this cost constitute a violation of the collective agreement? Did such a cost amount to a disciplinary penalty, or was the requirement to stay off work a constructive lay-off out of seniority order, or did this cost vitiate consent to the vaccine or amantadine administration? Ultimately I am persuaded that the answer to each of these questions is no.

Clearly the policy was designed to encourage and provide an incentive to staff to accept vaccination or amantadine. The purpose of such measures was to encourage the widest vaccination of staff and residents possible, while not imposing these measures in the absence of apparent consent. The refusal to permit non-immunised staff to work was not disciplinary in purpose or intent. It was a measure designed to isolate potential sources for transmission of viral infection. There was no disciplinary notation made in the grievors' records, and the evidence indicates no disciplinary intent. On the other hand, the basis of the bargain is that an Employer must pay employees in exchange for their attendance at work. A fundamental obligation of the employee is to attend work and provide productive service. In a long-term care setting such as this, employees must realise that special measures may be needed to safeguard the health and safety of the frail elderly population that they serve. If such employees choose not to be immunised or to refuse an alternative antiviral medication, why should the Employer pay such employees for the balance they strike between their right to bodily integrity and the requirement to be present and fit for work? Where the employee may be unable to accept either the vaccine or antiviral medication for medical or religious reasons, different considerations may prevail and a different balance struck between the competing interests of the parties. Such employees do not really have a choice whether to accept the immunisation measures available or may have rights under human rights legislation that could protect their right to refuse these measures. The evidence before me does not establish that any of the grievors fit into this category of employees.

Furthermore, I do not accept that the refusal to permit non-immunised employees to attend work and be paid constituted a constructive lay-off. The intent and purpose of this measure was not to effect a reduction in the payroll and manpower requirements of the Employer by a means not contemplated by the collective agreement. Indeed, during an influenza outbreak at the facility, the need for every helping hand to assist with the increased care demanded for infected residents would increase the manpower requirements of the Employer. The

policy implemented provides a disincentive for employees to refuse vaccination or amantadine, but I conclude that such a disincentive is warranted on the basis of health and safety requirements and the demands of efficiency to manage the potentially grave effects of an influenza outbreak among the elderly residents.

Subsequent to Trillium Ridge, arbitrator Smith issued her award in Carewest with reference therein both to arbitrator Emrich's reasoning and also the Barkley award by adjudicator Cantin. It is the Carewest influenza immunization policy, on which the workplace policy here was modeled and hence the facts of that case need not be discussed in any detail. Suffice to say that there was evidence with respect to the importance, effectiveness and safety of the influenza vaccine, and its limited effectiveness on elderly patients who were seen to be especially susceptible by reason of their frailty. In her majority award, after canvassing the parties' positions which are not dissimilar to those taken here, including the employer's principal argument that the policy met the tests in KVP all things considered and the union's contention that it constituted unwarranted interference with the person's physical integrity, also a violation of the *Charter* which was not argued here, she reasoned as follows:

Having carefully reviewed the evidence, we are satisfied that the Influenza Vaccination Policy, adopted by the Employer in August 1999, meets the criteria set out in the KVP case. It is a reasonable rule designed to meet the legitimate and crucial objectives of the Employer. There is no doubt that influenza is a serious health concern for the frail elderly institutionalised in facilities such as those operated by the Employer. The Employer's primary goal given the serious consequences of influenza must be in preventing and containing outbreaks. There is also no doubt that a major element of prevention and containment is to avoid exposing elderly patients to influenza, by requiring those who have the most immediate and regular contact with such persons to be vaccinated.

As the Employer pointed out its policy is far from the most draconian that could be imposed. Policies have been adopted by other institutions and upheld by arbitrators which exclude all persons from working at the facility at any time who remain unvaccinated. But the Employer has chosen a policy that balances legitimate privacy concerns of employees with crucial patient safety concerns of the Employer.

The Employer has not required anyone to take the shot or lose his or her job. The Employer has recognised legitimate medical and religious

exemptions. The Employer has not applied the policy to everyone in the facility, but only those persons involved in front line delivery of health care with daily, frequent and intimate contact with patients. The Employer has not excluded employees without pay for the entirety of the flu season if they are unvaccinated, but only during the periods where the risk of transmission from patient to patient is highest, namely, during outbreaks.

Finally, the Employer did attempt less intrusive ways to increase the vaccination rate education and incentives. The results were not acceptable given that less than 50% of employees at the George Boyack Centre voluntarily took the flu shot.

