In the Matter of the *Labour Relations Code*, R.S.A. 2000, c. L-1.2, as amended;

And in the Matter of Collective Agreements between Alberta Health Services ("AHS") and Alberta Union of Provincial Employees ("AUPE") governing employees employed in Auxiliary Nursing Care (the "ANC Agreement") and General Support Services (the "GSS Agreement");

And in the Matter of Grievances filed by AUPE in respect of Employees placed on an unpaid leave of absence pursuant to the AHS Immunization of Workers for COVID Policy;

And in the Matter of a Marshalling Order of the Labour Relations Board granted March 16, 2022 and Amended March 24, 2022.

Between:

**ALBERTA HEALTH SERVICES**

Employer

-and-

**ALBERTA UNION OF PROVINCIAL EMPLOYEES**

Bargaining agent

# *MEDIATOR'S REPORT*

Before: Redacted, Mediator/Arbitrator
Mediation: April 11-12, 2022
Appearances:
For the Union: Redacted (Counsel)
For the Employer: Redacted (Counsel)

Written Submissions: June 6, August 1, August 17, 2022
Report Date: January 17, 2023

**MEDIATOR'S REPORT**

## I. Introduction

[1] On March 16, 2022, the Alberta Labour Relations Board (W.J. Johnson, K.C., Vice-chair) issued a marshalling order (the "Order") pursuant to section 67.1 of the *Labour Relations Code*. With the parties' agreement, the Order appointed me as arbitrator in respect of certain of the approximately 399 grievances in nine categories filed by Alberta Union of Provincial Employees ("AUPE"), all arising out of Alberta Health Services' ("AHS") adoption and implementation of its Immunization of Workers for COVID-19 Policy. The grievances arise in both bargaining units represented by AUPE, in Auxiliary Nursing Care and General Support Services. The groupings of grievances, and the scope of the Marshalling Order, are discussed presently.

[2] The parties later agreed to constitute me as a mediator in a preliminary process by which I would inquire into certain categories of the disputes, attempt to settle any or all of them, and, failing settlement, issue a Report containing my own recommendations for settlement of the disputes. This Report fulfills that request.

[3] Though this process is cast as a mediation and I as a mediator, the proceeding was conceived by the parties principally as more of an informal arbitration. Facts were presented over one day in an informal setting from sources on both sides of the dispute, with questioning not constrained by formal rules of evidence. The discussants were questioned by the other party, but without the full adversarial force of cross-examination. An Agreed Statement of Facts and many agreed documents were provided. Written submissions and case precedent followed. Several extensions were granted by consent. As I understand my mandate, it is to absorb all this raw material and provide the parties with an advisory opinion on the two questions they submit by agreement, together with any recommendations for settlement that I consider may assist the parties to resolve all or some of these grievances. It is very much in the vein of alternative dispute resolution that goes beyond the "pure" mediation model of brokering an acceptable compromise through exploration of the parties' interests, and instead uses a "mediation-

arbitration" approach that attempts to solicit the neutral's opinion of the actual merits of the case, for whatever assistance and persuasive value it carries. In the parlance of the *Labour Relations Code*, it is best characterized as an "enhanced mediation" that asks the neutral to adopt an informed view of the case, and recommend any possible solutions that are apparent from the neutral's analysis. The wrinkle in the present case is that it involves a rights dispute and grievances, not the more usual features of an interest dispute and collective bargaining. The essential aspect of an enhanced mediation, however, applies: the views here expressed do not bind, and the parties remain free to litigate some of or all the grievances in full.

[4] The parties have stated these two questions for opinion and guidance:

1. Was the Employer's issuance of its Immunization of Workers for COVID-19 policy effective September 14, 2021, reasonable in the circumstances?

2. What is the impact of the Ministerial Directives issued on November 29 and December 23, 2021, and on March 7, 2022, and the resulting amendments to the Immunization of Workers for COVID-19 policy?

[5] The parties identified nine groups of grievances in the application for the Marshalling Order. They were:

*Group 1:* Employees who have been on an unpaid leave of absence since December 13, 2021, and remain on an unpaid leave of absence as of the date of application because they have not agreed to the temporary rapid testing option available as of January 10, 2022, or applied for accommodation (113 grievances, 96 employees);

*Group 2:* Employees who applied for and were denied accommodation despite providing documentation and have been on an unpaid leave of absence since December 13, 2021, and remain on an unpaid leave of absence as of the date of application because they have not agreed to the temporary rapid testing option available as of January 10, 2022 (93 grievances, 62 employees). Of these, 3 employees filing 3 grievances sought

medical accommodation and 59 employees filing 90 grievances sought religious accommodation;

*Group 3:* Employees who applied for and were denied accommodation because they did not provide documentation or requested accommodation on the basis of religious beliefs after AHS' deadline to apply and who have been on an unpaid leave of absence since December 13, 2021, and remain on an unpaid leave of absence as of the date of application because they have not agreed to the temporary rapid testing option available as of January 10, 2022 (21 grievances, 15 employees);

*Group 4:* Employees who were on an unpaid leave of absence between December 13, 2021, and January 9, 2022, when they agreed to temporary rapid testing (30 grievances, 23 employees);

*Group 5:* Employees who were on an unpaid leave of absence between December 13, 2021, and January 9, 2022, when they agreed to temporary rapid testing, and who had applied for an accommodation that was denied by AHS despite providing documentation (90 grievances, 63 employees);

*Group 6:* Employees who were on an unpaid leave of absence between December 13, 2021, and January 9, 2022, when they agreed to temporary rapid testing, and who had applied for an accommodation that was denied because they did not provide documentation or requested accommodation on the basis of religious beliefs past the deadline (10 grievances, 7 employees);

*Group 7:* Employees who were not placed on an unpaid leave of absence because their accommodation requests were accepted (5 grievances, 4 employees);

*Group 8:* Employees who were not placed on an unpaid leave of absence and their accommodations were not accepted (45 grievances, 39 employees); and

*Group 9:* Employees who were not placed on an unpaid leave of absence and did not apply for accommodations (23 grievances, 21 employees).

[6] The Order appointed me as arbitrator only in respect of Group 1, and required the parties to proceed by way of representative cases. Nonetheless, the questions posed by the parties – the reasonableness of the Mandatory Vaccination Policy (or just the "Policy"), as it will sometimes be called henceforth, and the impact of the Alberta Government's directives to AHS resulting in successive amendments of the Mandatory Vaccination Policy – potentially affect others of the grievance Groups; since, if the Policy is bad as being unreasonable, either in its entirety or in part, requests for medical or religious accommodation were unnecessary to corresponding degree. This Report therefore speaks to the global questions stated by the parties, and they will be free to reassess the grievances across all groupings accordingly.

[7] I start this task with an acknowledgment that the factual matrix is less certain than it would be in a conventional arbitration hearing. Though many of the facts are either agreed by the parties, asserted but uncontested, or so notoriously true that arbitral notice may properly be taken of them, other facts have not been fully proven by quasi-judicial process or tested by cross-examination. I attempt to identify any factual matters upon which this sort of uncertainty exists, and to take the uncertainty into account in formulating the views and recommendations in this Report.

## II. Factual Background

[8] COVID-19 has been, in the universality of its spread and its global mortality numbers, the worst pandemic in at least the last 100 years, since the Spanish Flu pandemic following the First World War. This report will not belabour the by now almost universally-known facts of the COVID-19 pandemic. It is enough to say that, in the last months of 2019, epidemiologists and national and international health authorities received the first reports of a novel coronavirus circulating in the Wuhan area of China. It was characterized by high transmissibility, multiple possible transmission methods, and serious, sometimes fatal, respiratory symptoms. In percentage terms the mortality rate was relatively low, under 2% by general consensus; though

rates of both hospitalization and admission to intensive care units (ICUs) were significantly higher. Moreover, the risk of adverse outcomes was greatly increased among the elderly and immunocompromised. These factors taken together, such a highly transmissible virus posed an immense public health threat even at low (by historical pandemic standards) mortality levels.

[9] By late February 2020, the virus had surfaced in most countries of the world, including Canada. On March 11, 2020, the World Health Organization upgraded the status of COVID-19 to a pandemic. A week later, Alberta declared COVID-19 a public health emergency, thereby triggering enhanced powers in the Chief Medical Officer of Health and other government entities to combat the pandemic.

