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Legal Context for AHS's Immunization of Workers for COVID-19 Policy

The purpose of this analysis is to assess whether UNA has a basis to grieve a policy that places unvaccinated (or incompletely vaccinated) employees on an unpaid leave of absence. This analysis will assess the policy against the KVP test, applicability of the Charter, and in context of privacy, human rights and occupational health and safety legislation.

There are a number of cases where employer policies respecting influenza vaccinations have been upheld in Canada: Barkley v Mohawk Counsel of Akwesasne, [2000] C.L.A.D. No. 553; Trillium Ridge Retirement Home and Service Employees Union, Local 183, unreported, December 11, 1998; Carewest v. Alberta Union of Provincial Employees (Nasr Grievance), [2001] A.G.A.A. No. 76 (PA Smith); Chinook Health Region and United Nurses of Alberta, Local 120, November 25, 2002 (Jolliffe); and Re: Health Employers Association of BC and HSA BC (Influenza Control Program Policy Grievance) [2013] 237 L.A.C. (4th). There have also been two cases dealing specifically with COVID-19 Immunization policies: Electrical Safety Authority and Power Workers' Union (hereinafter, ESA and PWU); and UFCW Local 333 and Paragon Protection Ltd. In addition, the Alberta Human Rights Commission issued a decision dealing with COVID-19: Pelletier v 1226309 Alberta Ltd. o/a Community Natural Foods, 2021 AHRC 192.

In Barkley, a registered practical nurse refused to comply with a 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.

Trillium Ridge dealt with a policy imposed at a nursing home and retirement home requiring staff to have been vaccinated for influenza or take antiviral medication. In the event of an outbreak, if neither option was chosen staff could take time off without pay until the influenza outbreak was declared over at the facility.

The Carewest decision dealt with an influenza immunization policy that excluded unvaccinated employees from the workplace, without pay, for the duration of an outbreak.

In the Chinook case, UNA grieved an employer policy put in place at several continuing care sites. This policy stated that if Employees were not vaccinated annually with the influenza vaccine, then they would be placed on a leave of absence without pay during an influenza outbreak. There was an option to take anti-viral therapy in this case. The purpose of the policy was, "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 Union argued

the policy presented a “mandatory choice” for employees that amounted to no choice at all because it could result in denying the employee the right to work scheduled hours.

The Health Employers case dealt with a policy that required either influenza immunization or masking. Essentially, during an outbreak, an unimmunized employee would be required to mask at all times.

We identified two cases where an arbitrator struck down an employer’s immunization policy: Re St. Peter’s Health Systems and C.U.P.E., Local 778, (2002) 106 L.A.C. (4th) 170; and Re St. Michael's Hospital and ONA 2018 Carswell Ont 14889, 137 C.L.A.S. 172, 295 L.A.C. (4th)

In St Peters, the arbitrator found an immunization policy that had the effect of suspending employees (non-disciplinary) for refusing to undergo medical treatment is a violation of common law rights where there is no consent. St Peters dealt with staff vaccination within a chronic care geriatric facility.

St. Michael’s Hospital dealt with a Vaccinate or Mask Policy (VOM Policy) that stated health care workers who have not received the annual influenza vaccine, must, during all or most of the flu season, wear a surgical mask in areas where patients are present and/or patient care is delivered.

In ESA and PWU, the arbitrator dealt with a policy introduced by an Electrical Safety company during the COVID-19 pandemic. The arbitrator found that the Employer’s vaccination policy was unreasonable to discipline or discharge Employees or to place employees on unpaid leave for failing to get vaccinated. The arbitrator went on to clarify that it was not unreasonable to require employees to disclose their vaccination to gain entry to third party premises and the Employer’s premises. The arbitrator also left room for circumstances to change such that the Employer’s policy may be reasonable. Essentially, the Arbitrator noted there were some clients of ESA that did not require vaccination to provide services and that where clients required vaccination, the Employer had been able to manage the situation to date. The arbitrator also found a substantial amount of work could be completed remotely. The arbitrator dismissed the grievance and found the policy was reasonable. Interestingly, in reviewing caselaw, the Arbitrator rejected the analysis set out in St. Peter’s and did not reject the notion of vaccination policies entirely. Quite the opposite, the Arbitrator states at para 17:

> In workplace settings where the risks are high and there are vulnerable populations (people who are sick or the elderly or children who cannot be vaccinated), then mandatory vaccination policies may not only be reasonable but may also be necessary and required to protect those vulnerable populations.

In UFCW and Paragon, the arbitrator dealt with a mandatory COVID-19 vaccine policy. The company justified its policy on the basis that some of its clients had introduced or advised policies were forthcoming that required employees to be vaccinated. The Collective Agreement at issue specifically contemplated vaccination requirements required by law or by contractors and contemplated reassignment if an employee refused. The arbitrator upheld the Employer’s policy. In doing so, the

Arbitrator distinguished the situation in St. Michael's stating, "…I find there is a distinct difference between the influenza related considerations addressed in the St. Michael's Hospital Award and the current pandemic and COVID-19. In this regard, I refer to and rely on the comparison of key features of influenza and COVID-19…"

The Pelletier and Community Natural Foods decision did not deal directly with an immunization requirement, the primary focus of that hearing was the extent to which a mask mandate interfered with the complainant's religious beliefs as a customer. This decision provides helpful insight to the analysis to determine whether a complainant has established they hold a religious belief pursuant to human rights legislation. We will deal with that issue here, but the decision is helpful for its comments on the connection of a policy to a legitimate business purpose. It found, "In this case, the respondent argues, and I accept, that employee, customer and public health and safety are legitimate business purposes, and the policy is rationally connected to those objectives."

Background

Verna Yiu first announced AHS's intention to implement mandatory vaccination for all health care workers on August 31 2021. Alberta Health Services issued its policy on September 14 2021. The policy outlined a deadline of October 16 for submission of accommodation requests and October 31 as the implementation date for the requirement to be fully immunized. On September 17 2021, the United Nurses of Alberta wrote to AHS to advise that although we would not grieve the policy, we reserved the right to grieve in individual circumstances, including but not limited to: entitlements to be accommodated on the basis of protected grounds other than medical or religious beliefs; application to employees not currently required to report for work; the indefinite duration of the policy; and seeking non-disciplinary suspensions in place of an unpaid LOA.

On October 22 2021 AHS amended its policy by extending the deadline to comply with the policy to November 30 2021. On November 29, AHS announced another extension to December 13, 2021 for employees to be fully immunized. Further, the Employer implemented an option for certain employees at certain sites to submit rapid testing results in place of providing proof of vaccination. The Employer stated

> …at the direction of the Government, AHS will temporarily introduce frequent, targeted COVID-19 testing as part of our Immunization of Workers for COVID-19 Policy. Only work locations/program areas at significant risk of service disruptions due to staffing shortages resulting from employees who are not fully immunized will be part of the testing program, which will be reviewed by the end of March 2022. To ensure uninterrupted patient care, eligible employees who are not fully immunized at a limited number of work locations/program areas will be able to provide proof of negative COVID-19 tests starting Dec. 13, 2021. The immunization policy date will also be adjusted to Dec. 13 to accommodate the introduction of targeted testing.

