IN THE MATTER OF AN ARBITRATION

QUINTE HEALTH

("Employer"/"Quinte"/"Hospital")

and

ONTARIO NURSES ASSOCIATION

("ONA" / "Union")

COVID-19 Vaccination Policy and related grievances

BEFORE

James Hayes, Sole Arbitrator

APPEARANCES

Union:	**Employer:**
Howard Goldblatt, Counsel **Simran Prihar, Counsel** **Anna Goldfinch, Counsel**	**Maureen Houston, Counsel**

Zoom hearings: April 26, July 4, November 2, 16, 30, 2023; January 25, 2024.

AWARD

BACKGROUND

issue

1. All of the grievances here challenge the reasonableness of the Employer's implementation and application of its COVID-19 Immunization Program ("Policy") that requires all Hospital staff to be vaccinated against COVID-19 as a condition of continued employment absent a valid medical exemption or an approved creed exemption under the Ontario Human Rights Code.

2. Nine ONA members were ultimately terminated in 2022. One was terminated upon returning from a parental leave in 2023. There are approximately 600 registered nurses at Quinte.

3. Stated generally, ONA objects to the mandatory vaccination requirement on the basis of expert testimony. Alternatively, the Union says that the Policy should be struck given its "unreasonable" provision for automatic termination in the event of non-compliance.

4. I conclude that, when the Policy was introduced, the Hospital acted reasonably in introducing a mandatory vaccination requirement. However, for reasons set out below, I find that the automatic termination of non-compliant nurses was unreasonable. They should have been placed on unpaid leaves of absence.

parties

5. Quinte is comprised of four hospitals serving 180,000 people living in Prince Edward and Hastings Counties and the southeast portion of Northumberland County.

6. ONA represents 68,000 nurses and health care professionals, as well as 18,000 nursing student affiliates. It has more than 60 Locals and 540 Bargaining Units across Ontario.

process

7. The matter was tried efficiently by senior counsel on the basis of an Agreed Statement of Facts supplemented by testimony from Susan Rowe[1] and expert witnesses Dr. Neil Rau and Dr. Mark Loeb. The witnesses referred to an extensive body of exhibits including, in the case of the experts, many articles from authoritative medical journals. Counsel made written and oral submissions and filed Joint Books of Authorities.

AGREED STATEMENT OF FACTS

8. The following paragraphs are derived from or extrapolated directly from the ASOF as noted:

[1] Quinte Vice-President of Communications and People

COVID-19 and Directive #6

1. On March 11, 2020, the World Health Organization ("WHO") declared COVID-19 a global pandemic.

14. The SARS-Co-V-2 virus changes through mutation and new variants appear over time.

15. Variants of concern ("VOC") in Canada have included the:

a) Alpha Variant designated a VOC by the WHO on December 18, 2020

b) Beta Variant designated a VOC by the WHO on December 18, 2020

c) Gamma Variant designated a VOC by the WHO on January 11, 2021

d) Delta Variant designated a VOC by the WHO on May 11, 2021

e) Omicron Variant designated a VOC by the WHO on November 26, 2021

20. On August 17, 2021, the Ontario Chief Medical Officer of Health issued Directive #6 requiring all hospitals to establish, implement and ensure compliance with a COVID-19 vaccination policy mandating that employees provide:

a) Proof of full vaccination against COVID-19, or

b) Written proof of a medical reason, provided by a physician or registered nurses in the extended class that sets out:

i. A documented medical reason for not being fully vaccinated against COVID-19, and

ii. The effective time-period for the medical reason; or

c) Proof of completing an educational program approved by the hospital about the benefits of COVID-19 vaccination prior to declining vaccination for any reason other than a medical reason.

21. According to Directive #6, a person who chose not to be vaccinated or not to disclose their vaccine status and who participated in the education program would be required to participate in a regular antigen point-of-care testing program.

22. Directive #6 was revoked by the Ontario Chief Medical Officer of Health ("CMOH") on March 9, 2022.

Quinte COVID-19 vaccination policies

23. The first Quinte policy was that issued March 1, 2021, and approved April 6, 2021. It set out that "COVID-19 vaccination is encouraged but not mandatory".

