Trillium Ridge Retirement Home v. Service Employees Union, Local 183 (Vaccination Grievance), [1998] O.L.A.A. No. 1046

Ontario Labour Arbitration Awards

Ontario

Labour Arbitration

J.E. Emrich (Arbitrator)

Heard: Kingston, Ontario, August 8, 1998;

written submissions in argument, August 25 and

October 8, 1998.

Award: December 11, 1998.

File No. MPA/Y 600708

[1998] O.L.A.A. No. 1046

IN THE MATTER OF an arbitration Between Trillium Ridge Retirement Home, the Employer, and Service Employees Union, Local 183, the Union AND IN THE MATTER OF a Group Grievance Regarding Vaccination

(48 paras.)

Appearances

For the Employer: Paula Jourdain, President, Specialty Care Inc., Paula Lewis, Administrator, and Kim Clark, Head Nurse and Infection Control Nurse.

For the Union: David Jewitt, Counsel, Jodi Tarter, Student at Law, Gerry Goyer, Union Representative, Mandy Hooper, Union Steward, Donna Ferguson, Union Steward, Wilma Northmore, Grievor, Shawn Cusick, Grievor, Andrew Kish, Grievor, and Richard Luckham, Grievor.

AWARD

1. INTRODUCTION

1 This arbitration arises from a group grievance alleging a violation of Article 20 pertaining to the hours of work for which full redress is claimed. The Employer operates a nursing home and retirement home in the City of Kingston. Documents setting forth the material facts giving rise to the dispute were filed on consent before me.

2 The Union claims that the Employer introduced a mandatory policy requiring staff to be vaccinated and/or to take the antiviral-medication amantadine or miss shifts of work until immunity was acquired during an outbreak of influenza in the facility in February 1998. The Union characterises this policy as an unreasonable invasion of the grievors' bodily integrity. The Union argued that the Employer's requirement for employees to have a flu shot and/or take amantadine constituted an assault or battery for which damages are payable. The Union asserts that the grievors did not understand that they had a choice whether or not to take the vaccine and/or amantadine. The grievors were required to take the vaccine and/or amantadine during the flu outbreak at the facility in February 1998. Some of the grievors experienced unpleasant side effects from taking the drug amantadine such as nausea and insomnia.

3 The Employer maintains that it was implementing directives received from the Medical Officer of Health regarding preventive measures to take in respect to influenza and procedures to prevent the spread of influenza during an outbreak at the facility. The Employer maintains that the policy was not mandatory. Staff had a choice to be immunised through vaccination, or in the event of outbreak to be vaccinated and wait two weeks for the acquisition of immunity, or take amantadine and be able to report for work within 48 hours. If neither option were chosen, the staff member would be granted time off work without pay until the influenza outbreak was declared over at the facility. At the hearing the Employer clarified that if staff members were allergic to the vaccine, or pregnant or nursing, or if there was a sound medical basis for a refusal to take the vaccine or prophylactic antiviral medication amantadine, the staff member would be exempted from the requirement to take the vaccine or amantadine. The Employer argued that it had the right and duty to safeguard the residents of the facility from contracting influenza viruses that can be deadly to the frail elderly population.

2. EVIDENCE

4 A memo from Peter Shklanka, dated August 5th, 1998, was filed in evidence summarizing the events from the grievors' perspective. The Union Steward, Mandy Hooper, also prepared a report to the Business Representative, Gerry Goyer. These reports indicate whether and when the grievors obtained a flu shot, whether amantadine was administered, and the shifts missed by the grievors during the outbreak at the facility from February 12th to 14th, 1998. The latter report indicates that all the grievors but Richard Luckham exhibited no symptoms of respiratory infection or other illness during the period of the outbreak at the facility. Richard Luckham phoned in sick to work on February 13th stating that he had a cold. His doctor confirmed that he had a cold. He was required to take amantadine but not a vaccination, and was unable to report to work for 48 hours.

5 The Infection Control Nurse, Kim Clark, and the Assistant Head Nurse, Mary Learmonth, prepared reports outlining the steps taken by management to prepare for the onset of the flu season in the fall of 1997. These reports also outline the steps taken by management concerning the outbreak of influenza A at Trillium Ridge in February 1998. In early September 1997, posters promoting awareness of flu and the importance of vaccination were placed at the front entrance and near Nursing Station A. A sample posting prepared by the Lung Association was filed before me as Exhibit 7. It promotes awareness of the importance of vaccination against influenza, outlines the difference between cold and flu symptoms, outlines who can get the flu, who are at greatest risk of contracting flu, how effective vaccination is as a

prophylactic measure, and contraindications for vaccination. Among those stated to be at greatest risk for infection are those over the age of 65 and over, and all those who live in a long-term care facility.

6 Pamphlets and fact sheets were made available to staff and visitors at the front Reception desk in September. A brochure prepared by the Ontario Nursing Home Association was filed in evidence as Exhibit 6 which is directed primarily at family members and other visitors of residents. This material outlines the importance of infection control through frequent washing of hands and vaccination of seniors. Family members are asked not to visit if they have colds, fever, vomiting, or diarrhea. Children suffering from chicken pox are asked not to visit since this disease also is easily transmitted. After describing the symptoms of influenza, the brochure goes on to state the dangers presented by influenza infection:

> The real dangers of the flu are the complications that can arise from it. True influenza leaves you weak and at risk of other infections (e.g. pneumonia) or heart and kidney failure, nervous system disorders.