[10] The pandemic resulted in an unprecedented sharing of epidemiological information and collaboration among scientists. The COVID-19 genome was sequenced with impressive speed and vaccine development started almost immediately thereafter. Inevitably, however, the development and regulatory processes, even working at top speed, could not produce a vaccine without a gap of months (in fact, it turned out to be 9-10 months). During that gap, public health measures focused on slowing the spread of COVID-19 through a variety of the historical methods for combatting respiratory epidemics: masking, isolation of the infected, and many ways of reducing close human contact – like social distancing, restrictions on large indoor gatherings, substitution of outdoor events and services, working from home, and technological innovations like virtual meetings. The overwhelming majority of the public at large will have experienced some of these responses even without having contracted the virus.

[11] The first really effective vaccines received regulatory approval in very late 2020. There followed an intense period of mass vaccination drives in all the developed countries of the world and many of the developing ones. As resistance from both vaccines and initial infections accumulated, however, COVID-19 displayed a troubling ability to mutate through several variants and evade immunological defences to a degree, as it is still doing at the writing of this Report. This has spurred a continuous process of vaccine development and vaccinations, with many individuals now having received four "shots" of COVID-19 vaccine. As is generally the case with viruses, to this observer's understanding, some variants are more "successful" than

others and quickly drive out their less successful competitors. The more successful variants, to date, have been those mutating in the direction of higher transmissibility but lower virulence. At the writing of this Report in the winter of 2022-23, COVID-19 continues to infect people at very high rates; but the risk of death or very serious illness in the general public has declined to the point that, in Canada and most of the developed world, society has returned most of the way to the pre-COVID state of "normality". This is despite the ongoing physical, emotional and economic toll that the virus still inflicts. There nevertheless remains much anxiety, among both medical professionals and the public, about the ongoing mutation of the virus, the prospect of seasonal surges in infection, the impact of these surges on the medical system, and the residue of chronic, or "long COVID", conditions that the virus leaves.

[12] This is enough global background. In Canada, as elsewhere, health care workers have been at the centre of the response to the pandemic, and have felt its effects profoundly. In their daily proximity to those infected with COVID-19 and those most vulnerable to becoming infected, they are both a vector of transmission and a group at highest occupational risk of themselves contracting the disease. Like other health authorities, AHS has from the beginning of the pandemic taken extraordinary steps to contain the spread of the disease, protect its employees, and ensure the health and safety of patients.

[13] I take from the parties' Agreed Statement of Facts, agreed exhibits and uncontested submissions in the briefs filed, and the widely known public facts about the pandemic, these following facts of the measures AHS and the Alberta Government at large took with respect to workers in AHS facilities as second doses of vaccine (i.e., a full course) became available to the general public in the summer of 2021:

> 1. While waiting for COVID-19 vaccinations to became generally available to all adult Albertans, AHS implemented the following public health measures in its workforce and facilities:
>
> - Daily Fitness for Work screening for all employees attending AHS facilities;
> - Social distancing when and where available;

- Physical barriers where social distancing was not possible;
- Personal protective equipment, including mandatory masking for all AHWS Workers;
- Limiting access to its facilities for the public and visitors;
- Screening for visitors and the public attending at AHS facilities;
- Remote work for all AHS Workers that were able to work from home;
- Attending at Work Directives, amended throughout the pandemic to align with Chief Medical Officer of Health ("CMOH") Orders;
- Adherence to all CMOH Orders. This included a "single site order" of April 10, 2020, that restricted healthcare workers in long-term care homes or designated supported-living facilities to working in one facility.

2. Vaccination first became available to small numbers of priority AHS employees in December 2020. By June 2021, all AHS staff qualified for voluntary COVID immunizations. On August 31, 2021, AHS announced that it would require all workers to be fully immunized against COVID-19 by October 31, 2021.

3. After an approximately one week long consultation with affected healthcare unions, the Employer issued its Immunization of Workers for COVID-19 policy effective September 14, 2021 (the "September 14, 2021 Policy"): *Exhibit 5*. The September 14, 2021 Policy mandated employee disclosure of vaccination status by October 16, 2021.

4. The September 14, 2021 Policy required that all Workers (including AHS, its subsidiaries and Covenant Health employees, members of the medical and midwifery staff (or a corporation who employs or contracts any member of either the medical or midwifery staff), students and instructors, volunteers, and applicable contracted service providers (including anyone providing services for AHS on behalf of an applicable contracted service provider) fully immunized against COVID-19 effective October 31, 2021. It made exceptions for employees unable to immunize due to a medical reason or for any protected ground under the *Alberta Human Rights Act*, to whom it promised

reasonable accommodation up to the point of undue hardship. Employees not in compliance were required to attend an educational meeting with AHS representatives. Those continuing in non-compliance were to be placed on an unpaid leave of absence ("ULoA") for the time required to become fully immunized. The September 14, 2021 Policy contained no provision for a worker continuing to remain unimmunized, though the implication is that the ULoA would thereby be indefinite.

5. AUPE started to receive the first grievances in anticipation of the Policy shortly after it was published.

6.. On October 22, 2021, the Employer amended the Policy (the "October 22, 2021 Policy") *(Exhibit 6)*, specifically section 1.2 which was the deadline for all Workers to be Fully Immunized (as defined by the Policy).

7. The October 22, 2021, Policy amendment extended the deadline for Employees to be fully immunized to November 30, 2021. AHS explains this extension as being necessary to allow contracted service providers and continuing care facilities to develop mitigation plans to deal with staffing concerns caused by the Policy, together with the then-current Delta variant "third wave" of the pandemic.

8. Pursuant to the *Regional Health Authorities Act ("RHAA")*, the Minister of Health can give the Employer directives and require the Employer to take certain actions.

9. On November 29, 2021, the Minister of Health, Hon. Jason Copping, directed AHS pursuant to sections 8 and 16(b) of the *RHAA* requiring AHS to allow a temporary option for rapid antigen testing to permit unimmunized Workers (as defined in the Policy) to attend at sites of "significant risk" of service disruption because of non-compliance with the Policy: *Exhibit 7.*

10. In response to the Directive, on November 29, 2021, AHS amended the policy by extending the deadline for Employees to be fully immunized to December 13, 2021 and

allowed unimmunized Employees working at a facility identified by the Employer as at a significant risk of service disruption to work due to non-compliance with the Policy, subject to temporary use of regular rapid antigen testing: *Exhibit 8.*

11. Commencing November 30, 2021, unimmunized Employees not working at an at-risk site and participating in a rapid antigen testing regime, started to be placed on their unpaid leaves of absence.

12. Grievances continued to arrive after activation of the unpaid leaves under the Policy.

13. On December 14, 2021, AHS further amended the policy, also in response to the November 29, 2021 Directive, by adding a section on the temporary use of rapid antigen testing for unimmunized contracted service providers (i.e., non-Employees) at sites at significant risk of service disruption: *Exhibit 9.* Sites at significant risk of service disruption were to be identified by the Vice-President and Chief Operating Officer, Clinical Operations, from time to time.

14. In November 2021, the Omicron variant of COVID-19 was detected in southern Africa. The first Alberta case was identified in late November. By the end of December, the Omicron variant had displaced the Delta variant as the dominant variant virtually worldwide. Omicron is characterized by its sharply increased transmissibility and, as became clearer over time, its lesser average virulence. Omicron, however, still causes severe illness in an appreciable portion of infected hosts; and so, the much greater transmissibility threatened to greatly increase the infected population and threaten or overwhelm many jurisdictions' hospital capacity.

15. On December 23, 2021, and as a direct result of the risk imposed by the Omicron COVID-19 variant to Albertans, the Minister of Health, Hon. Jason Copping issued a further Directive pursuant to sections 8 and 16(b) of the *RHAA* to allow any AHS Workers (as defined in the Policy) who were unimmunized to return to the workplace

upon agreeing to participate in a temporary rapid COVID-19 testing program: *Exhibit 10.*

16. On December 28, 2021, AHS notified all unimmunized AHS employees in writing of the Directive and their eligibility to participate in a temporary rapid COVID-19 testing program commencing January 10, 2021.