25. Quinte adopted a policy dated August 26, 2021, that required all volunteers, learners, contractors, new employees, and physicians, and any others working on Hospital premises to provide proof of vaccination. Any employees and physicians who were not fully vaccinated were required to participate in an educational program about COVID-19 vaccinations and undergo rapid antigen testing twice weekly as of September 7, 2021.

26. An August 27, 2021, e-mail to ONA advised that the current policy was at "Stage 1" and it was "possible that QHC will move to Stage 2 requiring mandatory vaccination which aligns with the approach taken at other Ontario Hospitals".

29. On September 17, 2021. Quinte notified ONA of its intention to move to Stage 2 and advised staff of its adoption of a mandatory vaccination policy (the subject of the instant grievances).

33. The Vaccination Policy[2] required proof of at least one dose of a two-dose vaccination series by October 1, 2021, and proof of receipt of the second dose by October 31, 2021.

34. The Vaccination Policy provided for two exceptions: creed under the Ontario Human Rights Code or an approved medical exemption.

35. Employees and physicians who did not submit proof of at least one dose of a two-dose vaccination series or did not have an approved exemption by October 1, 2021, were placed on an unpaid leave until proof was provided, or alternatively, for a maximum of 14 days. The same requirements applied for a second dose by October 31, 2021.

36. The Vaccination Policy also noted that ***"all options [would be] considered to effectively enforce the policy including unpaid leaves of absence, altering of employment status, termination of employment, and temporary or permanent loss of privileges for credentialed staff"****.*

[I note that under the "Escalation" section of the Policy, the following warning is found: ***"If, at any time, an employee advises QHC that they do not intend to comply with the terms of this Policy, even for reasons that are important to them, that employee will be terminated for cause immediately."]***

[2] Only key elements cited here

[bold added]

37. ONA members who failed to become vaccinated or provide a valid creed or medical exemption by the end of the 14-day unpaid leave were terminated.

43. Nine ONA members were ultimately terminated. One was terminated upon returning from a parental leave on April 13, 2023.

46. The Vaccination Policy is still in effect and has not been modified to require more than the initial 'two doses' of the vaccine. ONA members who have not been 'boosted' are unaffected by the Policy and are able to continue to work.

47. The provincial government no longer requires Quinte to have a vaccination policy, pursuant to the CMOH's revocation of Directive #6 on March 9, 2022.

48. The CMOH issued several non-vaccine-related directives to the health care sector to prevent transmission of COVID-19 and Quinte developed its own internal hospital polices to protect against and prevent transmission.

49. Examples included: (i) personal protective equipment; (ii) droplet contact precautions; (iii) physical distancing; (iv) disinfection/hygiene; (v) screening; and (vi) testing.[3]

50. All of these measures operated in addition to the mandatory Vaccination Policy. Many have been revoked, relaxed, or amended since their introduction.[4]

93. While there has been a constant assessment, revision, and refinement of all of the other infection control and protective measures in place at Quinte throughout the pandemic, the requirement to have a two-dose vaccine has not changed since it was originally introduced in September 2021.

TESTIMONY

[3] Set out in detail in the ASOF
[4] Set out in detail in the ASOF

Susan Rowe

9. Ms. Rowe, Vice-President, Communications & People, served as Incident Commander for the Employer's COVID response from early 2021 until early 2022. She took the executive lead on the development of the vaccination policy and its implementation.

10. The ultimate decision was taken by the "leadership group" consisting of the Hospital President, Vice Presidents (4), the Chief Executive Officer and the Chief of Staff. It had gone first to the Medical Advisory Committee and also went to the Quality committee of the Board. Quinte had retained Dr. Gerald Evans, an Infectious Disease and Infection Protection and Control specialist with Kingston Health Sciences who was also on the provincial COVID science advisory table. Dr. Evans was not involved in preparation of the Policy, but Ms. Rowe testified that she routinely asked him if it was advisable to maintain it as written and was advised that it was. Dr. Evans did not give evidence.