7 Posters indicating the date of the Staff Vaccination clinic were put up one month in advance at the front Nursing Station beside the punch clock where all staff must punch in. An extra Registered Nurse was booked for 4 hours on the date of the clinic, October 29th, 1997, to administer vaccines. Further information concerning steps taken to follow-up from the staff clinic are set forth in the report dated August 4th, 1998 by Kim Clark filed as Exhibit 15B:

> INFLUENZA A IMMUNIZATION REPORT 1997-1998
>
> Prepared by: M. K. Clark, R.N., Infection Control Nurse/Head Nurse
>
> Qualifications: Worked in Infection Control for past 10 years
> Member of CHICA-Canada since 1993
> Member of EOPIC since 1993
> Held Executive office with EOPIC since 1995- Position: Secretary
> Position for 1998 - President Elect
> Position for 1999 - Chapter President
>
> The annual Staff Flu Shot Clinic was held on October 29, 1997. The poster informing staff of the time, date and location of this Clinic was posted in late September, one month prior to the Clinic. From October 29th to November 17th 1997, Flu Vaccine was made available for all staff wishing to be immunized, providing that one of the two R.N.'s qualified to give the vaccinations was on duty.

On November 17, 1997, I personally contacted all staff who had not yet been Immunized against the Influenza A virus. At this time, I informed and cautioned all staff I contacted that, upon the recommendation of the KFL & A Health Unit, non-immunized staff may be restricted from work in the event of an Outbreak of Influenza A at Trillium Ridge. Thirty-five (35) staff were contacted at that time

On or about January 27th, 1998, it was reported that Influenza A had been confirmed in the Kingston Health Care Community. At that time I obtained the list of all staff still not immunized, from the Assistant Head Nurse, Mary Learmonth. I conducted another telephone campaign on January 29th, 1998. I contacted all staff that were still not immunized against Influenza A. Sixteen (16) staff were contacted. At this time, I informed/cautioned these staff that Influenza A had been detected in the community, and that at least 2 Long Term Care facilities were already in Outbreak status. Staff were informed that there was still time to obtain their Flu shot, and that they would need 2 weeks of immunity from the vaccination prior to coming back to work if an Outbreak was declared. At this time, I informed these staff, via telephone, that if they still chose not to be immunized, they would have 2 remaining options, which would be as follows:

1) Amantadine Therapy (to be obtained from their family physician, x 48 hours, prior to returning to work.
2) Remain off work until the Outbreak was declared over by the Health Unit.

At no time was the Flu Shot OR Amantadine therapy made mandatory to the Staff of Trillium Ridge Nursing Home. Stiff always had 3 separate choices regarding immunization or non-immunization. As an Infection Control Practitioner for the past 10 years, I have continued to recommended that the best defense against Influenza A would be immunization, and will continue to do so. I have never indicated that either the Flu shot or the Amantadine were mandatory.

Any staff who chose to take the Amantadine Therapy, were directed to contact their family physicians. For those staff who were prescribed the Amantadine by their physician, it was the responsibility of their physician and/or pharmacist to inform them of any potential side effects, contraindications, etc. As employers, it was not our responsibility or obligation to interfere in the doctor/patient relationship.

The names of the staff contacted during these two (2) campaigns has not been supplied as this is a violation of their confidentiality, and will not be released without written consent for disclosure from each individual staff member.

RE: INFLUENZA A OUTBREAK

There were four (4) confirmed resident cases of Influenza A and one (1) confirmed staff case of Influenza A. There were five (5) other suspected resident cases of Influenza A. All suspected and confirmed resident cases were placed in Isolation for the duration of the Outbreak. Names of these residents will not be released due to the Rights of Residents for Strict confidentiality regarding all aspects of their care.

M. Kim Clark, R.N. "M.K. Clark, RN" Date August 4/98

M.K. Clark

8 The report filed by the Assistant Head Nurse, Mary Learmonth, corroborates the information set forth by the Infection Control/Head Nurse, Kim Clark. In particular, I conclude that the weight of the evidence indicates that two rounds of telephone calls were made to non-immunised staff. The first round of phone calls were made in November following the staff vaccination clinic. Toward the end of January 1998 a further round of telephone calls was placed to employees who had not been vaccinated. At those times staff were informed that if they chose not to be immunised, they would have the following options should an outbreak of influenza infection be declared at the facility:

1) Amantadine therapy, to be obtained from the employee's family physician and 48 hours off work without pay to ensure that the therapy has become effective.
2) Remain off work without pay until:
   * Influenza vaccination has been obtained and two weeks have passed to allow for effective immunity to be acquired.
   * The outbreak is declared over.