17. In direct response to the December 23, 2021 Directive, on December 28, 2021, AHS renamed and amended their Policy, naming it Immunization and Testing of Workers for COVID-19 policy which also expanded the temporary regular rapid antigen testing option to all unimmunized Employees, allowing them to return to work if they selected the rapid testing option: *Exhibit 11*. The amended Policy specified a commencement date of January 10, 2022 for employees returning to work through the temporary rapid antigen testing program. Some 200 AHS employees had agreed to participate by January 10, 2021. Employees bore responsibility to arrange and pay for the temporary testing.

18. On February 4, 2022, with hundreds of grievances filed, AHS made its application to the Labour Relations Board to marshal the grievances into a single process under s. 67.1 of the *Labour Relations Code*.

19. On February 8, 2022, AHS still further amended the policy to provide an exception to the temporary rapid testing option, for unimmunized Employees who tested positive for COVID-19 and permitted them to work for a period of 21 days before being required to resume rapid testing as a result of false positives: *Exhibit 12.*

20. On February 22, 2022, AUPE responded to AHS' marshalling application. The Union opposed the application as being unsuitable to an array of grievances allegedly characterized by such disparate factual circumstances. On March 16, 2022, the Board issued its Decision establishing the arbitration process that led to this mediation as earlier described.

21. Meanwhile, on March 7, 2022, the Minister of Health issued a Directive requiring AHS to amend its policy to permit current Workers (as defined in the Policy) who were not fully immunized to return to work without immunization or testing requirements: *Exhibit 13.*

22. On March 16, 2022, AHS amended its policy as a result of the March 7, 2022 Directive by lifting the immunization and testing requirement for existing unimmunized Employees currently on LOAs and allowed those on leave of absence to return to the workplace: *Exhibit 14.*

23. In accordance with March 16, 2022 Policy, prospective employees must be fully immunized in order to work for AHS. The Policy will be reviewed regularly and at least by March 31, 2023.

24. On or prior to March 11, 2022, AHS notified all unimmunized AHS employees in writing of the March 7, 2022 Directive and their ability to return to work on or before March 31, 2022. Since then, no vaccine mandate has been in force with respect to existing employees. The Policy continues in force with respect to new hires, who must be vaccinated.

[14] By these facts there existed a period of approximately three and a half months — from November 30, 2021 (later extended to December 13, 2021) to March 31, 2022, when unvaccinated Employees could have been absent from work and without income unless they had participated in either the narrow or broad rapid antigen testing program permitted by the successive Policy amendments mandated by the Minister of Health's directives. Practically, however, and as the Union acknowledges, it is harder for the Union to prosecute grievances for loss of income after January 10, 2022, when the Policy was amended to permit unvaccinated Employees to return to work upon participation in a rapid antigen testing program. At that point, the loss of income imposed by the Policy became avoidable without the employee submitting to vaccination. Accordingly, this Report proceeds on the assumption that for the great majority of

the Grievances, the amount of lost income in dispute would not exceed approximately four weeks of wages (i.e., from December 13, 2021, to January 10, 2022).

[15] To these facts are added the following provisional facts, "provisional" because they emerged in counsel's representations or the informal "testimony" of the discussants in the oral hearing. These facts were not contested at the time; it is assumed for purposes of this Report that they would be testified to in a grievance arbitration and tested by cross-examination then.

1. Leading up to the introduction of the Mandatory Vaccination Policy, AHS management had staff vaccination data from voluntary reporting. Though higher than the general population, they considered the vaccination rate still too low.

2. Estimates from an undisclosed point in time were that approximately 23% of staff COVID-19 cases were communicated in the workplace, and confirmed exposures among AHS workers numbered almost 3,500.

3. AHS executive managers in August 2021 considered three options: status quo without a vaccine mandate; rapid testing in lieu of vaccination; and mandatory vaccination. It was considered that status quo was undesirable. Factors identified, besides the current infection numbers, included a perceived danger of validating vaccine hesitancy among the public at large, and perceived inaction by AHS in the face of vaccine mandates adopted by many other jurisdictions and corporations. Rapid antigen testing was rejected because of logistical challenges and the relative inaccuracy of rapid testing. Logistical factors identified included who would deliver the testing, how often, at whose cost, and how to track results. Of accuracy, AHS operated on the understanding that about 30% of positive tests would be false positives requiring the employee to isolate; while up to 40-50% of negative results were likely to be false negatives, thereby placing patients and employees at risk. Mandatory immunization was considered to carry other benefits: it could be implemented without amending the *Public Health Act* and quickly updated as required; it demonstrated AHS leadership; and could be implemented quickly to respond to the current urgency.

4. "Wave 3" of COVID-19, driven mainly by the Delta variant, peaked in late September 2021, with more than 1100 COVID-19 patients in Alberta hospitals.

5. As of October 7, 2021, and with a disclosure deadline of October 30, 2021 in force, 62.01% of AHS employees had confirmed a full course of COVID-19 vaccination.

6. The first government directive to implement rapid testing as an alternative to immunization at sites identified as at risk of service disruption was given November 29, 2021. Rapid testing became available on December 13, 2021. At that time, 16 sites were identified as at-risk and about 260 employees there became eligible. At-risk sites were spread unevenly across Alberta. They tended to be smaller sites in remote areas where vaccine hesitancy was generally stronger, where internal redeployment had been exhausted and there was not a large local labour pool to tap.

7. At the time of the December 2021 amendment to permit rapid testing, 97.3% of AHS employees overall had received a full course of vaccinations. This left approximately 4000 AHS employees undisclosed and potentially non-immunized.

[16] AUPE also provided information about its experience in receiving member inquiries and filing grievances on their behalf. Steve Cowtan, AUPE Membership Services Officer at Edmonton's Royal Alexandra Hospital, outlined three grievances for purposes of illustration. Without detailing these, the Union's point in discussing their grievances was to show that the grievors cannot be caricatured as a solid group of vaccine deniers, impervious to science and considerations of public safety. They came to their hesitancy, in its submission, by various routes, different life experiences and family dynamics, and sometimes under the unfortunate influence of social media, which (these are my words) has uniquely in this pandemic divided the population and created "communities" of the vaccine-hesitant who recruit and reinforce each other with misinformation. The Union's message in this is clear: though the Union is on the record as strongly supporting vaccination against COVID-19 among its members, the Employer should have been more attuned and empathetic to the human frailties exposed by the vaccination

program, and to the human costs of the Mandatory Vaccination Policy; and should have chosen a less draconian and harmful policy approach than it did.

## III. Positions

[17] This summary of the parties' positions is not exhaustive of the detailed written briefs provided. It merely acknowledges the main thrust of their respective arguments.

[18] The Union's written submissions do not attack the basic Policy objectives of maximizing the number of vaccinated AHS employees and protecting patients, employees and the public at large to the highest possible degree. Its criticisms are that the Policy was unnecessarily strict, arbitrary and inconsistent in its implementation, and imposed disproportionate burdens on those who declined to be vaccinated. It points to the seeming disconnect in applying a harsh, "binary" choice to vaccinate or not, enforced by loss of income, upon health care workers who up to then hand been lionized in the public discourse as "heroes".

[19] The first broad aspect of the Union's criticism is that the Policy was unreasonable because it did not offer employees a COVID-19 testing alternative. It says that both rapid antigen tests and the slower but more accurate polymerase chain reaction (PCR) tests were reasonable alternative means to control COVID-19 in health care facilities without enforcing a vaccine mandate. It points to the fact that Canada's two largest provinces, Ontario and Quebec, among others, never went so far as to impose a mandatory vaccination policy without a testing alternative in their health care systems. It notes that the Alberta government allowed a testing alternative to vaccination for its own direct employees in the public service. Vaccination with a testing alternative, it says, became the consensus position in Canada to which even AHS eventually acceded. The positive proof of the unreasonableness of the original Policy, in its submission, is the fact that AHS, mandated by the Alberta government, eventually allowed a testing alternative to vaccination, first among employees at sites "at risk", and then across the entire workforce.