11. Ms. Rowe advised that there were a number of factors that led the Employer to move to a mandatory policy by mid-September 2021. The Hospital brief summarized this aspect of her direct evidence as including the following:

- Safety: to reduce infection and spread, to protect patients and staff
- Staff levels: concern that virus spread would further limit the number of people that could work at the hospital

- Leadership position: patients and staff expected this action where the vast majority in the community had chosen to be vaccinated and patients expected the people caring for them to be fully vaccinated

- Testing: the Senior Leadership Team determined that the testing alternative was impractical and did not provide the greatest measure of safety. Rapid antigen testing ("RAT") as an alternative to vaccination for 175-200 people, was not sustainable

- Other hospitals: Quinte did not want to be the only hospital not taking this leadership position

12. Ms. Rowe sent a memorandum to the Medical Advisory Committee that identified her view of the risks of permitting staff and physicians to remain unvaccinated and the risks of moving to a mandatory vaccination policy.

13. There was no discussion, at the time of implementing the Policy, about vaccine 'waning effectiveness'. Ms. Rowe explained that they received information and advice that the vaccine provided benefits above natural immunity: "based on Dr. Evans even if someone was vaccinated and they got infected they were likely to have better outcomes and shed less virus and therefore be less infectious. That as what I understood to be true then and now. We did weigh the efficacy of the vaccine knowing it wasn't perfect but still provided protection."

14. Ms. Rowe also spoke to employee recruitment: "If we did not terminate, we would have to hold positions for people and could only back fill those on a temporary basis. It would have been challenging to recruit into and retain individuals with temporary roles". Nevertheless, she agreed that the Hospital was already struggling with significant

vacancy problems that had been exacerbated by the pandemic, moving from 100 vacancies over the entire corporation, pre-COVID, to up to 225-275 vacancies at any given time during COVID throughout all of its union groups.

15. Ms. Rowe was cross-examined very fairly on a wide range of matters some noted summarily here. She acknowledged or stated in answering that:

- the Employer was aware that there was a significant number of breakthrough infections in the community – as many as 23% of reported COVID-19 cases since July 2021 were noted to be fully vaccinated individuals
- a large percentage of staff, in the 80%+ range had been vaccinated before September 2021

  [Infection Protection and Control Minutes, September 21, 2021, put the figure at 91%]
- no consideration was given to the thought that vaccinations given in March or June might have waned by the time of the Policy
- she could not say what “our understanding” of waning immunity was in August 2021, vaccinations had only been widely available for 8 months or so
- when asked if there had been any consideration of how much time had elapsed since employees had been vaccinated, she did not remember any discussion about waning immunity in August 2021
- both before and at the time the Policy was adopted, the Employer had access to, and was circulating internally amongst senior management, at least one study that raised concerns about waning immunity based on time since vaccination
- employees were not asked if they had been previously infected

- Dr. Evans advised that there was a benefit to vaccinations above natural immunity

- Dr. Evans provided the latest research about protection from getting COVID, against serious illness, and how well the vaccines were working

- we considered the evidence given by experts at the time and commentary in Directive #6

  [see above, presumably via Dr. Evans]

- Hospital statistics indicated that of the 335 staff infections between April 2021 and March 2022, only 60 were between April and December 2021. The other 275 (and likely some of the 60) were with a fully vaccinated workforce.

- a booster requirement was discussed in November at the time employees were being terminated, but that was not included in the Policy

- benefits of the booster shot did not outweigh the risk of losing further staff to terminations.

- notwithstanding waning immunity and natural immunity factors, unboosted employees can remain employed while unvaccinated persons who may have been infected may not

- Dr. Evans did not give advice concerning the termination aspect in the Policy: “that was not his advice to give”

- neither Public Health Ontario nor the Chief Medical Officer of Health required a Policy including a provision for terminations

- the Policy does not speak to possible revision on an ongoing basis due to evolving science, they have not moved to change it

- indefinite unpaid leaves of absence were discussed but rejected: “we did not foresee any short or mid-term change for a vaccine requirement, a core layer of COVID response”;

- “the other challenge was the recruitment issue, we would have to hold positions open, we would only be able to backfill temporary roles”

- there were approximately 350 vacancies for ONA jobs between November 2020 and March 2023, none related to terminations due to the Policy, a huge staffing problem

- the Employer did not consider whether terminated employees had worked in a high or low risk setting, nor whether they had been previously infected and had natural immunity, nor whether they had, at all times, complied with PPE and physical distancing requirements, nor their disciplinary history

- an individual without two doses before October 31sr would be terminated “without any exceptions”

Experts

16. Expert reports were filed by two highly accredited and accomplished physicians: Dr. Neil Rau and Dr. Mark Loeb. Their respective opinions were supported by reference to numerous international comparative studies conducted in people, that is, randomized trials, non-randomized studies, and meta-analyses reported in leading medical journals. Many of these were entered into evidence on consent and subjected to competing critiques by Dr. Loeb and Dr. Rau as to their internal quality and support for the propositions advanced. Both experts were cross-examined at some length.