Is the standard or policy inconsistent with the Collective Agreement?

Under Article 4.01 the employer "reserves all rights not specifically restricted or limited by the provisions of the Collective Agreement, including the right to (a) maintain order, discipline and efficiency and (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." The primary question, therefore, is whether the policy is in conflict with any provisions of the Collective Agreement.

The policy provides a mechanism for employees to request accommodation on the basis of protected grounds. The policy itself references the Alberta Human Rights Act. The Collective Agreement includes protections on the basis of "political beliefs," "membership or non-membership or activity in the Union," and "exercising any right conferred under this Agreement or any law of Canada or Alberta." The policy does not specifically reference accommodation on these grounds and to the extent it excludes those protected grounds the policy is inconsistent with the Collective Agreement. Further, in at least one case, UNA has been advised that employees are not entitled to accommodation on the basis of political beliefs; this is plainly inconsistent with the Collective Agreement. In addition, AHS has refused to consider requests unless they are submitted using a prescribed form. The employer has also applied the incorrect test when assessing claims on the basis of religious beliefs. While on its face, the policy may appear to comply with the requirements of the Collective Agreement, AHS has not implemented the policy in a manner that meets those requirements.

The Employer's revised policy imposes a cost on some employees, not all, for proof of illness (or lack thereof in this case). Article 19.04 states,

> Employees may be required to submit satisfactory proof to the Employer or its agents of any illness, non-occupational accident or quarantine when circumstances make it reasonable to do so. Where the Employee must pay a fee for such proof, the full fee shall be reimbursed by the Employer.

Article 34.06 states,

> 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.

Even if Article 19.04 does not entitle the employee to reimbursement on its own, the combined effect of Articles 19.04 and 34.06 was to minimize costs and losses associated with employees who must provide medical information or attend medical appointments. In the case of 19.04 and 34.06, which both deal with costs associated with providing proof to the Employer, the requirement is employer driven and the language is clear that the Employer must pay. While the requirement for Rapid Testing does not establish proof of illness, the effect is similar: to require an employee to provide medical proof. Further, it is reasonable to conclude that the concept of Testing falls within the continuum of illness and quarantine. Quarantine does not require an actual illness, just as testing does not require an illness. Further, some testing could result in a positive test which the Employee is required to provide to the Employer. It is not fair, reasonable or professional (as required by Article 4) to reimburse Employees for positive tests while denying those who receive a negative test. Further, it is not fair, reasonable or professional to require the employee to pay for tests, and prohibit the employee from seeking those tests through the public health care system, while also refusing to reimburse for the costs of those tests. The Employer's policy contradicts Article 19.04 and 34.06 of the Collective Agreement.

The revised Employer policy paragraph 4.2(e) states, “The testing must be completed on the worker’s own time.” This contravenes Article 19.11 which states,

> If an Employee requires time off for the purpose of attending a dental, physiotherapy, optical or medical appointment, provided they have been given prior authorization by the Employer such absence shall be neither charged against their accumulated sick leave, nor shall the Employee suffer any loss of income provided such absence does not exceed two (2) hours during one work day. If the absence is longer than two (2) hours, the whole period of absence shall be charged against their accumulated sick leave. Employees may be required to submit satisfactory proof of appointments.

The COVID test is clearly a medical appointment and the Employer’s requirement to obtain the test on the worker’s own time is in direct contravention with their right to either be paid for attendance at a medical appointment or to use earned sick time to attend a medical appointment.

Article 23 Discipline and Dismissal and specifically Article 23.09 prohibits the suspension, dismissal or discipline except for just cause. On its face the unpaid LOA imposed on employees who are not immunized imposes a suspension on employees. The question remains whether this suspension is disciplinary or non-disciplinary. If non-disciplinary then the requirement is not in conflict with the collective agreement. If disciplinary then it is in conflict. In the Trillium Ridge decision, the arbitrator found, “The refusal to permit non-immunized staff to work was not disciplinary in purpose or intent.” Trillium Ridge also commented that the underlying bargain is that employees will provide work in exchange for pay and the arbitrator found that employees who choose not to be immunized cannot provide work and should not expect to be paid.

Article 34.06 says, “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.” As stated in Chinook, “it is apparent that the Employer finds some support in the collective agreement language, which is 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 reasonable necessary.”

Article 22 sets out provisions for leaves of absence including unpaid leaves of absence. Article 22.02 says,

> “Leave of absence without pay may be granted to an Employee at the discretion of the Employer and the Employee shall not work for gain during the period of leave of absence except with the express consent of the Employer. If a request for leave of absence is denied, the Employer will advise the Employee in writing of the reasons for denial.”

The employer’s policy states that employees will be placed on an unpaid leave of absence. The wording of article 22.02 does not permit the employer to unilaterally place an employee on a paid leave of absence; an employee must make a request for a general leave of absence. The alternative to an Article 22 LOA would be a non-disciplinary suspension that may restrict access to benefit entitlements contained in Article 22. UNA’s analysis is that Article 22 unpaid leave is preferable and will be

supporting its application in this circumstance. To the extent an Employee requests a non-disciplinary suspension in place of a General Leave of Absence, the Union will advocate for the same to the employer.

The Employer's policy is inconsistent with the Collective Agreement. The Employer policy does not meet the requirements of Article 6. The policy excludes some protected grounds, imposes arbitrary deadlines for employees to request accommodation, denies requests based on an unreasonable requirement to utilize a prescribed form, and applies the incorrect test when assessing requests for accommodation on the basis of religious beliefs. The requirement for some employees to pay for testing is inconsistent with Articles 19 and 34. The requirement is also unfair, unreasonable and unprofessional as required by Article 4. The policy further contradicts Article 19 by denying Employees the right to receive paid time off for medical appointments to obtain the tests required by the Employer. The Employer's decision to place someone on a leave of absence may be inconsistent with the Collective Agreement in certain circumstances and will be dealt with on a case-by-case basis.

Is the standard or policy connected to a legitimate interest of the Employer?

The AHS policy describes its objectives: "To set out worker immunization requirements for COVID-19 to protect the health and safety of workers, patients, and the communities Alberta Health Services (AHS) serves." Alberta Health Services is the largest employer of health care workers in Canada and has borne the responsibility of managing and responding to the COVID-19 pandemic. The vast majority of the emergency, acute care and intensive care units who provide care to COVID-19 patients fall under the purview of AHS. Those that do not, fall under the purview of Covenant Health.
In Barkley, the arbitrator found, "There was on the part of the Council a legitimate interest which was the residents' health and well-being."

In Trillium Ridge, the arbitrator found evidence that although vaccinations were not perfectly effective, the vaccination of staff and residents was an effective means to prevent transmission of influenza A and reduced the severity of symptoms and incidence of complications arising from infections with the virus. Additionally, "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." On this basis, the arbitrator concluded the Employer's policy was rationally connected to the legitimate objective of protecting the health and safety of residents and staff at the facility.