[20] The second broad thrust of the Union's criticism is that there was inconsistency and arbitrariness in AHS' approach that made it unreasonable. It notes first that AHS' own statistics established that a "relatively insignificant" number of employees (771) were conclusively proven to have contracted COVID-19 through occupational exposure. Second, it alleges (and would presumably lead evidence to establish) that even after introduction of the Policy, there were cases of asymptomatic workers being called to work after testing positive to meet debilitating staff shortages. It similarly says there were instances of unvaccinated employees being tested when the Policy made no such provision, to deal with a staff shortage.

[21] The Union makes strong criticism of the fact that the Policy was applied to employees who had been allowed to work from home and so posed no threat to colleagues, patients or the public. Equally, it criticizes the fact that AHS never tried to apply a vaccination requirement to the "thousands" of visitors and members of the public who attended at AHS facilities any given day. It says, "this inexplicable inconsistency added to the confusion, skepticism and general sense of unfairness felt by many Union members". The perceived unfairness, the Union notes, was only exacerbated when AHS policy changed and employees learned that their unvaccinated colleagues at sites at risk of service disruption could work without vaccination, while others were deprived of income.

[22] Finally, the Union argues that if one analyzes AHS' vaccination policy through the lens of the *KVP* case (*Lumber & Sawmill Workers' Union, Local 2537 v. KVP Co. Ltd.,* [1965] OLAA No. 2 (Ont., Robinson) and the long line of jurisprudence that follows it (in particular, the judgment of the Supreme Court of Canada in *Communications, Energy and Paperworkers Union of Canada, Local 30 v. Irving Pulp & Paper, Limited*, 2013 SCC 34), the Policy is not a proper application of management rights. Altogether aside from the unreasonableness of the failure to offer a testing alternative for employees, a reasonable employer rule under *KVP* demands "unequivocal clarity and consistency of application". The Union says (though this is yet unproven) that there was inconsistency in application of the Policy, that it was sometimes ignored, and especially where staffing problems occurred.

[23] AHS argues that the Policy was at its introduction in September 2021 a reasonable balancing of its and its employees' rights. It says that it was consistent with its statutory and collective agreement obligations to maintain a safe workplace and its need to prevent infection among both its patients and its workforce. Placing unimmunized employees on unpaid leave was not, it says, a disciplinary measure, but enforcement of a requirement that employees be fit for work. It argues that the Policy was proportionate and appropriately nuanced, as it made allowances for *bona fide* medical and religious exemptions. Further, it argues that the case law on mandatory immunization policies "almost unanimously" finds them to be reasonable, and the same result should apply here.

[24] AHS submits that the Policy reasonably excluded an alternative of rapid antigen testing, on grounds that it does not reduce transmission; it is easily subverted; it is insufficient to give confidence if too infrequent, and impractical at the daily frequency that would be required; it imposes logistical burdens, including unpredictability of scheduling, upon front line operations; and, if paid by employees, would impose financial burdens and possible inequities among employees according to their means. Nor, it says, could PCR testing be adopted as an alternative without imposing unacceptably high costs upon the Employer.

[25] It was an ongoing theme in AHS's submissions that the changed circumstances it faced from time to time were fundamental to the reasonableness of its Mandatory Vaccination Policy as it developed during this time. Changes to the Policy adopted under changed circumstances do not demonstrate its unreasonableness as originally framed. AHS argued that the Policy was responsive to Alberta conditions at specific points in time, and that the reasonableness of the Policy cannot be judged by how other Canadian governments responded to conditions in their own jurisdictions, and at other times. It further argued that the Ministerial Directives requiring amendments to the Policy did not make the Policy unreasonable. It says that the Directives were explicitly aimed at avoiding service disruptions; they were thus exercises in balancing AHS's obligations to protect patients, workers and the public with the government's broader obligation to ensure delivery of health services to all Albertans. In any event, the December 23, 2021 Directive offering rapid antigen testing to all unvaccinated employees was made in the face of

changed circumstances, namely the reaching of over 95% vaccination rates among AHS employees and the resulting "herd immunity" effect that is important to immunization strategies.

## IV. Analysis

[26] To restate, my task is to express an opinion on the two questions posed by the parties:

1. Was the Employer's issuance of its Immunization of Workers for COVID-19 policy effective September 14, 2021, reasonable in the circumstances?

2. What is the impact of the Ministerial Directives issued on November 29 and December 23, 2021, and on March 7, 2022, and the resulting amendments to the Immunization of Workers for COVID-19 policy?

[27] I have reached the following conclusions in respect of the questions posed:

1. The Policy of September 14, 2021, was reasonable in the circumstances, with the sole exception that it *may* have overreached in its application to workers working exclusively from home, and with no reasonable expectation of being recalled to in-person duties. Whether any such workers existed, whether there was a reasonable expectation of recall in any individual case, whether there were feasibility or hardship justifications for applying the Policy to them, and whether any suffered loss, are unknown on the information before me. These are issues for the parties to further discuss and, if necessary, litigate.

2. If the Policy was unreasonable in respect of such workers, the issue is a severable one and the overall reasonableness of the Policy is not affected.

3. The Ministerial Directives and resulting amendments to the Policy had no impact on the reasonableness and consequent validity of the Policy of September 14, 2021. In particular, they did not render the Policy retrospectively unreasonable.

## A. Question 1: Reasonableness of the Policy

[28] In addressing the parties' first question, we may start from some propositions that are uncontested, or are matters of judicial or consensus arbitral precedent, or are so notoriously true that they are overwhelmingly likely to be accepted by any arbitrator.

[29] The COVID-19 vaccines approved for use in Canada are highly effective at preventing severe outcomes in infected persons. They have a less remarkable, but still very significant impact, in reducing transmission of the virus by reducing the viral load and consequent shedding of viral particles. See, e.g., *Sembaliuk v. Sembaliuk,* 2022 ABQB 62; and the summary of the expert evidence of Dr. Mark Loeb recited in *Canada Post Corporation v. CUPW (National Mandatory Vaccination Practice)* (Canada, Jolliffe, April 27, 2022) at paras. 40*ff.* The efficacy of vaccination in preventing transmission is less for the Omicron variant than for previous variants.

[30] Serious health risks of vaccination with the COVID-19 vaccines are extremely rare.

[31] AHS is under a statutory obligation in the *Occupational Health and Safety Act* to maintain a safe workplace. The *OHSA* obligation is incorporated into the parties' collective agreements as a work-related statutory norm, as per the judgment of the Supreme Court of Canada in *Parry Sound (Parry Sound (District) Social Services Administration Board v. OPSEU, Loc. 324*, 2003 SCC 42*)*. AHS is also under a duty of care to its patients, as are its physicians and other health care professionals who operate under ethical obligations to do no harm to their patients.

[32] Health care facilities are occupied in substantial proportion by persons vulnerable to respiratory viral infections like COVID-19. Naturally, while there, they are living in enclosed areas, where transmission rates are higher.

[33] Accordingly, health care facilities are among the most risk-averse workplaces among which the reasonableness of infection control measures is to be assessed.

[34] To these points may be added the following. These are facts and observations drawn from the COVID-19 arbitral jurisprudence provided.

[35] A rapid antigen test (RAT) detects significant viral loads. It does not detect mere presence of the virus in the host. It is therefore a test for infectiousness, and then not in all hosts because "there if no reference standard for infectiousness": Expert evidence of Dr. Mark Loeb, recited and accepted in *Toronto Public School Board v. CUPE, Loc. 4400 (Re: PR734 COVID-19 Vaccine Procedure)* (Ontario, Kaplan, March 22, 2022). RATs do not directly reduce transmission in workplaces or other settings: *id.*

[36] RAT accuracy is highly variable when used by asymptomatic individuals. Accuracy of RATs can be compromised, either by incorrect swabbing or by intentional non-compliance: *id.* Though specific measures of the accuracy of RATs, whether by false negative or false positive results, is a matter for evidence, I am prepared to accept that the measure of inaccuracy is significant, especially for the Omicron variant. See *id.* at pp. 28-29.

[37] Next, one must note some important analytical principles. First, the parties are agreed (or at least no dissent has been expressed) that the Mandatory Vaccination Policy is an application of the Employer's power to make workplace rules outside the express terms of the applicable collective agreement, and is grievable by the Union through application of the *KVP* analysis, *supra*. For our purposes, the key elements of the *KVP* analysis are the requirements that the rule be reasonable; and that it be enforced consistently.