17. An additional report, authored by Dr. Peter Juni, was tendered during the course of the hearing. His opinion had been offered in a prior arbitration case [5] to address the question of whether unvaccinated employees could have been permitted to return to work later in 2022, as directed by the City of Toronto. That opinion took issue with aspects in a previous report offered by Dr. Rau, one not in evidence before me. Dr. Juni did not testify and, therefore, was not cross-examined. Dr. Rau had no opportunity in this case to respond to Dr. Juni's comments.

18. Dr. Rau is the Medical Director of Infection Prevention and Control at Halton Healthcare where he has been responsible for the institutional response to COVID-19 since the outbreak began. He has been in private practice as an Infectious Diseases specialist since 1996, and as a certified medical microbiologist since 2008.

19. Dr. Loeb holds the Canada Research Chair in Infectious Diseases at McMaster University. He is a Professor in the Departments of Pathology and Molecular Medicine and Health Research, Methods, Evidence, and Impact. He describes himself as "internationally recognized for my research in the epidemiology and prevention of respiratory and other infections".

20. Dr. Juni is Professor of Medicine and Clinical Trials at the University of Oxford and a Professor of Epidemiology at the University of Toronto. From June 2020 to May 2022, he served as Director of the Ontario COVID-19 Science Advisory Table.

Dr. Neil Rau

[5] *Toronto (City),* 2023 CanLII 94043 (ON LA) (Herman)

21. The core of Dr. Rau's Report and oral evidence was well summarized in the Union Brief.

22. Dr. Rau opined that there were two issues that contributed to the continued spread of COVID-19 in the face of mass vaccination: waning immunity and immune evasion in the population due to the emergence and evolution of variants. By Summer 2021, it was becoming clear that the COVID-19 vaccine was not preventing infection or re-infection. Further, the greater the time elapsed since vaccination, the greater personal immunity wanes. With the emergence of the Delta variant around the same time and the rise in breakthrough infections, it also became clear that the variants could evade immunity acquired through vaccination. Dr. Rau agrees that vaccines continue to limit the severity of disease including hospitalization and death.

23. Waning immunity leads to a loss of protection from infection or reinfection over time. That is, those infected or vaccinated at an earlier time may be reinfected in the case of prior infection or infected in the case of prior vaccination. Dr. Rau explained that the loss of the indirect benefit of the COVID-19 vaccine against prevention of transmission became evident in the summer and fall of 2021. He cited studies said to show that those who had survived a prior infection had lower case rates than those who were vaccinated alone. He referred to a study published in September 2021 to illustrate that transmission rates were high even among vaccinated persons. Dr. Rau concluded that, by late 2021 and certainly by February 2022, it was clear from the scientific literature that an unvaccinated nurse, as compared with a nurse who had received only a primary series of the vaccine, had a similar risk of transmission because vaccine

efficacy had fallen over time to nearly zero both because of immune evasion and waning immunity.

24. During cross-examination, Dr. Rau confirmed his understanding that hospital workers were given vaccine priority from the start and that probably 80% of front-facing staff had been vaccinated by May 2021, 90% by October 31, 2021. He did not challenge Dr. Loeb's view that 75% of the community would have been exposed to the disease and acquired hybrid immunity, emphasizing that vaccine efficacy drops over time. He countered: given that the unvaccinated without infection constituted a small group, what is the point of the Policy? Referring to the literature, he emphasized that measures of severity of outcome and the risk of transmission are not the same. If hybrid immunity is so good, why do we still see COVID? Given that almost everyone has now been infected in the context of vaccination, the added benefit of vaccination for the unvaccinated is minimal.

25. Dr. Rau's opinion -- that inability of the vaccine to prevent transmission was evident in the summer and fall of 2021 -- was not challenged directly in cross-examination. Nor was his evidence as to the significance of time since vaccination.