In Carewest, the arbitrator accepted evidence that influenza was a serious health concern for the frail elderly. In light of those consequences, the arbitrator accepted the employer's goal to in preventing and containing outbreaks. And found a rational connection between that goal and immunization having regard to "the importance, effectiveness and safety of the influenza vaccine."

In Chinook, the arbitrator adopted a balancing of interests approach. The decision says, "…a balancing of interests 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."

In September 2021, when the Employer first announced its policy, the fourth wave threatened to collapse the Health Care system. COVID-19 cases and hospitalizations surged, and the capacity of AHS to respond to the health care needs of Albertans was jeopardized. Emergency departments shut down and surgical services reduced or stopped due to a shortage of beds, health care workers, or both. The pressure on the health care system resulted in overtime, canceled vacation and widespread burnout among health care workers. The health care system was in crisis.

On September 16, 2021 the Government of Alberta declared another State of Public Health Emergency in order to protect the health care system during the 4th wave of the COVID-19 pandemic. Dr. Verna Yiu, AHS President and CEO, stated in regards to this announcement "Our health care system continues to experience severe capacity challenges, greater than we have faced throughout this long and exhausting pandemic. Yesterday, we reached 270 patients in ICU, that is the highest number of ICU patients we have ever seen at any time during the pandemic or ever in our provincialized health care system." Dr. Yiu indicated that in response to this capacity crisis, AHS will be reaching out to other provinces to see if they have any available ICU space or if they have skilled front line staff to come to assist in Alberta. In addition, Dr. Yiu announced they are taking further steps to educate their clinical teams on a critical care triage protocol, as a planned and pre-determined province wide approach to guide their response should the demand for life-sustaining critical care support become greater than the available resources. Throughout October and November 2021, AHS expressed confidence they could prevent the collapse of the health care system, even at sites with poor vaccination rates, through a combination of transfers, agency staff, and service decreases.

On November 29th, when the Government and AHS announced plans to further delay the implementation of the Employer policy, the Health Care system did not face the same challenges, which existed in September. UNA acknowledges that avoiding service disruptions in certain locations or programs falls under the broad rubric of avoiding the collapse of the health care system. However, with the introduction of the option for testing for some employees in areas with highest risk of transmission, hospitalization and death, we are not satisfied this policy is directed towards a legitimate interest of the employer to protect the health and safety of patients and staff.

For the purposes of this analysis, we conceded that AHS continues to have a legitimate interest in preventing the collapse of Alberta's Health Care system. The requirements to be fully immunized and the alternative option for regular testing for COVID-19 set out in the standard or policy are rationally connected to a legitimate interest. We will focus on the reasonableness of the policy.

Is the Policy reasonable?

We will deal with the requirement to submit testing results and the requirement to be fully immunized separately. We will start with the requirement to submit COVID 19 tests.

Is the option to submit COVID-19 tests reasonable?

UNA takes issue with this revised standard in several respects. First, the distinction between locations/programs that are at risk and those that are not is arbitrary. It is unclear how locations/ programs are chosen and at the time of this opinion, the Employer has not shared which locations/ programs will be eligible for testing. The Employer has also indicated the list will evolve as they are able to identify adequate coverage to address potential service disruptions.

Second, the pandemic has reinforced for front-line health care workers that the health care system is an integrated system. Staffing deficits and service disruptions in one location or program impact other locations and the services they provide. Throughout the pandemic nurses have been reassigned from one program to another, from one site to another, and from one employer to another. Patients have likewise been transferred across programs, sites, employers and even provinces. Introducing a targeted measure in isolated areas of the health care system betrays a fundamental misunderstanding of the health care system in Alberta.

Third, tests are not a suitable substitute for full immunization at this time. The Government of Canada states that the use of tests as a screening tool is another layer of protection but it is not a substitute for other public health measures including mask wearing, hand hygiene, physical distancing, proper ventilation, and getting the COVID-19 vaccine. Reference: https://www.canada.ca/en/public-health/services/diseases/coronavirus-disease-covid-19/testing-screening-contact-tracing/workplace/rapid-antigen-tests.html In the past, AHS stated that testing was not an alternative to immunization as "there are significant safety and efficacy concerns with testing. Current testing technology is designed for those experiencing symptoms, which creates a large risk of false positives (up to 30 percent), and this could lead to workers being unnecessarily restricted from work. The occurrence of false negatives is even more significant (reported as high as up to 50 percent) where workers may be entering care environments infected with COVID-19)." Reference: https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-vaccine-immunization-policy-faqs.pdf We also point to comment from the arbitrator in ESA and PWU at para 25: "I acknowledge that testing is fallible and a less effective intervention than vaccination."

Arbitrators have consistently concluded that the risks in the health care setting are significantly higher. The sites where AHS contemplates testing as an option have the lowest vaccination rates among staff. This decision would appear backwards - one might expect greater openness to testing at sites where the risks are lower. UNA is not aware of scientific basis to conclude that testing is a reasonable alternative to vaccination to achieve the precautionary principle. Quite frankly, we regret the Employer's decision and we conclude the Employer's decision fails to meet the requirements of Occupational Health and Safety legislation by failing to take every measure necessary to protect employees and patients from acquiring COVID-19. This is not a workplace similar to the one in ESA and PWU.

Is the requirement to be vaccinated unreasonable?

Registered Nurses and Registered Psychiatric nurses are and have been required to obtain vaccines as a pre-condition of enrolling in the degree and diploma programs

for those areas of study. As such, it will not be uncommon for these health care workers to have been vaccinated in the past. It is reasonable to conclude that the vast majority of the opposition is not to vaccines generally, but rather to the specific vaccines designed to address COVID-19. Therefore, we will begin our analysis of the reasonableness of the employer's policy with an examination of the COVID-19 vaccine.

Does the COVID-19 vaccine limit the transmission of COVID-19, limit hospitalizations and limit severe outcomes for those who become infected?

The policy in St. Michael's was struck down, in part based on inadequate or insufficient evidence that vaccination prevented or significantly reduced nosocomial influenza: "the case establishing a link between vaccination and prevention of nosocomial influenza was not made." In other cases, arbitrators accepted that health care workers served as 'vectors' because they circulated throughout the health care setting from patient-to-patient.
UNA has concluded that an arbitrator will accept that vaccination against COVID-19 is a highly effective way to prevent COVID-19 infection, severe disease, hospitalization, and death, and as such, encourages all nurses, other health care workers, and the general public to be vaccinated against COVID-19 to protect themselves, their families, their colleagues and vulnerable patients/residents/clients, as well as to prevent the overextension of all our health care services, including hospital, long-term care, home care and public health resources. This position is in line with the Canadian Federation of Nurses Unions COVID-19 Vaccination Position Statement: https://nursesunions.ca/wp-content/uploads/2021/08/2021-08-24-CFNU-position-statement-on-SARS-CoV-2-vaccination_EN.pdf

This position is based on the latest evidence on COVID-19 vaccination from leading public health and disease control institutions in Canada and around the world and from real-world vaccine outcome data as reported by the Government of Alberta.