[38] Second, I acknowledge and agree with the applicability of what has been termed the "precautionary principle" used to assess the reasonableness of employer rules on health and safety in the workplace. The thrust of the principle is that employers are under an obligation to take all reasonable precautions available to protect the safety of their employees, even if scientific knowledge cannot predict with certainty the degree of risk present, or the efficacy of

the measures taken. The principle is put this way in *Power Workers' Union v. Elexicon Energy Inc.* (2022 CarswellOnt 1223, Mitchell, January 14, 2022), quoting *Ontario Nurses Association v. Eatonville/Henley Place*, 2020 ONSC 2467 (CanLII):

> [the] precautionary principle which justifies that action be taken to protect employees where health and safety are threatened "even if it cannot be established with scientific certainty that there is a cause and effect relationship between the activity and the harm. The entire point is to take precautions against the as yet unknown" (…)

[39] Third, a dynamic view must be taken of what is "reasonable" in an employer's response to a safety risk. In my opinion, it is fundamental to the assessment of the reasonableness of the Mandatory Vaccination Policy that reasonableness can change over time as the factual context within which the Policy operates, changes. What may be an unreasonable policy can become a reasonable one, and vice versa, depending upon facts like the characteristics of the then-dominant variant of the virus; the current rates of infection, hospitalization and severe outcomes; vaccination rates in the workforce and the resultant risk of occupational infection; and the employer's ability to absorb absenteeism from time to time and location to location.

[40] Finally, one must proceed in this enquiry with a proper respect for science and the enormity of the challenge COVID-19 posed to policy makers. The Union, for example, at one point in its submissions refers to the Policy as an exercise in "guesswork". With respect, and however deeply some members may have felt this, this is an overstatement. Just about any workplace policy adopted to deal prospectively with a global pandemic caused by a novel virus will involve some uncertainty as to its efficacy, costs and benefits. If to some extent the Policy could be said to rest on "guesswork", it is important to acknowledge that it was informed guesswork based on accepted epidemiological principles and the policy-makers' best understanding of the evolving scientific evidence. The precautionary principle enunciated in the case law is relevant when dealing with unknown risks like this.

[41] With these things in mind, and considering the jurisprudence supplied by the parties, I would conclude first, that the Mandatory Vaccination Policy was reasonable in its inception, in October 2022. The first aspect of reasonableness to test the Policy for, is whether it was

responsive to an objective need of the Employer. This test is easily met. From the outset of the pandemic, both AHS practices and broader public health policy had pursued the goal of protecting the health care system from being overwhelmed by the numbers of severely ill patients. AHS was at that time facing a surge in hospitalizations and ICU admissions associated with the Delta variant of COVID-19, already much more transmissible than the original "wild" strain of COVID-19. Further, it faced caring for these patients with a workforce that, in September 2022, exhibited what I must call a distressingly low level of full vaccination of approximately 62%. There had been a significant incidence of verified occupational transmission of COVID-19 within facilities (I consider the stated number of 771 cases to be significant); and the percentage of staff COVID-19 cases attributable to occupational exposure recorded (about 23%) almost certainly greatly understates the actual impact of COVID-19 in these facilities because it only counts cases not in doubt. AHS had every reason to consider these things to pose an unacceptable level of risk to both patients and its other employees and to look for solutions that it had power to impose.

[42] A second aspect of reasonableness to test for is the presence of alternatives that would still meet AHS' valid goal. In this part of the analysis, I consider that no proffered alternative would have met the goals of minimizing infection risk and protecting access to the health care system nearly as well as the Policy. The scientific evidence, as recognized repeatedly in the COVID-19 case law, is that mass vaccination is the single best tool for reducing the spread of the virus. Comparatively, testing takes a poor second place. It does not directly prevent transmission or limit the severity of the disease if contracted, as vaccination does. It can assist in reducing the spread by allowing the employer to remove contagious employees from the workplace, but at significant cost in money and (more importantly) unavailable personnel who test positive and must isolate.

[43] AHS management's initial rejection of an alternative to the Mandatory Vaccination Policy utilizing rapid antigen testing was explained by AHS discussant Dr. Mircea Fagaranasu, in terms that I consider reasonable and would likely be so found at arbitration. It is clear that RAT does not prevent transmission of COVID-19, but only identifies the period of highest viral load in the subject. The case law speaks of the inability of RAT to consistently detect COVID-

19 for a period of infectiousness before the threshold viral load, meaning infected employees will tend to still be present in the workplace for a time under an RAT regime. The logistical difficulties of administering RAT among large numbers of employees dispersed across many sites, as articulated by Dr. Fagaranasu, were significant. Finally on this point, the facts articulated before me speak of significant levels of false results with RATs. False negatives carry the obvious risk of allowing an infected employee to circulate in the workplace until, at least, their next test. False positives are damaging in a different way of forcing a healthy employee to isolate at a time when all able-bodied employees may be needed.

[44] The Union did not strongly develop an alternative submission that the Employer could have implemented a regime of testing using polymerase chain reaction (PCR) testing. The Employer in its argument maintained that PCR testing is so comparatively expensive that it would impose undue hardship; the Union asserted that PCR tests had been offered as cheaply as $30 per test by commercial vendors and would be even cheaper if administered "in house" by AHS using its greater buying power and internal resources. I am prepared to take notice that PCR testing is substantially more expensive than rapid antigen testing, though the actual extent of the difference is a matter that would have to be established by evidence. More important, however, is that PCR testing foregoes the rapidity and ease of self-administration that are the chief advantages of rapid antigen testing. PCR testing requires more time, and sophisticated laboratory equipment, to produce a result. Time is of the essence when trying to staff hospitals amidst a surge of COVID-19. Sophisticated laboratory equipment is in limited supply. I am therefore not persuaded of the assertion that PCR testing could have furnished a viable alternative to vaccination, especially in a workforce that (in October 2021) might have had upwards of 30% of its members less than fully vaccinated and requiring frequent testing. For purposes of this Report, I decline to consider PCR testing a plausible alternative to the Policy.

[45] The Union's argument that the unreasonableness of the Policy is demonstrated by the refusal of authorities in Ontario and Quebec to adopt a mandatory vaccination policy that did not offer rapid antigen testing as an alternative, is in my opinion not persuasive without a much more fulsome and searching analysis of the conditions facing health care authorities in those provinces during the pandemic. Just as reasonableness of an employer policy must be assessed from time

to time, it must be assessed place to place. One important fact, for example, can be taken notice of: vaccination rates among the general public in Ontario and Quebec were at almost every stage of vaccination rollout higher than in Alberta, generally by a margin in the range of five to ten per cent. One would expect vaccination rates among health care workers to also differ among the provinces. It is in my view a strong possibility that Ontario and Quebec health care workers were similarly more comprehensively vaccinated than their Alberta counterparts and more closely approaching the ideal of herd immunity. Another point of likely factual difference among provinces is the level of health care resources – like hospital beds, ICU beds, and trained workers – available from time to time during the Delta and Omicron waves of COVID-19. If, for example, Ontario or Quebec facilities tended to operate with smaller pools of labour than their Alberta counterparts, and smaller reserves of, say, ICU beds per unit of population, it might go far to explain why authorities there would opt to keep as many employees working and beds open as possible.

[46] I do not find these considerations as facts, but cite them only to illustrate that there may be many reasons why a public health policy might be reasonable if adopted by health care authorities in one part of Canada but unreasonable in another; or, more likely, that different policies may all be reasonable considering the circumstances prevailing in the different provinces. In my view, an arbitrator would be unwilling to place weight on the differing policy responses adopted, without some evidentiary assurance that the situations in the comparator provinces were at that time quite similar to those in Alberta. Even so, such evidence might be of limited assistance when it is remembered that reasonableness is not a point, but a continuum, and more than one reasonable response can exist even to identical circumstances.

[47] Similarly, the Union's reliance on the experience of its members in the Alberta public service, who were allowed to work unvaccinated if participating in an approved testing regime, is not persuasive. Few members of the public service would have worked in close contact with highly vulnerable populations like their health care colleagues. Many more than in health care could be allowed to work from home. The risk profile in public service workplaces is, even on a superficial analysis, likely to be so different from health care facilities that the existence of different vaccination policies carries no significant weight.