Dr. Mark Loeb

26. As explained in the Hospital Brief, Dr. Loeb's opinion was that the two-dose regime of vaccination was appropriate both at the time the Policy was promulgated and even as of the last date he testified (November 30, 2023). Most vaccinated individuals by now either had an infection prior to that vaccination or since vaccination, acquiring thereby a 'hybrid immunity'. Hybrid immunity is more effective than whatever immune

response may have been experienced by an unvaccinated person who has at some point had a COVID infection. Vaccines, even the two-dose regime alone, reduced and continue to reduce rates of infection and transmission, in addition to reduction in the severity of outcome of an infection,

27. Dr. Loeb took issue with a number of conclusions advanced in the Rau expert report. As Dr. Rau had done, he referred to numerous studies in support of his opinions.

Dr. Peter Juni

28. In cross-examination of Dr. Loeb [6], the Union presented an expert report by Dr. Juni filed in an earlier proceeding in which Dr. Rau had also filed a report.

29. In his report, Dr. Juni recorded that: "I will provide my opinion about when the scientific evidence suggested that there likely was no ongoing benefit to continuing mandating Covid-19 vaccination for the City of Toronto's employees.".

30. In doing so, Dr. Juni challenged his interpretation of certain statements authored by Dr. Rau for that case, as Dr. Loeb did in this one.

31. On the question of when it was appropriate to lift the mandatory vaccination policy, Dr. Juni wrote the following:

> The control of at least one more wave through recently acquired immunity from infection was reasonably necessary before changing vaccination policies, along with maintaining a manageable burden on the healthcare system and a continuous decrease in Covid-19-related deaths. [at para.53]

[6] Over the objection of the Hospital. Quinte then asked that the report be entered as an exhibit.

> On October 17, 2022, at the request of the City of Toronto, I provided my opinion regarding the ongoing need for a Covid-19 vaccine mandate for City of Toronto employees. Upon retrospective analysis, I concluded that the conditions outlined in paragraph 53 had been fulfilled by the end of August 2022. Therefore, I advised that there was likely no longer an ongoing benefit in mandating Covid-19 vaccination for the City of Toronto's employees moving forward. [at para.59] [bold added]

SUBMISSIONS (briefly summarized)

32. The short outlines that follow do not, by any means, purport to capture the detailed representations set out in the parties' Briefs.

ONA

33. It was unreasonable for the Employer to implement a mandatory vaccination Policy that resulted in the automatic discipline and discharge of unvaccinated employees. Quinte knew or ought to have known by Summer 2021, and certainly by the time of the terminations, that vaccination did not effectively prevent transmission. The Employer failed to consider whether important and relevant factors like prior infection and available alternatives would contribute to health and safety goals. It did not consider whether temporary removal of infected staff would have better addressed its pre-existing vacancies rather than a Policy that automatically discharged unvaccinated ONA members and augmented understaffing. The Employer ought to have allowed employees to report to work under Directive #6 conditions.

34. In the alternative, at most, a leave of absence might have been a more reasonable alternative. Had the Hospital taken this approach, it would have certainly

appreciated by January or February 2022, at the latest, that there was no reasonable scientific basis to exclude unvaccinated employees from the workplace and that they should be recalled.

35. The Hospital's failure to review the Policy and amend it to reflect the changing realities of the pandemic and the evolving scientific evidence was unreasonable. The Policy did not properly balance the individual interests of ONA members. It did not accomplish or contribute to the stated Policy goal of working "to protect QHC's population including patients and all health care workers". The Policy was applied universally to all staff and disciplinary consequences were automatic with no consideration of individual factors. The Policy was and is not supported by the science available both at the time of the adoption of the Policy and throughout to date.

36. ONA relied in particular upon the following cases: *KVP Co. Ltd.,* 1965 CanLII 1009 (ON LA) (Robinson); *Irving Pulp & Paper,* 2013 SCC 34 (CanLII); *Toronto (City)*, 2022 CanLII 78809 (ON LA) (Rogers) ("*Toronto Firefighters"*); *Consumers' Cooperative Refineries Ltd.,* 2023 CanLII 88216 (SK LA) (Ish); *BC Hydro*, 2022 CanLII (BC LA) (Somjen); *Elexicon Energy Inc.*, 2022 CanLII 7228 (ON LA) (Mitchell).