9 The evidence indicates that the Employer was willing to accept medical reasons for refusal to be vaccinated or to justify a refusal to take amantadine. However, in such circumstances the Employer was not willing to allow non-immunised staff to work if an influenza outbreak was declared at the facility. In the staff bulletin issued on January 4th, 1997, after one resident was diagnosed with influenza, the following message is stated in bold capital lettering:

> DON'T PANIC!!! THIS FLU IS MOST DANGEROUS TO THE ELDERLY NOT THE STAFF, AND FLU SHOTS ARE STILL AVAILABLE FOR THOSE STAFF WHO STILL HAVE NOT HAD THEM. ALSO FOR THOSE STAFF WHO MAY BE PREGNANT, ALL THE READINGS INDICATE THAT THE FLU VACCINE IS SAFE TO ADMINISTER TO THEM AS WELL, BUT BE SURE TO CHECK WITH YOUR DOCTOR FIRST.

10 Filed as evidence were the "Guidelines for the Prevention and Management of Influenza in Long-Term Care Facilities" published by the Ontario Nursing Home Association. These guidelines do not form part of the legal regulations to which nursing homes must comply. Rather, the guidelines are stated to "offer a prudent approach to the management of influenza in long-term care facilities". As such, the guidelines would be relevant to setting the standard of care that a reasonably prudent long-term care facility would adopt to prevent harm to residents and staff from influenza. The guidelines contain a wealth of information concerning the nature of the infection, how it is spread, about influenza vaccine, and amantadine. The significance of an outbreak of influenza for the frail elderly is clearly stated in the ONHA Guidelines at page 1:

> Influenza infections often lead to high rates of transfer of residents to acute care facilities with the subsequent functional decline of the resident that so often accompanies hospitalization. Secondary bacterial infection, often the Streptococcus pneumoniae or Staphylococcus aureus is the most common serious complication. Influenza may cause an acute deterioration in long-term care

> facility residents with underlying pulmonary and cardiovascular disease. Furthermore, outbreaks of influenza infection will frequently lead to increased antibiotic utilization. This results in increased potential for toxicity, the development of resistance, and increased costs of care.

11 The way in which influenza is spread and how it can be prevented is explained at page 2 of the guidelines. In particular, it is important to note that influenza is communicable even before the onset of respiratory symptoms. The need for preventative vaccination is addressed at pages 3-4 of the report:

> People of any age who are residents of Long-Term Care Facilities and other chronic care facilities are recommended to receive influenza vaccination. Long-term care facility staff who have contact with people at risk of an influenza infection should be vaccinated as well. A study of nursing homes in Scotland demonstrated that vaccinating health care workers was effective in reducing influenza-associated morbidity and mortality in residents.

12 The report goes on to state at page 4 that "Anyone with a serious reaction to a previous dose (i.e. hives, swelling of mouth, difficulty breathing, hypotension or shock) or an allergy to eggs should not get the influenza vaccine." None of the grievors appear to have fallen within the category of those for whom the vaccine was contraindicated. At page 6, the guidelines state that amantadine hydrochloride is the only antiviral agent that interferes with the replication of influenza Type A virus approved for use in Canada. It is 70-90% effective against Influenza A but is ineffective against Type B influenza. In the influenza outbreak report filed as Exhibit 16, laboratory testing confirmed the infection as stemming from Influenza Type A.

13 Section A, subsections 7, 8 and 9 of the guidelines set forth how effective the vaccine is and who should and who should not receive it:

> 7. How Effective Is The Influenza Vaccine?
>
> The effectiveness of the vaccine depends on the age and immunocompetence of the recipient, as well as the degree of similarity between the virus strains included in the vaccine and the circulating strain during the influenza season. The influenza vaccine is approximately 50 to 70% effective in preventing hospitalization and pneumonia and up to 70 to 85% effective in preventing death. Vaccinated people may still get influenza, but will often have a less severe illness.
>
> 8. Who Should Receive The Vaccine?
>
> Long-term care facility staff who have contact with people at risk of an influenza infection should be vaccinated as well;
>
> A study of nursing homes in Scotland demonstrated that vaccinating health care workers was effective in reducing influenza-associated morbidity and mortality in residents.
>
> 9. Who Should Not Receive The Vaccine?
>
> Anyone with a serious reaction to a previous dose (i.e., hives, swelling of mouth, difficulty breathing, hypotension or shock) or an allergy to eggs should not get the influenza vaccine.

14 Section A, sections 17-19, and pages 12-14 deal with the proper use of amantadine. The guidelines direct that amantadine be given to all non-ill residents during an outbreak. The timing of administration is crucial for the antiviral medication to be effective in containing an outbreak. It must be given within 24-48 hours of onset of symptoms among the resident population. "If not all residents can receive amantadine at the same time, the use of amantadine should be questioned." The side effects of amantadine include confusion, dizziness, nausea, vomiting, insomnia, fatigue, depression, and/or decreased appetite. In subsection 18, the guidelines indicate that the Ontario Drug Benefit Plan covers the cost of amantadine for residents during an outbreak. Administration to staff members is mentioned in the following way:

> Facilities who wish to have their staff take amantadine may consider covering the cost of the amantadine and providing an on-site clinic or the staff may be advised to see their family physician.