[48] The third aspect of reasonableness to test for is whether the Policy as initially constructed was minimally intrusive of employees' rights and interests. This is something subtly different than the analysis of alternative means above. The focus is on whether the Policy was overbroad in its application, or unnecessarily harsh in its effects.

[49] Overbreadth raises the issue of the Policy's application to employees working from home. This is addressed separately below.

[50] As to whether the Policy was unnecessarily harsh in its effects, it cannot be denied that it posed a stark choice to employees who had not yet been fully vaccinated: get vaccinated, or be placed on leave and lose your income. Unquestionably, this is a harsh result that would have gone down badly among vaccine-hesitant employees. Case law is replete with passages emphasizing the importance of work, not just in the obvious sense of furnishing necessary income, but in realizing the self-worth of people in the workforce. To be deprived of work and income over a choice about a medical procedure that one feels deeply about, is certain to cause fear and resentment. See, for example, *PWU v. Elexicon, supra,* at para. 92.

[51] Yet, one must be careful to not overstate the severity of the Policy either. Though the Union sometimes refers to the consequences of failure to comply with the Policy as "loss of livelihood", this is not entirely so. Unlike some vaccination policies adopted elsewhere and in other industries, the employees were not terminated. Such a course would almost certainly have been disproportionate. Instead, employees were placed on unpaid leave of absence until they could establish compliance with the Policy (or, as it turned out, until the Policy was abandoned). Rather than permanent loss of livelihood, they suffered indefinite but temporary loss of income, for a length of time within their control.

[52] And further, it must be asked: once the need for mandatory vaccination had been decided upon, what else could have been done to make the Policy effective? There apparently had to be some form of economic measure employed to cajole or compel employees to get fully vaccinated within a reasonable time frame. Education and moral suasion to that point does not seem to have

worked. A full course of vaccines had been available for six months and more by October 2021, yet a scant 62% of AHS employees, among whom one would expect enthusiastic uptake, were then fully vaccinated. It is a reasonable inference that the sanction of unpaid leave turned out to be extremely successful. Directly, or indirectly by demonstrating the Employer's resolve, it appears to have helped bring the overall level of fully vaccinated employees to 97% by December 2021. By rough arithmetic, the ratio of employees becoming fully vaccinated after introduction of the Policy (97% - 62% = 35%) to those remaining non-compliant (3%) exceeded 10:1. There is no sanction of lesser severity apparent that might have produced such results, and none was offered in argument. Severe as the sanction of unpaid leave may have been, it was in my opinion a proportionate one.

[53] The Policy as initially implemented, then, passes scrutiny: it was responsive to a real operational need, there were no alternatives of equal or superior efficacy, and it was proportionate in its sanction. The Policy in its inception was reasonable, with the possible exception of overbreadth as it applied to employees working from home (again, addressed below).

[54] This conclusion is also the one supported by the arbitral jurisprudence. Of the precedents supplied, I find the most persuasive to be *CUPE, Loc. 5500 v. Toronto Public School Board (Re: PR734 COVID-19 Vaccine Procedure)* (Kaplan, 22 March 2022). It is persuasive because (a) it was decided after the onset of the highly contagious Omicron variant; (b) it analyzed a very similar mandatory vaccination policy; (c) it involved a high-risk setting, schools, where there was a significant vulnerable population (unvaccinated students, somewhat analogous to patients in facilities); and (d) it recited and evaluated expert evidence focused on the major point of this mediation, whether the employer was obliged to offer a testing alternative to the mandatory vaccination policy. Arbitrator Kaplan preferred the evidence of the Employer's expert witness to the effect that testing was a complementary tool, but not an effective alternative, to mandatory vaccination in the schools setting. He found that the policy did not contravene the *Canadian Charter of Rights and Freedoms,* nor was it an unreasonable management rule according to the *KVP* analysis.

[55] I also find support for the result in this case in Arbitrator Jolliffe's award in *Canada Post Corp. v. CUPW (National Mandatory Vaccination Practice), supra*. Though the facts of the *Canada Post* case lacked the feature of a peculiarly vulnerable population in the workplace that existed in *Toronto Public School Board*, the arbitrator there too evaluated conflicting expert evidence and accepted the evidence of the Employer's expert that rapid antigen testing was not an effective alternative to a mandatory vaccination policy. The review of expert evidence in both cases is instructive, and establishes to my satisfaction that this is the likely result of any contest of expert evidence that might be offered in this case, were it to proceed to a litigated conclusion.

[56] Other cases supportive of the Employer's position include *UNIFOR, Loc. 973 v. Coca-Coca Bottling Co.* (Ont., Wright, March 9, 2022) (mandatory vaccination policy among employees of a beverage bottling plant reasonable; rapid antigen testing not a suitable alternative); *Wilfred Laurier University* (Ont., Wright, July 22, 2022) (university's removal of a statutorily-permitted rapid testing alternative to a mandatory vaccination policy was reasonable); *Chartwell Housing REIT v. Healthcare, Office and Professional Employees Union, Local 2220* (mandatory vaccination policy without a testing alternative found reasonable after automatic termination for non-compliance removed from policy); and *Bunge Hamilton Canada Ltd.* (Ont., Herman, January 4, 2022) (mandatory vaccination policy for employees of oilseed processing facility that excluded a rapid antigen testing alternative was reasonable).

[57] By contrast, the case precedents advanced in favour of the Union's position are not persuasive because they are distinguishable. The most favourable case is the award in *Electrical Safety Authority v. Power Workers' Union* (Ontario, Stout, 11 November 2021), which applied the *KVP* analysis and found the employer's mandatory vaccination policy unreasonable in so far as it allowed employees to be disciplined, discharged, or placed on unpaid leave for failure to become fully vaccinated. Aside, however, from the fact that the case was decided before the Omicron variant had been identified in Canada, it is readily distinguishable for several reasons. It dealt with employees in the electrical safety industry, who mostly worked outdoors or remotely and away from sustained physical contact with others. There was evidence that 88% of all employees, and over 90% in the Operations positions, had been vaccinated. And there was evidence that the Employer had not had a single COVID-19 outbreak using its regime of

voluntary vaccination augmented by testing. In that factual context, the arbitrator found a mandatory vaccination policy unreasonable.

[58] Even then, the arbitrator acknowledged a couple of points that factor in the analysis of the present case. First, that scrutiny of an employer rule for reasonableness is a dynamic exercise that must account for the circumstances present at the time:

> [19] It must also be noted that the circumstances at play may not always be static. The one thing we have all learned about this pandemic is that the situation is fluid and continuing to evolve. What may have been unreasonable at one point in time is no longer unreasonable at a later point in time and vice versa.

Second, the arbitrator recognized the importance of the workplace context in terms that almost invite the contrary conclusion in industries like health care and education:

> [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.

[59] In the case of *CKF Inc. v. Teamsters, Loc. 213 (COVID Testing Policy Grievance)* (B.C., Saunders, January 28, 2022) cited by the Union, the issue was the reasonableness of an employer rule that unvaccinated employees submit to regular rapid antigen testing. The employer operated a manufacturing facility. The Union took the position that this was an unwarranted and excessive intrusion on employees' personal integrity. The arbitrator upheld the testing requirement as reasonable. But, and leaving aside the problem that *CKF Inc.* is not a health care case, the case does not stand for any conclusion about whether a workplace vaccination policy that *excludes* a testing alternative is reasonable.

[60] The same is true of *Caressant Care Nursing and Retirement Homes and CLAC*, 321 L.A.C. (4th) 235 (Ont., Randall). There, a requirement of regular testing amongst workers in a resident care home was considered to be reasonable. But not only did the case not address the

reasonableness of a vaccination policy, it could not: the award (December 9, 2020) pre-dates the mass rollout of COVID-19 vaccines in Canada.

[61] Finally, the Union's case of *Ellis Don Construction Ltd. et al. v. Labourers, Loc. 183 (Rapid Testing Grievance)*, 2021 O.L.A.A. No. 33 (Ont., Kitchen, June 10, 2021) again deals with an employer requirement of periodic rapid testing, there in the construction industry. Mandatory vaccination, with or without a testing alternative, was not under discussion. Once more, while the case finds testing to be a useful and reasonable course in the circumstances of that industry and time, it does not assist in determining whether it is such an effective alternative to mandatory vaccination that the latter is rendered unreasonable.