Canada's National Advisory Committee on Immunization (NACI), a national advisory committee of experts in the fields of pediatrics, infectious diseases, immunology, pharmacy, nursing, epidemiology, pharmacoeconomics, social science, and public health, makes recommendations to the Public Health Agency of Canada (PHAC) for the use of vaccines currently or newly approved for use in humans in Canada, based on the best current available scientific knowledge. As such, they have issued an Advisory Committee Statement on Recommendations on the use of COVID-19 Vaccines (July 22, 2021). In this statement they conclude that "the first dose of the authorized COVID-19 vaccines has been shown to offer at least short-term protection against confirmed COVID-19 disease. For mRNA vaccines, the highest efficacy is seen after the second dose is administered" and that "emerging real world evidence from studies in the United Kingdom (UK), Israel, the United States (US), and Canada suggests moderate to high vaccine effectiveness against severe COVID-19 outcomes after the first or second dose of mRNA COVID-19 vaccines in adults."
Reference: https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci/recommendations-use-covid-19-vaccines.html#a7.2

The United States Centers for Disease Control and Prevention (US CDC) in their Science Brief: COVID-19 Vaccines and Vaccination (Updated September 15, 2021) state that "all COVID-19 vaccines currently authorized in the United States (Pfizer-BioNTech/Comirnaty, Moderna, and Janssen [Johnson & Johnson] are effective against COVID-19, including against severe disease, hospitalization, and death. Available evidence suggests the currently approved or authorized COVID-19 vaccines are highly effective against hospitalization and death for a variety of strains, including Alpha (B.1.1.7), Beta (B.1.351), Gamma (P1), and Delta (B.1.617.2)." In terms of the effect of vaccination on transmission, the US CDC states "a growing body of evidence suggests that COVID-19 vaccines also reduce asymptomatic infection and transmission. Substantial reductions in SARS COV-2 infections (both symptomatic and asymptomatic) will reduce overall levels of disease, and therefore, SARS-CoV-2 virus transmission in the United States. Investigations are ongoing to further assess the risk of transmission from fully vaccinate persons with SARS CoV-2 infections to other vaccinated and unvaccinated people. Early evidence suggests infections in fully vaccinated persons caused by the Delta variant of SARS-CoV-2 may be transmissible to others; however, SARS-CoV-2 transmission between unvaccinated persons is the primary cause of continued spread."
Reference: https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html

The Government of Alberta publicly reports up to date data on vaccine outcomes for Albertans who have been vaccinated. This data provides real-world Alberta specific evidence that vaccines are highly effective against preventing infection, severe disease, and death. As of September 14, 2021:

- 89.3% of cases (152,290/170,555) since Jan 1, 2021 were unvaccinated or diagnosed within two weeks from the first dose immunization date.
- 88.3% of hospitalized cases (6,696/7,586) since Jan 1, 2021 were unvaccinated or diagnosed within two weeks from the first dose immunization date.
- 81.7% of COVID-19 deaths (785/961) since Jan 1, 2021 were unvaccinated or diagnosed within two weeks from the first dose immunization date.
- Data on alberta.ca (updated to September 15, 2021) shows that in the previous 120 days, there were 800 COVID-19 cases that required admission to ICU. 40 patient (5%) were completely vaccinated, 47 (5.8%) were partially vaccinated, and 713 (89.1%) were unvaccinated.

As of December 2 2021:

- 78.1% of cases of cases (181,901/232,781) since Jan 1, 2021 were unvaccinated or diagnosed within two weeks from the first dose immunization date.
- 78% of hospitalized cases (9,033/11,582) since Jan 1, 2021 were unvaccinated or diagnosed within two weeks from the first dose immunization date.
- 67.4% of COVID-19 deaths (1,164/1,726) since Jan 1, 2021 were unvaccinated or diagnosed within two weeks from the first dose immunization date.
- Data on alberta.ca (updated to Dec 2, 2021) shows that in the previous 120 days, there were 1,260 COVID-19 cases that required admission to ICU. 150 patients (11.9%) were completely vaccinated, 40 (3.2%) were partially vaccinated, and 1,0670 (84.9%) were unvaccinated.

The evolution of the statistics is notable. Our assessment is that a larger numbers of vaccinated employees will result in larger number of breakthrough infections and the consequences associated with those breakthrough cases. Even with reduced

numbers, we still see nearly 4 out of 5 cases of infections and hospitalizations were unvaccinated. In the other arbitration decisions, the arbitrators dealt with annual influenza vaccines that provided less reliable protection against infection for staff than the efficacy evident for the COVID-19 vaccine. UNA's assessment is that an arbitrator will find the evidence is clear that vaccination prevents or significantly reduces infection, spread, hospitalization and death. Additional data is also pointing to vaccination reducing transmission.

Are there other measures the employer could have used in lieu of mandatory vaccines?

Alberta Health Services began to roll out their immunization program for health care workers in December 2020, using a phased approach, based on priority groups and available vaccine supply. On April 12, 2021, all health care workers became eligible to book a first dose COVID-19 immunization appointment in Alberta. On April 21, 2021, the Government of Alberta introduced job-protected paid leave to allow Albertans to access their COVID-19 vaccine. This means that all AHS Employees, whether full-time, part-time, or casual, can access up to three consecutive hours of paid leave (or longer if the employer deems it reasonable) to get each dose of the COVID-19 vaccine. On May 7, 2021 AHS launched a COVID-19 immunization awareness campaign directed at their employees titled "Stick with the facts, stick together" to share fact based information and encourage vaccination. As employee vaccination was voluntary prior to the introduction of its policy, AHS did not yet know the exact number/proportion of Employees that had been vaccinated but shared with UNA that they believed the number to be higher than the rate of the general public in Alberta, where just over 71.5% of the 12+ population in Alberta is fully vaccinated as of September 15, 2021.

Since the implementation of the policy, this data is more readily available. Gaps continue to exist. Immunization for children aged 5-11 has commenced offering some hope that the spread of the virus will be less widespread and there will be reduced hospitalizations and less severe symptoms for those admitted. However, the variant of concern threatens to bring a fifth wave and initial reports are troubling regarding its potential impact on the population.

UNA asserts the application of a hierarchy of controls to protect health care workers against COVID-19 is necessary. This approach is in line with Alberta's Occupational Health and Safety legislation, which requires employers to conduct hazard assessments and to eliminate the hazards identified. If they cannot be eliminated, the employer must introduce controls to protect against them.