Quinte

37. Quinte maintains that mandatory vaccination was a reasonable means of protecting the health and safety of both its employees and patients. It says that "there is no serious legal or scientific dispute that a two-dose vaccine mandate as of the date the policy was introduced, was the single best method for reducing transmission and mitigating the seriousness of the effects of the illness". A measure that reduces the

severity of illness in its staff is an entirely appropriate measure for an employer to adopt. The Hospital was faced with an unprecedented crisis. It was not required to rely upon less effective methods such as RAT and masking.

38. Although there had been an impressive number of staff vaccinations, the Policy "shifted the needle" from 180 (unvaccinated) to 44 across all employee groups. There would be no labour relations purpose served by having policies differing between union and non-union groups.

39. The Policy was reasonable at the time it was introduced. The science and the subsequent rollout of waves is irrelevant for present purposes. The Hospital takes issue with the statement that 'waning immunity' was "on the table"; there was limited understanding at the time that it was a scientific issue. Nor was "natural immunity in mainstream scientific parlance in August 2021 as Dr. Rau asserts".

40. Dr. Rau's position that vaccination policies were no longer effective as of January or February 2022 has not been accepted in caselaw where experts have testified, and his opinion was rejected by Arbitrator Herman in *City of Toronto*, 2023 CanLII 94043 (ON LA) (Herman). Dr. Loeb's report "goes the distance" in his opinion concerning vaccine protection and transmission. There is no tool to measure elements of infection and the unvaccinated. We just don't know the level of protection and it is too tangential and challenging to expect hospitals to have gone down that route in September and November 2021 and beyond.

41. Dr. Evans had no role in the development of the Policy. He was hired as an expert to provide support and direction concerning infection protection and control. But,

as submitted by Employer counsel in oral argument: “These policies [including the Policy at issue] were labour relations exercises”. It was decided to call Dr. Loeb as an independent expert in this litigation.

42. The evidence provided by Dr. Loeb (“an esteemed, internationally recognized expert”), should be preferred over that of Dr. Rau (“a clinician, who is candid in his admission that he has not been engaged in research”).

43. The Hospital points to ss. 25(2)(h) of the *Occupational Health and Safety Act*. The fact that the government, through Directive #6, left the question of mandatory vaccination to individual employers does not undermine the reasonableness of the policy.

44. The Employer adopts *Central West LHIN,* 2023 CanLII 58388 (ON LA) (Goodfellow) and *Lakeridge Health,* 2023 CanLII 33942 (ON LA) (Herman) in full, citing excerpts from *Central West* at great length in its Brief. It promotes *Corporation of the City of North Bay,* 2023 CanLII 83430 (ON LA) (Newman) (an award released while this arbitration was underway) where it was said:

> Relying on the Central West award, I am satisfied that the arbitral jurisprudence is now settled. These issues have been put to rest. Termination as a disciplinary response to non-compliance with a mandatory vaccination policy is a reasonable requirement of that policy.

DISCUSSION

witness testimony: good faith

45. To be clear at the outset, in my opinion, Quinte and its leadership group acted in good faith throughout. Ms. Rowe testified honestly and directly as to why, how, and when the Policy at issue came to be. When tested in cross-examination, she responded to all questions without equivocation or artifice. In the result I accept her testimony with reservation only about her comment on staffing, a matter of no little importance here. Without question, the leadership group sought to take best steps to protect their patient community and all of their staff. When asked in her direct evidence what drove adoption of the mandatory vaccination policy, Ms. Rowe promptly answered: “safety first and foremost for staff and patients”.

46. I accept the opinions and testimony of the expert witness in the same way. Both Dr. Rau and Dr. Loeb are distinguished professionals whose opinions are worthy of respect. Neither were shy about disagreeing with the other and neither gave ground easily when challenged at the hearing. But both grounded their opinions on the developing medical research as they perceived it. And they did their best to translate their differing opinions to a lay arbitrator even as it was frequently rendered ‘rapid fire’ without benefit of a transcript. Both witnesses displayed their expert competence in the field. Their contribution to this process was significant and appreciated.

the question

47. This is a labour arbitration, one that should not be permitted to slide simply into a contest of medical participants to determine rights under a collective agreement. It is critically important to respect this distinction without in any way discounting the significance of the medical evidence.