[62] Accordingly, I come to the opinion that AHS's Mandatory Vaccination Policy was in general terms a reasonable one when initially adopted in September 2021. The sole possible reservation to this opinion concerns employees who were working from home when subjected to the Policy. The Union placed significant weight on the Policy's application to these employees as demonstrating the overall unreasonableness of the Policy. It criticizes what it calls the "absurdity" of requiring employees working from home to vaccinate when AHS refused or failed to control access to hospital facilities by unvaccinated members of the public.

[63] I am unable to agree with this latter aspect of the Union's submission. Among its employees, AHS could bring about the desired result – minimizing contact between COVID-19 carriers and patients and other staff – by using its management rights to impose a workplace policy backed by a sanction of unpaid leave, subject to the *KVP* analysis. It had no comparable power with respect to the public. I am prepared to take notice that vaccination screening more intrusive than the normal self-reporting at the entrance to a facility would have been logistically difficult, and rapid testing of hospital visitors would have been both logistically difficult and expensive, to an extreme. Even if undertaken, these measures could only be enforced by a policy of exclusion of members of the public from seeing and assisting their sick loved ones in hospitals and care facilities. I believe that this option was so draconian and (small "p") politically unpalatable as to be impossible of serious consideration by AHS policy makers: some of the most wrenching stories of the first wave of the COVID-19 pandemic concerned family members

barred from seeing their gravely ill relatives in hospital. Employees agitated about AHS's failure to enforce a vaccination mandate against members of the public are urged to follow the advice of Voltaire, to "not let the perfect be the enemy of the good"; a policy is not unreasonable because it does not include all possible measures to minimize risk, so long as it has a beneficial effect to the extent it goes.

[64] That said, one cannot dismiss out of hand the criticism that the Policy was overbroad by being applied to employees working from home. AHS in its submissions justifies this aspect of the Policy as follows:

> 11. (…) AHS made the decision to implement the Policy on a consistent basis among all employees, including those who work remotely, on the understanding that they would be required to return to AHS facilities in the future and or on occasion for workplace meetings. Many of the employees who were working remotely during the height of COVID-19 have now returned to in-office work.

In its Reply brief, AHS adds this:

> 22. The Union's position that the Policy was unreasonable in that it applied to remote workers fails to recognize the contingency requirements AHS had to have in place. The uninterrupted provision of essential health services was the paramount interest, and vaccination of all workers was required for the worst possibility of redeployment to sites if necessary.

[65] These submissions have some plausibility, but by themselves are in my opinion not persuasive without additional evidence. Working remotely eliminates the employee's contact with patients and other staff. *Prima facie,* it is a complete answer to the problem of managing COVID-19 risk, provided it is operationally feasible and does not impose undue hardship upon the Employer. I am unable on the materials submitted to express an opinion on whether there are feasibility limitations or considerations of hardship that would justify extension of the Policy to these employees. It is expected that the answer would probably vary between employee classes or among individual employees. Some employees, especially regulated health care professionals, might have to return to the workplace on short notice to meet staffing or other

operational issues. Others might have to return to the workplace at some point, but their return might be predictable sufficiently far in advance to enforce a vaccination mandate only at the point of return. Others might have expected to not return until the COVID-19 risk had receded to an acceptable level. I am not convinced that all work-from-home employees were so at risk of sudden call-in or redeployment that application of the Policy to them can be justified by a blanket explanation of "contingency requirements".

[66] It is possible that contingency, feasibility and hardship considerations exist that would justify *in toto* the application of the Policy to work-from-home employees. But the materials in the record before me do not establish that, and it would be the Employer's onus to establish those considerations to justify extension of the Policy to these employees. I hasten to note that there is no criticism of the parties for the lack of information put before me concerning the work-from-home employees. They were a (probably small) sub-category of employees filing grievances, whose importance to the overall result may not have been clear until preparation of the parties' written submissions.

[67] However, even if extension of the Policy to some work-from-home employees is unreasonable and unjustified, this in my opinion does not render the Policy unreasonable in its application to the main body of employees, who did not work from home. The situation of the work-from-home employees is, and in principle should be, severable from that of others. It would be a regrettable and unjustified example of bootstrapping to allow work-in-facility employees to avoid compliance with the Policy just because it may have overreached against their work-at-home colleagues. The Grievances in this case are filed as separate individual grievances. As they assert discrete circumstances for each of the affected employees, so too can the Employer assert discrete reasons why individual work-from-home employees should still have been required to comply with the Policy.

[68] It follows that, to the extent there are work-from-home employees who filed grievances, and who lost income by being placed on unpaid leave of absence, the proper result *may* – with emphasis on the conditional – be different than for employees in the main body. How this affects a recommended resolution will be discussed presently. The starting point, however, is

that the onus will be on the Union to assess the filed grievances and determine whether there are work-from-home employees among them, whether they were actually placed on an unpaid leave, and whether their circumstances warrant pressing the grievance.

[69] There remains to discuss one other aspect of the analysis of the initial validity of the Policy beyond its reasonableness. The *KVP* analysis considers that an employer rule formulated as an application of management rights, i.e., one unsupported by a specific term of the collective agreement, must be "unequivocally clear and consistent in its application". The clarity of this Policy is not in issue, but its consistency of application is. As earlier noted, the Union says that it possesses anecdotal evidence that there were cases of asymptomatic employees called in to work during isolation (albeit, it admits, with a "scrupulous respect for safety protocols"). The Employer contests those allegations. It says that employees were not called to work except in compliance with the Policy and applicable Chief Medical Officer of Health orders. It offers an explanation that over time, those orders came to distinguish between vaccinated and unvaccinated employees in the length of the isolation period required following a positive COVID-19 test (five days and ten days, respectively). The implication is that the differential isolation periods may have been a source of confusion and misunderstanding among employees.

[70] I am unable to express any opinion on whether the Policy fails the *KVP* test of consistency of application on the materials presented to me. If the Union maintains this avenue of attack upon the Policy, it may have to be litigated. I offer a caution against doing so without serious consideration beforehand. The Union will have the onus to establish that the Policy was sometimes ignored by AHS. The Employer's explanation of the differing isolation periods prescribed for employees during the pandemic is, in my view, a plausible one that will place a secondary evidentiary onus on the Union to show that the facts of individual cases of inconsistent application of the Policy are not explained away by this phenomenon. Finally, I believe the Union would have to show more than a few, isolated incidents of employees being called in to work in violation of the Policy to undermine the overall validity of the Policy. In an organization as large as AHS, and a workforce so large as the affected bargaining units, I would be receptive to the argument that there is a *de minimis* exception to this aspect of the *KVP* analysis: i.e., the inconsistency of application must be of such significance that it cannot be

explained as an inconsequential aberration that must be expected when dealing with such large numbers of employees and their managers.

### B. Question 2: Impact of the Ministerial Directives

[71] We may now consider the second question put by the parties, as to what impact the government-mandated changes to the Mandatory Vaccination Policy had upon the reasonableness of the Policy. I have concluded that these changes did not render the Policy unreasonable, either retrospectively to their initial implementation, or at the times of change to the Policy. I reason as follows.

[72] AHS changed the Mandatory Vaccination Policy three times in response to directives given by the Minister of Health:

- November 29, 2021: The Minister directed that an exception to the Policy be made for unvaccinated workers at AHS sites identified as posing significant risk of service disruptions due to non-compliance with the Policy, who would be permitted to work if participating in a rapid antigen testing program. AHS amended the Policy twice to accomplish this, on November 29, 2021 for employees and on December 13, 2021 for contractors. In doing so, AHS also pushed back the deadline for employees to show they were fully vaccinated to December 13, 2021. These two amendments can conveniently be considered as one single response to the November 29, 2021 Ministerial directive.

- December 23, 2021: The Minister directed that the exception for unvaccinated workers at sites subject to risk of service disruption be expanded to all unvaccinated employees, who would be permitted to work if participating in a rapid antigen testing program. AHS amended the Policy accordingly on December 28, 2021.

- March 7, 2022: The Minister directed that all unvaccinated employees be permitted to work without vaccination or testing requirements, effectively ending application of the Policy to current employees. AHS amended the Policy accordingly on March 16, 2022.