15 The evidence before me is that the Employer referred staff members to their family physicians to obtain a prescription for amantadine. It was expected that the staff member's physician would inform the staff member if there was any reason that the staff member could not take the prophylactic drug safely. The guidelines contain a consent form for use of amantadine which states the possible side effects. This form was not used by the facility. At pages 8-10 of the guidelines, the policy and procedures for the influenza season are detailed. The primary mode to prevent the transmission of influenza is to facilitate the vaccination of all staff and residents. Note 8 at page 10 states, "If feasible, encourage only vaccinated staff to provide direct care to ill residents". Note 9 at page 11 states, "Staff members ill with acute respiratory symptoms must stay home. Encourage staff to not work in other health care institutions during the outbreak."

16 The Guidelines contain a sample report form for an influenza outbreak at pages 21-24. This form has been adopted as evidenced by Exhibit 16. In situations where there was a negative reaction to amantadine, the staff affected discontinued use. Trillium Ridge did not provide amantadine and it was expected that staff considering the therapy would consult with their physician to obtain a prescription and information about the antiviral agent. The Guidelines indicate that staff who are pregnant or breastfeeding should not take amantadine. The facts before me do not indicate that any staff for whom the therapy was contraindicated were required by management to take the medication. On the other hand, if the staff were not immunised and did not take amantadine therapy, the staff would not be allowed to work during the outbreak.

17 From the facts before me, I conclude that amantadine was made available to staff in accordance with the Ontario Nursing Home Guidelines. The evidence filed before me does not indicate that any staff member was required to take amantadine against medical advice. It is clear that pregnant and nursing mothers ought not to take amantadine, but I have no evidence before me that any of the grievors fell into that category and were required to take the drug. I conclude that it was reasonable for the facility to refer the staff members to their own physician to obtain advice concerning whether it would be safe for them to take this antiviral agent. Given the information that the Employer had already provided concerning influenza management through brochures, posters and by telephone, the Employer was entitled to expect that the staff member's doctor would inform the staff member about the nature of the medicine, the reason for its use, the proper way to take the medicine, and information about its side effects. The employee's

physician would carry responsibility to ensure that the employee's consent to take the drug was free, full, and voluntary. While it would have been prudent to evidence such consent by utilizing the consent forms contained in the Ontario Nursing Home Guidelines, failure to use the form does not of itself prove that a staff member who took the drug did not consent to its use.

18 The issue is whether loss of shifts and pay during a flu outbreak if the staff member refused to take either the vaccination or amantadine, or if any misunderstanding of the policy can constitute grounds to find either that no valid consent was given or that any consent given was vitiated. I will address that issue below. First I shall address whether the evidence provides any basis to conclude that the grievors consented to administration of the flu vaccine.

19 I conclude on the facts that management took a variety of reasonable steps to give advance notice to the grievors of the importance of early vaccination as a prophylactic measure against the transmission of influenza virus in long-term care facilities. Furthermore, I conclude that management took reasonable steps to bring to the attention of all employees vaccination clinic offered by nurses at the facility on October 29th, 1997. In addition, the flu vaccine was made available from October 29th to November 17th, 1997 for all staff provided that one of the two Registered Nurses qualified to administer the vaccine by injection was on duty. I find that reasonable steps were taken by management through a variety of means to make it clear to all employees the nature of the options open to them and the implications of non-immunisation if an outbreak of the virus were declared at the facility.

20 Nonetheless, the grievors remained under the mistaken apprehension that they would be allowed to continue working in the event of a flu outbreak even if they were not immunised. They understood that they would not be allowed to work only if they were sick with respiratory symptoms. Such a misunderstanding would appear to derive from an assumption that influenza may only be transmitted when the respiratory symptoms of the infection are patent. While I accept on the basis of the evidence filed on consent that the grievors were labouring under these mistaken assumptions, I also find that the Employer did not know nor ought to have known that the grievors did not understand the Employer's policy. I conclude on the evidence that the Employer was not responsible for creating any misunderstanding. On the contrary, I find that the Employer through the posting of notices in places where the grievors should have seen the material, through educational posters and through telephone calls, took measures that ought to have made the grievors aware of the need for prophylactic vaccination or the use of an antiviral medication if vaccination were not obtained in sufficient time for immunity to be acquired before an outbreak. Furthermore, the Employer took steps through telephone calls and other means to alert staff of the policy that non-immunised staff would not be permitted to work at the facility during the period of an influenza outbreak.

21 The first case of a resident suffering from influenza A was identified in early January 1997 (Exhibit 4). An outbreak of influenza was declared at Trillium Ridge around February 12th and 13th, 1998. At that time all non-vaccinated staff, or staff who had not yet acquired 2 weeks' immunity following vaccination, were required to make a choice. They could choose to take amantadine and acquire immunity within 48 hours after which a return to work would be permitted, or they could choose to refuse the medication and return to work once the outbreak was declared over.

22 On behalf of management, a number of documents were filed to justify management's decision to

require non-immunised staff and those who did not yet have effective immunity from the virus to stay off work. An advisory bulletin dated February 5th, 1998 was received by the Employer from the Kingston, Frontenac Lennox and Addington Health Unit regarding an influenza outbreak at long-term care facilities in the region.