48. There was a similar evidentiary duel between medical experts some years ago relating to influenza and a 'vaccination or mask' controversy. I approached that dispute in the same way as I have attempted to do here:

> **To review the labour relations implications of the VOM Policy does not disregard or discount the medical expertise. It simply recognizes that the medical expertise has a different focus that is incomplete for the purposes of the legal question at issue. While important in assessing what is reasonable, the medical expertise is not controlling in and of itself because it does not engage the labour/human rights/privacy expertise that balances employee rights with scientific information.**
>
> [bold added]
>
> It is surely the case that there are better ways of resolving complex policy issues such as this, in which many stakeholders have an interest, but this does not in any way displace or discredit the legitimate role of labour arbitration. It is very likely that the science will evolve and opinions about the prevention and control of influenza disease may coalesce into more of a consensus than has been achieved to date. But there are lines to be drawn in the meantime. Where their working lives are directly affected, the interests of employees require consideration and typically their unions have recourse to rights arbitration to test judgments that have been made.
>
> *Irving* balancing demands nuance and it is not sufficient to claim that scant, weak, "some", or imperfect data is better than nothing. While the precautionary principle (reasonable efforts to reduce risk need not wait for scientific certainty)

> surely applies in truly exceptional circumstances, one could not live in a society where only 'zero risk' was tolerated. It cannot be right that a labour arbitrator should effectively abdicate by simply applying Dunsmuir-type deference to expert opinion planted in shallow soil.[7]

49. The ONA Brief puts this essential point far more succinctly: "The relevant question is whether this Policy – a Policy that suspended the grievors for two weeks and ultimately terminated them for refusing to be vaccinated – was reasonable in the circumstances, not whether there is medical evidence to support a mandatory vaccination policy.".

50. Nor was this perspective lost on Employer counsel who submitted, as noted above: "These policies were labour relations exercises". She did not mean, of course, to suggest that they weren't more than that. But this case is not to be resolved simply by choosing the opinion of one expert over the other.

KVP/Irving: reasonableness/balancing

51. As noted in *Central West*, all of the arbitral awards to date dealing with COVID applied the universally accepted test drawn from *KVP*[8], most with the assistance of the 'balancing of interests' approach to reasonableness identified by the Supreme Court of Canada in *Irving*.[9]

52. *Central West* cited lengthy excerpts from *Irving* (challenge to a mandatory drug and alcohol testing policy) including the following:

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[7] *Sault Area Hospital,* 2015 CanLII 55643 (ON LA) at paras. 338-340
[8] *KVP Co. Ltd.,* 1965 CanLII 1009 (ON LA) (Robinson)
[9] *Central West,* at para. 11

> **Determining reasonableness requires labour arbitrators to apply their labour relations expertise, consider all the surrounding circumstances, and determine whether the employer's policy strikes a reasonable balance. Assessing the reasonableness of an employer's policy can include assessing such things as the nature of the employer's interests, any less intrusive means available to address the employer's concerns, and the policy's impact on employees.**
>
> ***
>
> In the end, the expected safety gains to the employer in this case were found by the board to range "from uncertain…to minimal at best", which the impact on employee privacy was found to be much more severe…Random, alcohol testing was therefore held to be an unreasonable exercise of management rights under the collective agreement. I agree.
>
> This is not to say that an employer can never impose random testing in a dangerous workplace. If it represents a proportional response in light of both legitimate safety concerns and privacy interests, it may well be justified.
>
> [bold added]

53. I adopt this analytical course.

legal context: previous COVID arbitrations

54. The previous awards in this area have emanated from all manner of workplaces and the nature of the challenges to vaccination policies have varied to some degree. Arbitrators have often rejected union submissions that mandatory vaccination policies were unreasonable given what were said to be less intrusive alternatives such as rapid antigen testing, augmented PPE, work from home protocols and the like. These cases, apart from *Lakeridge*, did not involve hospitals and none involved ONA.