The Canadian Federation of Nurses Unions (CFNU) also advocates for application of the occupational health and safety principle of the hierarchy of controls as it relates to COVID-19 and worker safety. It starts with eliminating the hazard whenever possible. When that cannot be accomplished, a combination of engineering and administrative controls, combined with appropriate personal protective equipment, must be applied. The system is called a hierarchy because you must apply each level in the order they fall in the list; a systematic comprehensive and integrated approach must be taken to reducing hazards; a hierarchy of controls cannot be applied in a piecemeal fashion. Reference: https://nursesunions.ca/position-statement-on-covid-19/

Alberta Health Services (AHS) and other health care employers implemented various controls to attempt to protect their Employees throughout the pandemic including engineering controls such as designated COVID-19 units and isolation spaces; administrative controls such as fit for work screening and outbreak management protocols including rapid testing; and provision of PPE for workers (masks, gowns, gloves, eye wear). Despite these measures being in place, hundreds of COVID-19 outbreaks were declared in health care facilities across Alberta, where hundreds of patients and employees acquired and transmitted the virus, resulting in significant morbidity and preventable patient deaths. According to AHS, "while PPE used diligently is highly effective in preventing virus transmission, there is always the potential for equipment failure and human error. Unfortunately, a large portion of the healthcare worker cases determined to be occupationally acquired are attributable to these causes." Reference: https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-vaccine-immunization-policy-faqs.pdf

For all of the reasons outlined throughout this analysis. UNA does not agree that testing is a viable substitute for immunization. UNA will not rule out the possibility that testing may be a viable alternative for locations or programs where existing immunization rates are sufficiently high to mitigate the risk of the less effective protective measures. We are not aware of any scientific studies or expert recommendations that guide when such steps might be appropriate at this time.

We also do not rule out the use of testing as a reasonable accommodation in some cases. The arbitrator in UFCW and Paragon who ordered rapid antigen testing as a reasonable accommodation for staff members. UNA takes the position that Employees exempted from the requirement to be fully immunized pursuant to the protected grounds outlined in Article 6 of the Collective Agreement can be accommodated by permitting a testing protocol paid for by the Employer. The employer policy, paragraph 4.2(d) contemplates paid testing for accommodated Employees working in a facility that is at a significant risk of service disruption. Paid testing is not extended to accommodated employees at other facilities and not extended to Employees without an approved accommodation. Paragraph 3.1 of the Policy states, "An AHS employee will not be permitted to undergo rapid testing as a reasonable accommodation unless section 4 of this policy applies." Offering paid testing to accommodated Employees is balances the interests of Employees to continue to work during the pandemic, the interest of AHS in maintaining safe staffing levels, the interest of AHS in providing a safe environment for patients, and the interests in maintaining a safe working environment for all Employees. As with any analysis for a duty to accommodate, whether a specific accommodation is reasonable will depend on the specific circumstances at the time. Offering paid testing to some accommodated employees at a limited number of facilities while refusing to make the testing option available to any other employer is unreasonable, unfair and violates the Collective Agreement.

UNA has consistently advocated for AHS and all health care employers in Alberta to apply a hierarchy of controls, the precautionary principle, and take every measure necessary to protect employees and patients from acquiring COVID-19. It is clear that vaccination against COVID-19 is another highly effective control that can be used by employers, as one of several layers, to mitigate transmission and infection in their facilities among employees and patients. Notably, the arbitrator in the Health

Employers described the precautionary principle: “The essence of that principle is it can be prudent to do a thing even though there may be scientific uncertainty.” The arbitrator then gave due regard to this principle in upholding the masking component of the employer’s policy, having found the science less settled on that consideration than with respect to vaccines. UNA accepts that immunization is a more reliable control measure than testing.

UNA also considered whether this policy is unnecessary for individuals who have previously been infected with COVID-19, essentially considering the issue of natural immunity. It is not currently known that antibody level correlates with protection against COVID-19. Although an employee may test positive for antibodies through serological testing, it does not tell us whether that employee is protected from reinfection. We understand there are studies examining natural immunity and we will continue to monitor progress in this regard. At this time, it is unlikely an arbitrator would find the evidence meets the evidentiary threshold necessary to render the employer’s policy unreasonable. In this case, the unsettled science of natural immunity works against the Union at arbitration, and works in the employer’s favour with respect to its rationale for requiring a vaccine.

It is our assessment that the employer attempted other measures to contain the spread of COVID-19 and to limit the severe impacts on the health care system prior to implementing a mandatory policy. From the outset of the pandemic UNA has advocated the safest approach to protecting patients and workers is to utilize the highest degree of protection for workers, first with the recommended use of n95 masks, then the use of N95 and eye protection and now the use of those measures and a fully vaccinated workforce. The Employer’s decision to implement less stringent safety precautions in communities with low vaccination levels runs counter to Occupational Health and Safety legislation and therefore is not reasonable at this time. While a combination of immunization and testing likely provides an additional hierarchy of control to protect staff and patients, the Employer’s immunization requirement remains likely to be upheld by an arbitrator, while the current policy that permits testing in lieu of immunization for some employees but not others, is unreasonable.

Is there reason to believe that workplace transmission presents a risk to health care workers?

The National Advisory Committee on Immunization (NACI) identified frontline healthcare workers as a key population for early COVID-19 immunization because they are a group more likely to acquire and transmit COVID-19, because of the nature of their work, to and from those at high risk of severe illness and death and are essential to maintaining the COVID-19 response. Reference: https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci/guidance-key-populations-early-covid-19-immunization.html

A study conducted on the early impact of Ontario’s COVID-19 vaccine rollout on Long-Term Care home residents and health care workers concluded that the “rollout of COVID-19 vaccines in Ontario’s LTC homes substantially reduced SARS CoV-2 infections, COVID-19 hospitalizations and deaths among LTC residents and HCWs. Completing and maximizing the uptake of the full COVID-19 vaccine series

according to recommended schedules will maximize the safety and well-being of Ontario's LTC residents and staff." Reference: https://covid19-sciencetable.ca/sciencebrief/early-impact-of-ontarios-covid-19-vaccine-rollout-on-long-term-care-home-residents-and-health-care-workers/

According to data released by the Canadian Institute for Health Information (CIHI) over 90,000 health care workers in Canada have been infected with COVID-19, including 43 deaths, since the start of the pandemic, representing 6.8% of all COVID-19 cases, as of June 15, 2021. Although the origin of these health care workers infection is not known, this data demonstrates the disproportionate burden that health care workers face when it comes to acquiring COVID-19 in Canada. https://www.cihi.ca/en/covid-19-cases-and-deaths-in-health-care-workers-in-canada

AHS regularly shares information with UNA on the number of Employees that have tested positive for COVID-19 and the likely origin of that infection (occupational, non-occupational, or indeterminate) based on case reviews they conduct internally within AHS. As of September 7, 2021, for those cases where the source of infection had been determined, 11.6% (608 positive cases) were likely acquired in the workplace (i.e. occupational). As of November 30, 2021, for those cases where the source of infection had been determined, 10.2% (679 positive cases) were likely acquired in the workplace (i.e. occupational). Occupational origin of infection continues to be a significant issue.

To what extent does the COVID-19 vaccine pose risks to the public? What about long-term side effects?

UNA believes an arbitrator will conclude all approved COVID-19 vaccines in Canada are safe and effective and the benefits of receiving the vaccines outweigh any potential risks. This assessment is based on the following information.

Health Canada's independent vaccine approval process is recognized around the world for its high standards and rigorous review. Their decisions are based only on scientific and medical evidence showing that vaccines are safe and effective. The benefits must also outweigh any risks. The development of COVID-19 vaccines has progressed quickly for many reasons including: advances in science and technology; international collaboration among scientists, health professionals, researchers, industry, and governments; and increased dedicated funding.