Influenza Advisory

To: Infection Control Practitioners/Departments

From: K.F.L.&A. Health Unit

Date: Thursday February 5, 1998

Notice about Influenza

We have had laboratory-confirmed cases of Influenza A in the following facilities:

* Pine Meadow

* Extendicare

* St. Mary's of the Lake

* Lenadco

We provide this information to you so that you can take necessary precautions concerning patient transfers and cross facility staffing.

There have been some questions about cross facility staffing. The KFLA Health Unit's recommended guidelines are as follows:

If an employee works in an institution in which influenza A has been documented, he or she should not work in your unaffected facility unless: immunized and not ill. If they are unimmunized and they opt to get the vaccine, it will take two weeks to provide protection. If they opt to get the vaccine and go on amantadine, you may consider them for work.

These are only our recommended guidelines based on our experience and knowledge. If you have further questions please contact Nadine Radisch at 549-1232 or 1-800-267-7875 ext 222.

23 An advisory letter from the Medical Officer of Health, Dr. Ian Gemmill dated February 11th, 1998 states the following measures would help to reduce the risk of introducing and spreading the infection throughout a facility during an outbreak:

Possible options are:

- an unaffected facility may choose to restrict unimmunised staff from working if they also work in a facility that has documented cases of influenza A, until that latter facility is clear of influenza.

- unimmunised staff who work in another facility in which there is influenza may be requested to take amantadine until the other place of employment is clear of influenza.
- some facilities may ask their staff who also work in a facility that has documented cases of influenza A to get the vaccine immediately, and to start on amantadine until the vaccine has taken effect (10 to 14 days).

24 A follow-up letter, dated March 10th, 1998 from Dr. Gemmill was also filed in evidence as Exhibit 11, emphasized that during an influenza outbreak at a facility that staff either have prior immunisation, take antiviral medication or remain off work.

> 10 March 1998
>
> Mrs. Paula Lewis
>
> Director of Residential Care
>
> Trillium Ridge Retirement Centre
>
> 800 Edgar St.
>
> Kingston, Ontario K7M 8S4
>
> Dear Mrs. Lewis:
>
> Mrs. Kim Clark has asked me to write to you regarding the Health Unit's recommendation for the control of influenza in long term care settings.
>
> The Ontario Ministry of Health provides and the KFL&A Health Unit distributes influenza vaccine free of charge to both residents and patient care staff of long term care institutions.
>
> The purpose of this free programme is to reduce the serious complications, hospitalization, and deaths from influenza among those at risk, namely the medically compromised and the elderly. The KFL&A Health Unit strongly encourages all patient care staff to be immunised against influenza at the beginning of each influenza season so that the disease is either mitigated or eliminated in these institutions.
>
> Should a patient care staff member have a medical contraindication to an influenza vaccine and thus not be able to take it, an alternative is to use an antiviral medication should an outbreak occur. This intervention should also reduce the likelihood of disease transmission and occurrence, along with the complications of the disease.
>
> The Health Unit strongly recommends that, during outbreaks, nursing home staff either have prior immunisation, take antiviral medication, or remain off work. These recommendations am made in an effort to control the outbreaks and protect vulnerable residents from severe illnesses and the complications of influenza. The Health Unit recommends that this matter become policy for all long term care institutions.
>
> I trust that this is the information which you require. Please contact me if you need any further information or clarification.
>
> Yours faithfully,
>
> "Ian MacDonald Gemmill"

Ian MacDonald Gemmill

Acting Medical Officer of Health

25 The evidence indicates that all the grievors but one took a flu shot at the time of the outbreak in February, except Wilma Northmore who took amantadine which she obtained from her doctor. The grievors did not testify and there is no evidence to suggest that they did not understand the nature and purpose of taking the influenza vaccination. Furthermore, all the grievors except Wilma Northmore went to the office of the nurse and presented themselves for vaccination after being reminded to do so by their immediate supervisor or following a reminder by the Head Nurse. The actions of the grievors at the time would seem to indicate that they apparently were consenting to having a vaccination shot against influenza. Wilma Northmore would have had the benefit of a medical consultation concerning the nature and purposes of taking a prescription for amantadine, and side-effects could have been addressed by her physician. I have no information before me to indicate that her physician prescribed the medication without ensuring that her consent to the medication was informed.

26 Rather, the real substance of the dispute between the parties is whether the Employer's policy of requiring a loss of shifts and pay if an employee refused to take the medication or did not have effective immunity, constituted grounds for vitiating the employee's consent to the prophylactic measures taken or constituted an unreasonable or arbitrary exercise of management's rights under the collective agreement. The grievors and the Union seem to be of the view that such a measure would only be justified if the employee were patently ill and manifested symptoms of respiratory illness or other influenza symptoms.