[73] The Union strongly argues that these amendments to the Policy demonstrate the unreasonableness of the Policy as initially framed and bolster the case for rapid antigen testing as a reasonable alternative to the Policy. I am unable to accept that submission, for two related reasons. First, the amendments to the Policy were made at times of significant change in the circumstances of the pandemic and Alberta's response to it; second, the amendments were forced by directions given to AHS by government, which was entitled to make and enforce an analysis different from AHS as to what measures best served the overall public interest.

[74] This Report earlier expressed as fundamental concepts that the reasonableness of employer rules may consider the circumstances then present, and that the reasonableness of a rule can change over time as those circumstances change. These concepts are expressed regularly in the arbitral precedents submitted. The first Ministerial directive, of November 29, 2021, occurred early in the life of the Omicron variant of COVID-19, at approximately the time it was first identified in Alberta. At that time, it was known that Omicron was much more transmissible than previous variants. It was not known with certainty that it was, on average, less deadly than the then-current Delta variant. In addition, it could be expected that COVID-19 admissions to hospitals would increase in any event with the Canadian winter season. It was known that uptake of full vaccination among AHS employees had been at the disappointing level of some 60% in September. It was known, anecdotally at the least, that the distribution of fully vaccinated employees was skewed in favour of the larger urban facilities, and that vaccination rates were properly a matter of serious concern in some rural areas of Alberta.

[75] There was by late November, then, ample reason to fear that the coming Omicron variant would strike Alberta health care facilities at a time when not enough employees were yet fully vaccinated overall, and some rural facilities (where the labour pool was smaller anyway) were badly short of fully vaccinated workers. It would be logical, then, to fear that some facilities

could be at risk of "service disruption" – a euphemism for closure to new patients, cancellation of procedures, early discharges, and other undesirable health outcomes. This was a significantly different constellation of risk than AHS had to consider in September 2021, and one that could reasonably admit of different solutions than those favoured in September.

[76] Elected officials of government were by law entitled to make and enforce their own assessment of risk and the appropriate balance point between, for example, the risk of exposing patients to infection from unvaccinated employees, and the risk of having to turn away new patients from some facilities altogether. Whether the creation of an exception to the Policy for unvaccinated workers at some facilities was more reasonable than the original Policy, even in late November 2021, might be debatable, but the Alberta government was entitled to do it. Presumably it did so upon expert advice. That it did so in November in my opinion cannot logically amount to evidence that the Policy as adopted in September, when a significantly different set of facts existed, was unreasonable.

[77] The second Ministerial direction occurred on December 23, 2021. Again, circumstances had changed. The Omicron variant had displaced previous variants in Alberta and had proven every bit as contagious as feared, driving up hospitalization rates to near or over capacity. Importantly, though, there were strong indications by then that the Omicron variant tended to attack different areas of the respiratory tract than previous variants, and was overall less deadly. Also important, and this cannot be stressed enough, by late December the rate of fully-vaccinated employees in AHS facilities had risen to 97%. Whether by passage of time or the pressure of the Mandatory Vaccination Policy, 90% of employees not fully vaccinated in September had become fully vaccinated three months later. Health care facilities were in this way, less likely to spread COVID-19, and an overall less deadly variant of it, to patients and their staff in December than in September. All this could reasonably lend itself to a judgment that gains in health care outcomes from keeping as many facilities as possible as fully staffed as possible, outweighed the risk of having a now-diminished number of unvaccinated (but periodically tested) workers providing services there. Whether this judgment was open to debate, elected officials were again entitled to make it. The fact that they made this decision in response to the constellation of risk

apparent to them in December 2021, again logically does not mean that the original Policy, framed in the risk profile of that time, was unreasonable.

[78] Much the same can be said of the final Ministerial direction of March 7, 2022, permitting return of all unvaccinated employees without vaccination or testing requirements. The risk profile at that time had changed again. The winter "flu season" was coming to an end. The characteristics of the Omicron variant, particularly reduced mortality and morbidity, were well known. The vaccination rate among AHS workers had reached its peak. And there had been several months of experience in facilities at managing the Omicron surge. All these things could reasonably support a judgment that, *at that time,* the public interest was best served by returning all unvaccinated employees to work; or, simply, that the time had come to remove workplace restrictions the continued existence of which might provide only marginal additional benefits.

[79] The making of the Ministerial directives, in my view, did not even necessarily mean that the Mandatory Vaccination Policy had become unreasonable at the time the directives were issued. The goal of minimizing patient and staff exposure to COVID-19 was arguably still best served by maintaining the Policy as originally framed. But the other, overriding, goal of provincial COVID-19 policy, keeping hospitals and care facilities from being overwhelmed, had acquired greater force with the onset of the Omicron variant. It was arguably the case that AHS and the Alberta government were then faced with two, three or more reasonable responses to the changed circumstances. That the Minister chose successively less restrictive responses does not mean that the original Policy had ceased to be a rational alternative; only that the political decision-makers guiding the health care system believed them to be the best ones in the overall public interest at that time.

[80] Accordingly, I am of the opinion that the Ministerial directives of November 29 and December 23, 2021, did not render the Policy unreasonable, either retrospectively to its adoption or at the times the amendments to the Policy were directed.

## V. Conclusion and Recommendations

[81] For the above reasons, I am of the view that, in the main, the Group 1 Grievances the subject of this Report lack an appearance of merit. The threshold of reasonableness of the original Policy is easily met. The reasonableness of the Policy is supported by a strong preponderance of arbitral case law. No contrary precedent has been supplied that is not distinguishable. The *KVP* criterion of consistency of application is in question and conceivably could be litigated; but in my opinion the evidence that the Policy was inconsistently applied would have to be relatively strong, and would have to establish more than a *de minimis* level of cases where the Policy was ignored by AHS. And the successive Ministerial directives mandating amendment of the Policy were governmental decisions made in response to significantly changed circumstances, that did not reflect upon the reasonableness of the Policy earlier adopted. It is my considered opinion, then, that the great majority of the grievances filed in Group 1 would be dismissed by an arbitrator.

[82] It follows that it is my recommendation that the Union withdraw these grievances. However deeply felt was the opposition to the Mandatory Vaccination Policy among some employees, and however they came to this opposition, it remains the case that they put themselves in, speaking frankly, a dubious position in one of the greatest public health issues faced by the world in 100 years. One can feel compassion for the disrupted lives and lost income endured by the employees who made these choices. Choices, however, have consequences, and it was manifestly the grievors in this case who made these choices and brought about the consequences, all in response to an Employer policy that was reasonable and within its power to impose.

[83] The only exception to this recommendation concerns grievances filed by work-from-home employees who were placed on unpaid leave of absence and thereby lost income. For the reasons expressed, it remains in question whether the application of the Policy to these employees was reasonable. I view it as a triable issue whether individual such grievors were reasonably placed on unpaid leave of absence. It would be open to AHS to defend these grievances by evidence that exempting work-from-home employees from the Policy, either

collectively or individually, would not be operationally feasible or would impose undue hardship on the Employer. Other defences are not foreclosed by this observation.

[84] The threshold question to be answered by the Union is, were there in fact work-from-home employees among the grievors who were placed on unpaid leave of absence and thereby lost income? If so, I recommend that these grievances be remitted to the parties to craft a dispute resolution process in respect of them. Without in any way restricting the manner in which they do so, it is suggested that any such viable grievances identified, be assigned to one or two senior representatives for each party, who can co-ordinate investigation of individual cases and lead efforts to resolve those that remain in dispute after investigation. Arbitration remains a possibility for any grievances left unresolved. This suggestion flows from an assumption that only a small number of such grievances will be identified by the Union. In any event, as indicated, the parties are free to craft a process that best fits the number and nature of grievances that are identified as remaining in dispute.

[85] This completes this Report into the Group 1 grievances. I consider my appointment as arbitrator (now mediator) to continue until discharged by the parties or by order of the Labour Relations Board. Accordingly, I remain available to assist the parties in the aftermath of this Report as they may wish.

[86] I express my thanks to the parties for the co-operative and professional manner in which this novel grievance mediation was carried out, and for their patience.

ISSUED and DATED this 17th day of January 2023, at Edmonton, Alberta.

Redacted

Mediator