Health Canada has put in place a fast-tracked review process to assess COVID-19 vaccines. They've dedicated more scientific resources to complete these reviews so that they're done quickly without cutting corners. A similar process was used in 2009 to review and authorize the H1N1 pandemic vaccine.

Reference: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevention-risks/covid-19-vaccine-treatment.html

The Government of Canada publicly shares data on reported side effects following COVID-19 vaccination in Canada. As of November 26, 2021:

- **59,635,768** total doses administered

- **26,734** (0.45% of all doses administered total adverse events following immunization were reported. That's about **4** people out of every 10,000 people vaccinated
- Of the 26,734 individual reports (0.045% of all doses administered), 6,268 were considered serious (0.011% of all doses administered).
- Most adverse events are mild and include soreness at the site of injection or a slight fever
- Serious adverse events are rare, but do occur. They include anaphylaxis (a severe allergic reaction), which has been reported **643** times for all COVID-19 vaccines across Canada. That's why you need to wait for a period of time after you receive a vaccination so that you can receive treatment in case of an allergic reaction.
- Reference: https://health-infobase.canada.ca/covid-19/vaccine-safety/

According to the United States Centers for Disease Control and Prevention (US CDC), "Researchers have been studying and working with mRNA vaccines for decades. Interest has grown in these vaccines because they can be developed in a laboratory using readily available materials. This means the process can be standardized and scaled up, making vaccine development faster than traditional methods of making vaccines. mRNA vaccines have been studied before flu, Zika, rabies, and cytomegalovirus (CMV). As soon as the necessary information about the virus that causes COVID-19 was available, scientists began designing the mRNA instructions for cells to build the unique spike protein into an mRNA vaccine. Beyond vaccines, cancer research has used mRNA to trigger the immune system to target specific cancer cells." Reference: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/mrna.html

The US CDC also concludes that long-term side effects are unlikely stating "serious side effects that could cause a long-term health problem are extremely unlikely following any vaccination, including COVID-19 vaccination. Vaccine monitoring has historically shown that side effects generally happen within six weeks of receiving a dose. For this reason, the FDA required each of the authorized COVID-19 vaccines to be studied for at least two months (eight weeks) after the final dose. Millions of people have received COVID-19 vaccines, and no long-term side effects have been detected." Reference: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/safety-of-vaccines.html

Safety monitoring is ongoing in Canada. The Public Health Agency of Canada, Health Canada, and provincial and territorial health authorities continue to: monitor the use of all COVID-19 vaccines closely and examine and assess any new safety concerns. According to Immunize BC, the medical and scientific community is confident in the vaccine's long-term safety, because of the track record of Canada's vaccine approval process and provincial and territorial monitoring systems that are in place. Overall, this means that the end data and safety tests are exactly the same as other vaccines that have been approved in Canada. The safety monitoring system in Canada happens both passively and actively. Reference: https://immunizebc.ca/ask-us/questions/are-there-long-term-side-effects-caused-mrna-covid-19-vaccines-how-do-we-know

The vaccines are widely regarded as safe for the public and for health care workers. The issue of safety does not therefore render this policy unreasonable.

Does this policy subject employees to an assault or battery?

In Trillium Ridge, the arbitrator concluded the policy did not mandate vaccination: "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." Similarly, Arbitrator Smith in the Carewest decision found, "The Employer has not required anyone to take the shot or lose his or her job."

While there are consequences for those who choose to remain unimmunized, the policy does not force an employee to be vaccinated. It is a choice with consequences.

Is the application of the policy to all employees unnecessarily broad?

In Carewest, the arbitrator noted, "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." Adding, "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."

Those aspects do not exist with the AHS policy. So, it is possible that the broad application and unlimited timeframe to the unpaid leave could be seen as unreasonable, but given that COVID-19 is a global pandemic with more serious risks than influenza, an arbitrator is unlikely to make a direct comparison, and instead find a higher threshold for what is reasonable.

While the policy does not explicitly state that there will be no exceptions to the requirement except those unable to be vaccinated, the accompanying FAQ makes this clear. The standard or policy is clear that even those who work remotely and have no reasonable expectation of contact with patients, families or colleagues are required to be immunized. The FAQ states, "It is important that all AHS workers, including those working remotely are fully immunized as you may need to access an AHS site, facility or have contact with another AHS worker at any time." As noted above, one of the factors relied upon by the arbitrator in ESA and PWU was the availability of remote work. The arbitrator found that a combination of voluntary vaccination disclosure and testing policy might be adequate.

UNA previously advised AHS that while we will not grieve the standard or policy, we reserved the right to take issue with individual circumstances where in our opinion the employer's application of its policy is unreasonable. In light of recent changes to the policy and our assessment of AHS's implementation of its policy in other respects, it is UNA's assessment that this aspect of the policy should be challenged.

Does AHS require an order by a Medical Officer of Health under the Public Health Act to impose this policy or standard?

The United Nurses of Alberta strongly believes that the issue of mandatory vaccination for health care workers is a public health issue and should have been addressed through an order of a medical officer of health. While we maintain that

position, our finding is that the standard of policy does not violate the Collective Agreement and rather the possibility has been contemplated by the parties as evidenced by Article 34.06.

The MOH should have issued an order but it was not necessary for AHS to issue this standard or policy. It appears the Government of Alberta has ordered AHS to adjust its policy. We believe if the Government wished to influence how immunization was implemented then this should have been transparent and undertaken through the Medical Officer of Health. We particularly note that the Government did not oppose the policy but rather chose to impose special rules for some sites with higher rates of non-compliance while maintaining the requirement for others. We are compelled to identify where ultimate accountability for this decision lies: with the Alberta Government.

Is it reasonable to impose the immunization requirement in perpetuity or should it be tied to a declared Public Health Emergency or outbreak?

In each of the previous decisions that upheld employer immunization policies, the standard or policy only applied for the duration of a declared outbreak. UNA's assessment is that a policy that ties unpaid leave to an ongoing pandemic or outbreak would be reasonable. The AHS policy does not tie an unpaid leave of absence to the duration of an outbreak and therefore could result in an indefinite period of unpaid leave. This must be viewed as a significant departure from existing caselaw where the expected duration of unpaid time could be days or weeks. The lengthier and therefore more severe consequences place additional influence or coercion on employees to comply with the order.

While there is no specific end date to the consequence of being unimmunized, the current policy states, "This Policy will be reviewed regularly, and at least every six (6) months, to ensure alignment with public health measures and regulations, and to confirm it adequately cover the health and safety risks it addresses." AHS revised its policy in October and again in November. The current policy contemplates further review in March 2022. Does this save the policy? The requirement for employees to immunize is an extraordinary measure and the employer's policy has been issued in the midst of a pandemic unlike any seen in the last century. UNA is mindful that distress and burnout levels among front line care providers are at dangerous levels. Nonetheless, in light of AHS's recent revisions to the policy, the United Nurses of Alberta concludes the policy cannot be justified in perpetuity and the requirement for immunization and testing should be tied to an active outbreak or pandemic.