3. ISSUES

27

1) Does the Employer's policy to require non-immunised staff and those who are not willing or able to take the prophylactic medication amantadine to stay away from work without pay during an influenza outbreak, constitute an arbitrary disciplinary and unreasonable exercise of management's rights in violation of the collective agreement?
2) Does the Employer's policy constitute an unlawful assault or battery at law so as to entitle the grievors to damages for invasion of their bodily integrity? If there was consent to the vaccination or administration of flu vaccine or to the administration of amantadine, was the consent vitiated by mistake induced by the Employer or by economic coercion?

4. ANALYSIS AND DISCUSSION

28 The grievance refers to breach of Article 20 which sets out the normal hours of work as 7.5 hours per day and 75 hours in a bi-weekly pay period, excluding meal periods. Certainly if management was not justified in requiring the employees to abstain from work pursuant to its policy, the normal hours of work would be abridged wrongfully. The grievors would be entitled to compensation for loss of pay for the hours they would have worked if the collective agreement had not been breached.

29 The grievance raises the question of the extent of management's right to take measures to safeguard the residents of the facility from potential sources of transmission of influenza infection. Article 7 pertains to management's rights:

> The Union acknowledges that it is the exclusive function of the Employer to:
>
> 7.01 maintain order, discipline and efficiency and to establish and enforce reasonable rules and regulations. The Employer agrees to consider any representation made by the Union concerning any change in rules or the introduction of new rules and may be the subject of a grievance if both parties cannot agree on any of the above-mentioned.
>
> 7.03 The Employer shall not act in an arbitrary manner.
>
> 7.04 a) Without restricting or limiting the generality of the foregoing, the Employer retains all rights and responsibilities of Management nor specifically relinquished or modified by the Agreement.
>
> b) The Employer agrees that these rights shall not be exercised in a manner inconsistent with the terms of this Agreement and that an allegation that these rights have been exercised in a manner inconsistent with the terms of this Agreement may be subject to the Grievance Procedure.

30 Furthermore, the parties to the agreement have committed themselves in Article 25 "to maintain standards of safety and health in the Home, in order to prevent injury and illness". To that end they have a joint Health and Safety Committee to address such concerns. No argument was addressed concerning the relevance of Article 25. Argument centered on whether the Employer's policy was properly characterised as mandatory and whether it was reasonable.

31 The Union concedes that safeguarding the health of the residents is a legitimate and important objective of the policy. To this end, the Union notes that vaccination and amantadine treatment was made available to residents, but only when they were willing to sign consent forms. The outbreak report filed for the February influenza outbreak reveals that 73 of 89 residents (82%) were vaccinated in the fall of 1997. During the outbreak 79 of 89 residents (89%) were given amantadine. Of those who were vaccinated, 6 residents contracted influenza, notwithstanding.

32 The Union argues from this basis that vaccination is not effective against transmission of the illness. Furthermore, the Union points out that staff were treated with less consideration of their rights because

they were not required to sign consent forms either for vaccination or for treatment with amantadine. On behalf of the Union it was pointed out that the Health Unit directives for management of an influenza outbreak did not require that consent be dispensed with. Furthermore, the Ontario Nursing Home Guidelines envisage that staff consent forms be obtained for both vaccination and for amantadine. In respect to amantadine, the Union points out that the ONHA Guidelines are directed primarily to residents for amantadine treatment in any event. Furthermore, the Health Unit directives were all phrased as recommendations and do not have the force of law so as to compel the Employer to institute the policy that it did. On behalf of the Union it was argued that there was no basis in the licensing or regulatory requirements to require asymptomatic staff to remain off work during an outbreak until immunity had been acquired.

33 Therefore, the Union argues there was no objective basis to require immunisation or amantadine treatment as a mandatory condition of employment during the influenza outbreak in February 1998. Given that neither vaccination nor amantadine provide reliable measures to protect residents from infection with influenza virus, the policy requiring that these measures be submitted to by staff on penalty of loss of shifts for non-compliance constituted an unreasonable and arbitrary application of the Employer's management rights. The Union contends that such a requirement constitutes a disproportionately intrusive and irrational means to address the legitimate objective of protecting residents from influenza infection.

34 Counsel for the Union indicated that he was unable to find any case which raised the same issue. Counsel maintained that the issue involves a balancing of the interest of management in providing a safe and healthy environment for residents at Trillium Ridge with the rights of the employees to consent to medical treatments. By dispensing with the use of forms and by requiring employees to stay off work without pay if the medical treatments were refused or until the treatment would confer effective immunity, the Employer had committed a trespass to the person amounting to a battery of the affected employees.