In the result we are satisfied that the rule is reasonable, and that the relatively modest intrusion into the bodily integrity of employees is justified in all of the circumstances. In that regard we have no difficulty distinguishing the Anthrax case cited to us by counsel for the Union. Firstly, it was key to the military court's finding a violation of charter rights that the defence demonstrated on the balance of probabilities that "the anthrax vaccine contained in lot 020 was unsafe and hazardous and could be responsible for the important symptoms reported by so many persons who received that vaccine'. No such evidence was presented in this case. Indeed the opposite is the case - the flu vaccine is remarkably safe. Secondly, it must be noted that the policy being challenged in the anthrax case was an absolute one - imposing a requirement to be vaccinated in order to serve. No such requirement exists in this case.

Therefore, even if the Charter applies to Carewest and it policies, which is doubtful, given that the Charter applies only to state action, we are satisfied that the adoption and application of the Employer's policy does not in these circumstances offend the Grievors' charter rights or alternatively, is justified as a reasonable limit on those rights under Section 1. With respect to the interests of the state and mind of the individual. This is very much the same type of analysis required in balancing the interests of employers and employees, and referred to in the Esso case. With the rule that has been passed by the Employer, we are of the view that the appropriate balance has been struck, for the reasons we earlier set out.

Given that the rule is reasonable, we must then consider whether it has been properly applied to the Grievors. We are satisfied that it has. The Employer took all reasonable steps to bring the rule to the

> **attention of all of the employees, including the Grievors. To the extent that either of the Grievors suggests that they did not understand the policy or its consequences, we reject their evidence. It makes no sense that the Employer would have specifically identified those who had not taken the vaccination, and specifically speak to them which did happen, and then not specifically outline the policy and its consequences. The Grievors were unvaccinated; an outbreak occurred; they were excluded without pay from the workplace. The policy was properly applied to them.**

Thereafter, in St. Peter's Health Systems, arbitrator Charney in dealing with Carewest noted that the facts of the case were very similar, and specifically disagreed with the case as follows:

> **With respect, this board disagrees with that decision (Carewest) both as to the conclusions reached and primarily due to the fact that there was no analysis of the cases cited above (there being numerous cases presented to arbitrator Charney dealing with personal privacy and bodily integrity issues) nor was there any argument to that effect. A mere statement that the Charter does not apply is not persuasive and that board simply balanced the issues and did not deal with the preliminary matter.**

Arbitrators in Canada for many years have continued to reassert the significance of applying a balancing of interests approach in reaching any conclusion as to whether a management promulgated rule is reasonable, all things considered, as a permissable intrusion of some kind or other on an employee's privacy right, or even to his physical person. The latter scenario, as arbitrator Emrich points out, is considered to be at the top of the list for protection purposes. Arbitrator Picher, in his C.N.R. and C.A.W. case after quoting from his previous analysis in C.N.R. and U.T.U. describing drug and alcohol testing as almost universally accepted amongst Canadian arbitrators in reasonable circumstances while also constituting "a singular and limited exception to the right of freedom from physical intrusion to which employees are generally entitled by law", nevertheless went on to acknowledge that essential to the balancing of interests approach when reviewing an employer promulgated rule was to consult the standards "best articulated in KVP". It includes considering the policy's connection to the employer's legitimate business interest and whether it is reasonable. He points out, as have many other arbitrators, that such a rule must not be inconsistent with any substantive provision of the collective agreement. It would appear, however, that arbitrator Charney in St. Peter's Health System, once having concluded that the situation

was one of medical treatment, realistically non-consensual, moved the discussion beyond a balancing of interests over what was reasonable or unreasonable and into the realm of common law rights, and *Charter* protection, against forced medical treatment and whether it could be permissible on the several factors disclosed in evidence which he found to be significant. Nevertheless, as we understand our role in dealing with a disputed policy, one drafted, discussed and well known amongst staff with no lack of clarity suggested or any lack of consistency alleged, it still requires the board to examine its reasonableness and whether it is consistent with the collective agreement, by KVP guidelines. Certainly, both arbitrator Emrich in Trillium Ridge and later arbitrator Smith in Carewest had considered it reasonable to apply KVP guidelines. >From their discussions reviewing the circumstances of the Employer's perceived need, in doing so, they can be seen to have set out to still carefully balance the competing interests. It is the same kind of approach traditionally taken by arbitrators in the drug an alcohol testing cases and was applied by arbitrator Picher in C.N.R. and C.A.W.