In addition to these considerations, a standard or policy may be unreasonable if it violates other legislation. UNA has considered the standard or policy in light of legal requirements or standards set out in the Canadian Charter of Rights and Freedoms, Privacy legislation, human rights legislation and professional standards.

Does the standard violate the Charter?

There is a two step test to make out a violation of section 7 of the Canadian Charter of Rights and Freedom. First, there must be a deprivation of life, liberty, or security of the person, and second, such a deprivation is contrary to the principles of fundamental justice. It is unlikely the first step will be found to be met. The choice to

receive the vaccine remains with the employee, notwithstanding that the choice to not receive a vaccine may carry financial consequences. In Interior Health Authority v. BCNU, 2006 Caswell BC 3377, Arbitrator Burke dismissed a section 7 Charter argument with respect to an influenza vaccination policy on this basis (para 102): "The employees have a choice in the matter. Financial consequences may occur if there is both an outbreak declared and they do not have any residual vacation or other leave remaining, other than sick leave. That does not eliminate the reality of a choice, albeit one that may be difficult." Vaccination policies that provide for appropriate human rights exemptions will also not infringe freedom of religion protected under section 2 of the Charter.

The standard or policy does not violate the Charter.

Does the standard violate Privacy legislation?

Section 2.4 of the AHS policy states that proof of immunization records are collected under the authority of Section 33(c) of the Freedom of Information and Protection of Privacy Act (Alberta) and shall be used, accessed, and disclosed in accordance with the legislation and AHS's Collection, Access, Use, and Disclosure of Information Policy.

Section 33(c) Purpose of collection of information

> No personal information may be collected by or for a public body unless … (c) that information relates directly to and is necessary for an operating program or activity of the public body.

AHS is a public body. AHS has a legitimate purpose for requiring employees to be immunized. The collection of proof of immunization records is directly related to and is necessary to monitor the immunization status of its employees.

AHS must inform employees of the purpose for which the information is collected (this has been addressed already), the specific legal authority for the collection (the policy references s. 33(c) of the FOIP Act), and the title, business address and business telephone number of an officer or employee of AHS who can answer questions about the collection. With respect to the latter requirement, AHS has confirmed this information will be included on the forms where employees provide or enter their personal information (Got My Flu Shot) on inside. The requirement to provide proof of immunization does not violate privacy legislation.

The standard or policy meets the requirements of privacy legislation.

Does the standard violate human rights legislation?

The policy specifically contemplates and references the Alberta Human Rights Act. Section 3 of the employer policy permits employees who are unable to be immunized for reasons related to a protected ground of discrimination under the Alberta Human Rights Act to request reasonable accommodation to the point of undue hardship. The policy sets out the process for employees to request accommodation. This process sets an arbitrary deadline for employees to request accommodation. This deadline has resulted in some employees being advised that they either cannot amend their request or cannot submit a new request. In addition, some employees were turned

away because they did not use the Employer's specific template form. The Employer cannot promulgate and rely on this policy to disentitle Employees of their legislated right to be free from discrimination on the basis of protected grounds in the Human Rights Act.

The term "unable to be immunized" may be overly restrictive as it relates to employees making a request for accommodation. For example, there may be employees of indigenous backgrounds who are vaccine hesitant due to experience with or knowledge of historical injustices perpetrated by the Canadian government or the Canadian health care system. They may or may not be "able" to be immunized but they should not be required to justify a request for accommodation on a medical basis (physical or mental disability).

Further, since October 16, 2021, UNA has filed more than 85 grievances relating to denials on the basis of religious beliefs. While some of these denials might be appropriate, the Union is not convinced that the Employer has applied the proper legal test for assessing requests for religious accommodation as set out by the Supreme Court in Amselem. The Employer has not taken reasonable tests to individually assess the sincerity of each claimant's religious beliefs. It would appear the employer is making decisions regarding the validity of claimants' religious beliefs rather than assessing the sincerity of those beliefs.

In addition the employer's policy appears to contemplate testing as a form of accommodation for employees at some sites but not others. The result is that those who make requests at locations/programs without the testing option will be disadvantaged in relation to others in a similar position. The employer has the ability to reduce the effects of discrimination by offering a viable option for accommodation and they refuse to do so. The employer recognizes that paid testing is a reasonable accommodation and arbitrarily restricts access to this reasonable accommodation. Worse still, the Employer will pay for testing for accommodated employees at the small number of sites where testing is an option but will not pay for non-accommodated employees' testing and will not pay for accommodated employees at other sites.

The standard or policy does not meet the obligations set out in human rights legislation by setting an arbitrary deadline to submit requests, by denying claims not submitted on a template form, by applying incorrect standards to assess accommodation requests, and by refusing to make reasonable accommodations available to all accommodated employees.

<u>Does the standard violate professional standards?</u>

With respect to professional standards, the United Nurses of Alberta have heard from employees concerned that by administering the vaccine they will violate professional standards. The AHS Informed Consent Policy states that consent shall be voluntary. It then defines voluntary as:

> a) The patient shall have the opportunity, without undue influence , to accept or refuse a treatment/procedure(s).
> b) As time permits in the clinical circumstance, informed consent discussions shall occur when the patient has a reasonable opportunity to reflect on the decision and ask questions.

c) When appropriate to do so, informed consent discussions should not take place in the operating room or the operating room environment.
d) The patient shall be given an opportunity to take the time required to reflect on the information and to consult with whom they choose prior to making a decision.
e) A patient's decision to accept or refuse a treatment/procedure(s) shall not prejudice their access to ongoing or future health care."

For the purposes of this analysis we will focus on (a) and in particular consider the term "undue influence". First, UNA raised this concern with AHS. AHS response stated,

- AHS does not believe that the policy provisions will amount to undue influence and has consulted with CARNA on this topic. CARNA supports that employers make decisions on vaccination and defers to employers and public health measures. If a nurse needs to be vaccinated to go to work, CARNA supports the employer policies and public health measures to keep patients safe.
- Implied consent is obtained when the client arrives to the office. The nurse then obtains consent to go ahead with the vaccination after doing their due diligence to explain the risks and benefits. Documentation should reflect that the nurse obtained consent and that the client expressed discontent with having the vaccine.

It is instructive that the Arbitrator in UFCW and Paragon concluded that the Health Care Consent Act was not applicable to the matters addressed at hearing.

When the policy was originally imposed by the employer in September, the Canadian Nurses Association (CNA), had called for mandatory vaccinations for health care workers. We note that the decision in Health Employers' took note of a CNA position statement when assessing the policy in that case. Subsequent to UNA's original legal analysis, CARNA issued a statement on October 1 that supported the safety and effectiveness of the vaccine, strongly recommended vaccination to anyone who was eligible, addressed concerns with respect to spreading misinformation about the COVID-19 vaccine, and addressed concerns with respect to individuals claiming to be a nurse when they are not. Although they did not specifically comment on the notion of implied consent, they did not raise any ethical or practice concerns in that regard.

The policy or standard will not require nurses to violate professional standards.