35 Counsel referred me to the following cases which balanced the privacy rights of employees to be free from unreasonable searches or constant electronic surveillance against management's right to ensure security and efficient production: Re Thibodeau-Finch Express Inc. and Teamsters Union, Local 880 *(1988) 32 L.A.C. (3d) 271* (Burkett); Re Saint Mary's Hospital (New Westminster) and Hospital Employees Union (1997) 64 L.A.C. (4th) 383 (Larson). In St Mary's Hospital, Arbitrator Larson canvasses the jurisprudence thoroughly. At page 395, he concludes that in the electronic surveillance cases the balance is effected by establishing that surveillance is necessary in the circumstances because of cause grounded in employee misconduct and by establishing that less intrusive means of investigation would be ineffective to evidence the misconduct. At page 397, Arbitrator Larson points out that different considerations apply where the Employer's actions are not searches of personal property of the employee or electronic surveillance, but where the Employer action could constitute a trespass to the person as in bodily searches or mandatory medical examinations:

> Firstly, there would appear to be a kind of hierarchy of protection afforded by the right to privacy: Re Thibodeau-Finch Inc. and Teamsters Union, Local 880 (supra). At the top of the list are actions by the Employer which involve actual bodily intrusions. Since those actions are protected by the law of trespass and assault, the Employer is not entitled to do anything that would involve touching the employee except with that employee's consent, express or implied or, in some cases, an order may be obtained from an arbitration board: Re University of British Columbia and

A.U.C.E., Local 1 *(1984), 15 L.A.C. (3d) 151* (McColl). In such cases there can be no question of balancing of interests because the Employer does not obtain a right to commit a trespass or an assault on the employee by virtue of the employment relationship. There are no cases that have held that consent can be implied from the mere existence of the employment relationship. In fact where there is a collective agreement, it has been held that consent cannot be implied from the management rights clause or the health and safety provisions: Re Air Canada and Canadian Airline Employees Assn. *(1982) 8 L.A.C. (3d) 82* (Simmons). Examples of intrusions that are accorded this highest level of protection include such things as mandatory medical examinations: Re Thompson and Oakville (Town) *(1963) 41 D.L.R. (2d) 294* (Ont. H.C.J.) and bodily searches: Re Riverdale Hospital (Board of Governors) and C.U.P.E., Local 43 *(1977) 14 L.A.C. (2d) 334* (Brent).

36 In further support of its argument that the Employer's policy was unreasonable, I was referred to the case Re Air Canada and C.A.L.E.A. (1982) 8 L.A.C. (3d) 83 (Simmons). In that case the employee was told that she would have to submit to medical exam by an Employer-appointed physician or she would be removed from the Employer's payroll. The employee complied under protest, Arbitrator Simmons held that such a unilateral rule must be reasonable to be enforceable according to the tests set forth in Re Lumber & Sawmill Workers' Union, Local 2537 and K.V.P. Co. Ltd. *(1965) 16 L.A.C. 73* (Robinson). These requirements are set out at page 85 of the K.V.P. decision:

> A rule unilaterally introduced by the company, and not subsequently agreed to by the union, must satisfy the following requisites:
>
> 1. It must not be inconsistent with the collective agreement;
> 2. It must not be unreasonable.
> 3. It must be clear and unequivocal.
> 4. It must be brought to the attention of the employee affected before the company can act on it.
> 5. The employee concerned must have been notified that a breach of such rule could result in his discharge if the rule is used as a foundation for discharge.
> 6. Such rule should have been consistently enforced by the company from the time it was introduced.

37 In the Air Canada case, Arbitrator Simmons concluded that the rule was unreasonable on the following grounds:

* because medical examination by an Employer-appointed physician could be required even in the absence of reasonable grounds for making the request (i.e., whether or not the employee had had any symptoms of illness or not, or whether the employee had been absent from work due to illness).
* the employee had offered to submit to an examination by her own doctor under instructions from the company doctor as to the nature of the evidence required and concerning the prognosis. The Employer was obliged to accept this less intrusive means of

satisfying its legitimate objective of satisfying itself that the grievor was fit to return to work.

38 Counsel for the Union referred me to Re Empress Hotel and C.B.R.T., Local 726 *(1992) 31 L.A.C. (4th) 402* in which the employee was suspended from work for alleged contravention of a unilateral Employer policy pertaining to grooming standards. The grievor was a male employee who refused to cut his long hair which he kept fastened in a ponytail at work. Arbitrator McEwen applied the K.V.P. analysis and concluded that the rule was unreasonable and not clear and unequivocal. The Employer had failed to introduce any objective evidence to validate its concern that long hair would harm its image and offend clientele. Furthermore, the grievor had kept his hair neat and clean and was in compliance with the terms of the written grooming policy. To the extent there was disagreement over how the policy should be applied, the arbitrator held that it was unclear in its definition and application. Thus, a declaration was granted that the Employer had no just cause for imposing a suspension on the grievor for his refusal to cut his hair.

39 Finally the Union referred me to Re Etobicoke and Int'l Assoc. of Firefighters *(1974) 6 L.A.C. (2d) 251* (Rayner). The grievor was transferred as a disciplinary response to his refusal to trim his sideburns, which refusal the Employer treated as a violation of the unilateral Employer rules concerning personal appearance. At page 255 of the decision, Arbitrator Raynor reasons that it is not sufficient for the Employer to establish merely that the rule had been enacted in good faith and for a legitimate objective such as safety. Review of the substantive content of the rule must meet tests of reasonableness. There was no evidence to suggest that the length of the grievor's sideburns posed a safety hazard when wearing a respirator or mask.