In agreeing with the approach taken in Trillium Ridge and Carewest where the information received by the arbitrators can be seen to be similar to the facts of this case, the board observes that as there, it is not a situation of the Employer having made the vaccinations mandatory, in the pure sense disclosed in Barkley, or even requiring all unimmunized staff simply to be excluded from the facility during the flu season as the "choice". Rather, it has sought to take a more balanced approach in providing alternatives, admittedly with consequences, keeping in mind its hugely legitimate concern for residents' safety. There is no evidence that the vaccine has ever proven to be ineffective in immunizing caregivers as opposed to frail elderly persons for whom it is far less effective having regard to the "efficacy"limitations. The policy was well discussed and realistically assumed to be understood by staff, there being no real issue in that regard. It can certainly be viewed as rationally, even crucially connected to its legitimate business interest and objectives in properly caring for and protecting the safety of residents. Obviously, as pointed out, the goal is to have employees comply with this stated expectation of annual vaccinations, albeit care is taken in providing alternatives for those unable/unwilling to comply.

The circumstances presented at hearing can also be distinguished as to some of the facts considered significant by arbitrator Charney. There was no evidence suggesting any effectiveness in possibly approaching the medical officer of health for changes to regulation or statute to make immunization mandatory. The MOH who testified, Dr. Hassleback considers the role of his office to be one of dealing with the outbreak once it has occurred. He considers his powers sufficient for his limited

purposes. One might also note the Coroner's Inquest jury recommendations made in Kitchener over two years prior to arbitrator Charney's award, distributed to medical officers of health throughout the province without any indication that flu shots have been made mandatory in long term care facilities as a regulatory exercise. The fact of patients and visitors not having to be vaccinated, in the context of the circumstances presented in our hearing, is not helpful to the Union. The problem with patients is not their level of vaccination, but rather the efficacy of immunization once vaccinated. Visitors do not present the same kind of problem as caregivers going from resident to resident for reasons described both by Dr. Hassleback and Dr. Weaver. It is true that there is no indication the issue was ever raised during collective bargaining which does not suggest that an employer cannot promulgate rules or policies reasonably, for legitimate business reasons, in accordance with KVP guidelines. The fact of some unions in the hospital sector, elsewhere in Canada, having bargained for immunization clauses admittedly might well be a better way to proceed. It allows both sides to have a maximum of input, to carefully and mutually outline the limits and parameters of the obligations undertaken, and will provide a better level of certainty for the program given the inherent risk in trying to justify unilateral policies and rules under KVP dealing with physical intrusion. The fact of the matter is the parties have not bargained the policy which leaves it up to this board to determine its legitimacy.

On the whole, a balancing of interest approach strongly favours the Employer in the circumstances presented in evidence for all those reasons discussed by the arbitrators in dealing with the immunization policies in Trillium Ridge and Carewest. The right to refuse continues. The immunization policy cannot be viewed as somehow imposing a new condition of employment. One must also have due regard to the requirement which has often been pointed out by arbitrators that a unilaterally promulgated rule cannot be inconsistent with any terms of the collective agreement. The board does not find that the policy under review in the instant case is inconsistent with art. 19.01(a). In our view, it passes muster on a KVP examination of all the circumstances.

More particularly, as matters may work out in some circumstances, where affected employees continue to refuse immunization resulting in their being removed from the work schedule at the time of an outbreak in their area, it is difficult to say that the Employer's action somehow constitutes a true quarantine in the sense addressed by the *Public Health Act* as an MOH directed possibility in some circumstances. One should keep in mind the effect of quarantine addressed by sec. 43 and sec. 44 as well as the definition section. It does present the possibility of being removed for a time from the work schedule as one's choices unfold, as could the MOH's exclusion order.

However, in the event that it does have that ring to it, then the Employer's policy which includes removing unimmunized employees from an infected area provides a pre-existing alternative to any exclusion order to be made by the MOH, whatever the extent of his own powers to ultimately quarantine. Further, it is apparent that the Employer finds some support in the collective agreement language, which in article 34.03 referring to employee required specific immunization being provided at no cost at least indirectly suggests there can be situations arising at work where immunization is reasonably necessary.

On the evidence presented, and having reviewed what we accept to be relevant caselaw and collective agreement provisions, we conclude that the Union has not established that the policy is unreasonable or inconsistent with the collective agreement or in some way violates the employee's rights to refuse medical treatment. We must respectfully dismiss the grievance and declare the policy to be operative as developed, communicated to employees and understood to be consistently applied.

The chairperson is authorized to issue this award as a majority decision with the Union nominee, Ms. Byrne, dissenting and the Employer nominee, Mr. Kent, concurring.

DATED this 25th day of November, 2002.

Tom Jolliffe, Chairperson