<u>Does the standard or policy violate the Nuremberg Code?</u>

While the previous section dealt with the implications of the standard or policy from the perspective of employees who will administer the vaccine to others, UNA has also heard concerns from employees from the perspective of a patient. The most common concern raised is the belief that the vaccine is a form of experimentation and therefore subject to the Nuremberg Code. The Nuremberg Code has 10 principles for ethical, medical treatment and research. The first of those requirements is that a human subject must provide voluntary consent to participate in an experiment. The United Nurses of Alberta accepts that COVID-19 vaccination is not an experimental treatment. All approved vaccines have been approved by Health

Canada. As mentioned above, Health Canada has put in place a fast-tracked review process to assess COVID-19 vaccines. They've dedicated more scientific resources to complete these reviews so that they're done quickly without cutting corners. A similar process was used in 2009 to review and authorize the H1N1 pandemic vaccine. This is not experimentation.

The standard or policy does not violate the Nuremberg Code.

Does the standard find support in Occupational Health and Safety legislation?

Section 3 of Alberta's Occupation Health and Safety Act states,

> Every employer shall ensure, as far as it is reasonably practicable for the employer to do so, (a) the health and safety and welfare of (I) workers engaged in the work of that employer, (ii) those workers not engaged in the work of that employer but present at the worksite at which that work is being carried out, and (iii) other persons at or in the vicinity of the work site who may be affected by hazards originating from the work site.

As already discussed, the scientific evidence demonstrates that the COVID-19 vaccines prevent the spread of COVID-19 and contain COVID-19 outbreaks. Setting aside the benefits to those employees who receive the immunization (fewer hospitalizations and deaths), the science supports that vaccines will help prevent or reduce the risk of infection from one health care worker to another.

From the outset of the pandemic, the United Nurses of Alberta has advocated for the employer to apply the precautionary principle when addressing the health and safety of employees. Unfortunately, AHS chose to ignore this principle as it related to providing N95 masks to staff. The arbitrators in ESA and PWU and UFCW and Paragon make specific comment with respect to the obligation of Employers to meet statutory obligations under Occupational Health and Safety legislation and adopted an approach that balanced employees right to privacy and bodily integrity with the right of employees to have a safe and healthy workplace.

Given that the Employer previously refused to implement rapid testing due to its relative ineffectiveness when compared with immunization, this decision fails to withstand scrutiny. One might have expected that as the immunization rates at sites increased, the risk associated with unvaccinated employees would lessen and those reduced risks might be adequately managed through rapid testing. However, the Employer has chosen to implement less effective safety controls at the sites where the objective risk of infection is higher.

The revised standard or policy no longer applies a hierarchy of controls, the precautionary principle, or take every measure necessary to protect employees and patients from acquiring COVID-19. The standard or policy is therefore unreasonable.

Is the standard or policy clear and unequivocal?

The policy clearly defines what is meant by "fully immunized." The policy does explain how to provide proof of immunization records.

The policy, as amended, no longer applies to any person who provides services to or on behalf of Alberta Health Services - it applies to some but not others. Twice the Employer has extended deadlines for Employees to provide proof of immunization. In this context, it is not reasonable to conclude the timelines are clear. The policy sets forth consequences for non-compliance but those consequences have not been imposed at either of the deadlines set by the Employer.

The policy is not clear and unequivocal because it fails to provide clear timelines, sets out a flawed approach to accommodation and it has become clear that the consequences outlined are not real.

With respect to the option for testing, the policy is clear and unequivocal with respect to the type, timing, and source of the test. It also specifies the consequences for failing to comply with the policy. Clarity should not to be confused with reasonableness.

Has the standard or policy been properly promulgated to affected employees along with clear notice of the potential consequences for a breach of the standard or policy?

Verna Yiu first announced AHS's intention to implement mandatory vaccination for all health care workers on August 31 2021. Alberta Health Services widely distributed its policy on September 14 2021. The policy is clear that if an employee fails to abide by the requirement the Employer will first provide education to the employee and then place that employee on an unpaid leave of absence until such time as they comply with the policy.

The Employer promulgated a revised policy to Employees on November 29, 2021.

The standard or policy has been properly promulgated to affected employees. The Employer's failure to provide the education outlined in the policy means they have not provided clear notice of the potential consequences for a breach of the standard or policy. As mentioned above, consequences have not yet been imposed by AHS and this further erodes the clarity respecting the consequences.

Has the standard or policy been consistently enforced by the company?

The standard has been implemented in piecemeal fashion. The employer did not impose consequences on those who chose not comply with the October and November deadlines. Since implementing the policy it has become clear that employees have not consistently received the education contemplated by the policy. There are many individuals who have never met with their employer to discuss their views on the vaccine. Further, the employer now states that some will be required to be vaccinated and other will not. Specifically,

> Only work locations/program areas at significant risk of service disruptions due to staffing shortages resulting from employees who are not fully immunized will be part of the testing program, which will be reviewed by the end of March 2022. To ensure uninterrupted patient care, eligible employees who are not

fully immunized at a limited number of work locations/program areas will be able to provide proof of negative COVID-19 tests starting Dec. 13, 2021.

There are also inconsistencies with respect to paid testing for some but not all employees.

The policy is clearly not consistently enforced by the Employer.

Summary of conclusions

The United Nurses of Alberta determines that the employer's revised Immunization of Workers for COVID-19 policy does not meet the KVP test. We acknowledge the policy has been adopted for a legitimate purpose and the evidence relating to the ongoing and cumulative pressures placed on the health care system at this time is compelling, in particular in the face of potential (likely) fifth wave due to the Omicron variant of concern. The policy fails short in a number of ways:

The policy contravenes Article 6 because it excludes protected grounds enumerated in the Collective Agreement. It contravenes Article 6 and human rights legislation because it imposes arbitrary deadlines and excludes claims based on form rather than substance. Further the employer has applied wrong test for religious beliefs when assessing requests for accommodation.

The policy contravenes Article 4, 19 and 34. It Imposes costs and then refuses to reimburse Employees for the costs of COVID tests. In addition, the Employer proposes to pay for some employees but not others. And it denies employees the right to request paid time off for medical appointments.

The addition of the testing option is not reasonable because the selection of location/programs is arbitrary, viewing location/programs in isolation is flawed view of integrated system, and tests are unreliable and health care is higher risk environment - in particular the locations/programs with lower immunization rates.

The application of the policy to remote work environments is unnecessary and unreasonable.

The applicability of the policy is not tied to an ongoing outbreak or pandemic.

The testing option does not meet the precautionary principle and therefore fails to protect employees as required by Occupation Health and Safety legislation.

Delayed implementation undermines otherwise clear timelines to comply and consequences for non-compliance.

The employer has not consistently enforced its policy. The effect of the policy is that some have complied by getting vaccinated and others have not. There have been no consequences for those who have not. The policy contemplates a meeting with employees to discuss their views on vaccination that has not occurred in any consistent way, if at all. Effective December 13, some employees must be immunized, while others can provide testing. Likewise, some employees will be

reasonably accommodated by permitting them to submit test results. And, finally, some employees will have tests paid for while others will not.

Therefore, UNA has decided to grieve the policy at this time.