40 In the case before me there is ample evidence to show that vaccination of staff and residents at a long-term rare facility such as Trillium Ridge, which provides care to the frail elderly, is an effective means to prevent transmission of influenza A. The vaccination is also effective to reduce the severity of symptoms and the incidence of complications arising from infection with the virus. Although vaccination is not perfectly effective, this may have to do with the compromised immunity of the elderly patient population and the similarity between the vaccine virus strains and the circulating strain of virus during an outbreak. The preponderance of the evidence favours the beneficial effect of vaccination to prevent transmission of the infection and reduce the severity of infections and complications. Furthermore, the evidence substantiates that amantadine is an effective antiviral medication which can be taken instead of or in addition to vaccination to prevent transmission or reduce the severity of infection for those unable or unwilling to take the vaccination. I find that the Employer's policy was rationally connected to the legitimate objective of protecting the health and safety of residents and staff at the facility.

41 Furthermore, the evidence substantiates that the period of contagion begins before the display of respiratory symptoms associated with influenza. Thus, a policy simply to require staff to stay home when they display such symptoms would not be as effective to reduce transmission of the virus. The serious consequences for the frail elderly population of infection include the likelihood of serious complications developing such as infection with opportunistic bacteria, pneumonia, and death. These serious consequences for the resident population warrant measures being taken that will be effective in preventing the transmission of infection. On the other hand, the law cherishes the right of the individual to freedom from intentional infliction of harmful or offensive physical contact. Respect for individual autonomy and

the right to control one's body is at the heart of the law pertaining to consent to medical treatment. Deliberate infliction of harmful or offensive contact, without consent, is a battery at law and has been actionable since ancient times.

42 On the whole of the evidence, I must conclude that the Employer's policy was not mandatory in requiring employees to accept vaccination or amantadine. Ultimately the employee was permitted to refuse either measure, but there was a cost to such refusal. Such an employee would not be allowed to attend at work and be paid during the period of an outbreak. Did the imposition of such a cost render the policy arbitrary and unreasonable? Did the imposition of this cost constitute a violation of the collective agreement? Did such a cost amount to a disciplinary penalty, or was the requirement to stay off work a constructive lay-off out of seniority order, or did this cost vitiate consent to the vaccine or amantadine administration? Ultimately I am persuaded that the answer to each of these questions is no.

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

44 Furthermore, I do not accept that the refusal to permit non-immunised employees to attend work and be paid constituted a constructive lay-off. The intent and purpose of this measure was not to effect a reduction in the payroll and manpower requirements of the Employer by a means not contemplated by the collective agreement. Indeed, during an influenza outbreak at the facility, the need for every helping hand to assist with the increased care demanded for infected residents would increase the manpower requirements of the Employer. The policy implemented provides a disincentive for employees to refuse vaccination or amantadine, but I conclude that such a disincentive is warranted on the basis of health and safety requirements and the demands of efficiency to manage the potentially grave effects of an influenza outbreak among the elderly residents.

45 Did the disincentive constitute a kind of economic coercion that would vitiate the grievors' consent to taking the vaccination or amantadine? Consent to medical treatment must be genuine and be given voluntarily. Traditionally, the law took a narrow view of the sort of duress that would provide grounds for

consent to be vitiated. Latter v. Bradell (1880) 50 L.J.Q.B. 448. The modern approach is to take a more contextual view of the power imbalance in relationships and has vitiated consent to medical treatment where a power imbalance has been exploited by the dominant party to extract compliance by the weaker party to harmful or offensive contact: Norberg v. Wynrib *[1992] 4 W.W.R. 577* (S.C.C.). In the case before me, reasonable measures were taken by the Employer to inform the staff concerning the need for immunising both residents and staff to manage outbreaks of influenza effectively. Although the Employer is in a position of dominance, this position was not exploited for the self-interested advantage of the Employer and detriment of the staff. The policy objective and means of implementation sought to provide effective protection against viral infection for all. Furthermore, the Employer took reasonable measures to inform the staff of the nature and purpose of the immunisation measures required and the effect of the policy to ban non-immunised employees from the workplace during an outbreak. Thus, all the grievors should have understood the nature and purpose of the immunisation measures at the time they submitted to them. Any misunderstanding the grievors had concerning whether they would be permitted to work if unimmunised is not attributable to any steps taken by the Employer to deceive or mislead the employees in this respect. Thus, there is no basis on which to conclude that consent of the grievors to the immunisation measures taken was invalid or vitiated.

46 Finally, I conclude on the whole of the evidence that the objective of was sufficiently important and the serious consequences of ineffective immunisation for the frail elderly residents served at this facility sufficiently grave that the measure of refusing to permit non-immunised staff to work their scheduled shifts during the outbreak was reasonable and not arbitrary in the circumstances.

47 For the reasons given, I conclude that the Union has failed to establish that the policy was unreasonable, arbitrary, inconsistent with the collective agreement, or otherwise unreasonable because in violation of the right of the grievors' right to refuse medical treatment. The policy was clear and brought to the attention of the employees affected and it was consistently enforced. I would merely add that in order to foreclose any future misunderstanding about the content or application of the policy, the Employer should consider posting the policy in writing in accessible locations in all departments of its facility.

48 For the reasons given, the group grievance is dismissed.

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