55. Most assuredly, a patient-facing hospital is not the same as an oil refinery or a bottling plant. Nevertheless, there appears to have developed a general arbitral

consensus that mandatory COVID vaccination policies were reasonable when they were introduced. There has been recognition that the public health emergency caused by COVID required exceptional responses for all public, commercial, and workplace spaces.

56. The employee 'termination' issue, however, has not resulted in a similar consensus as even cursory review of the jurisprudence illustrates. I will return to this issue.

57. Quinte has relied entirely upon the analysis and findings in *Central West* and *Lakeridge*, requiring repeated reference to those awards here. As always, the facts of individual cases matter. Neither *Lakeridge* nor *Central West* are this case.

The mandatory COVID vaccination requirement issue

58. At the time the Policy was conceived and implemented, Quinte was faced with a public health emergency of unprecedented scope. The Hospital, rightly so, was alive to the expectations of its professionals, employees, and the public that responsive precautionary action be taken. [10] During the summer of 2021 the Delta virus was on the scene and threatening. The Employer responded with the Policy at issue.

59. While they were mentioned, the Union did not ground its objection to the mandatory vaccination requirement on a submission that less intrusive options such as RAT were sufficient in the teeth of the pandemic. And the focus in *Central West* upon

[10] While her evidence on this point was technically hearsay, I have no doubt that Ms. Rowe was hearing these things. It was notorious in this province, and likely everywhere, that patients were concerned about being cared for by unvaccinated nurses.

alleged work at home possibilities has no application to registered nurses working at Quinte. ONA, instead, challenges the science underpinning the Policy.

60. In this respect, Dr. Rau mounts a case very strongly that mandatory vaccines were of no assistance in preventing transmission at the relevant time. He stakes his opinion on a close reading of the medical literature. He well-explained the importance of concepts such as ‘natural immunity’, ‘waning immunity’, and ‘vaccine efficacy’ and much more. He explained there was a lower risk of transmission in workplace settings as compared with household settings. He presented statistical support for his opinions. He said that the vaccine does not prevent infections over the long term and therefore does not provide an indirect population benefit of stopping transmission. He reviewed what he said were the flaws in initial studies providing estimates of vaccine efficacy against infection, upon which many of the mandatory vaccine polies were likely predicated. He pointed to scientific evidence to demonstrate that vaccinated and unvaccinated (but infected) persons are equally infectious once infected or reinfected respectively. He stated that the loss of indirect benefit of the COVID-19 vaccine against prevention of transmission became evident in the summer and fall of 2021.

61. The expert reports of Dr. Loeb and Dr. Juni take issue with various conclusions drawn by Dr. Rau and/or the weight to be ascribed to aspects of the matter. Their opinions are also based upon their interpretations of the available literature, in some cases the same research as Dr. Rau. The opinions on core issues were not compatible, at least as they were presented.

62. However, stepping back from the ‘trees’ of the witness dialogue, it is important to recognize two matters in particular: 1) when it was that the Policy was devised by the local hospital leadership and what knowledge could reasonably have been attributed to them then, and, 2) what the experts agree upon -- as opposed to what they disagree about.

63. As the testimony and exhibits filed in this case demonstrate, COVID spawned massive international research into every aspect of the disease. Dr. Loeb and Dr. Rau provided a window into this global enterprise, and they do not disagree about the relevant elements requiring study. Researchers were faced with evolving variants requiring continual reassessment of previous assumptions. It is scarcely surprising that the experts began, in the challenging context of COVID, to explore and apply concepts such as transmission, asymptomatic infections, infectiousness, natural immunity, waning immunity, hybrid immunity, immune evasion, vaccine efficacy, and more. The experts, including Dr. Loeb and Dr. Rau, agree upon the ‘forest’ as it were. They study and work with infectious diseases after all.

64. But their learning and opinions about the ‘trees’ is necessarily hostage to the difficulties in conducting definitive studies in people about these core questions. And there are always circumstances where black and white answers are not available. There is always ample scope for expert disagreement. The translation of medical research to clinical application requires judgment.

65. All of this happening in real time as disease spread through the community through the previously vaccinated as well as those unvaccinated. All of this in an

environment of unprecedented public awareness in some cases bordering on panic. The pandemic demanded real time responses from public officials and professionals on the ground who did not have the luxury of delay for lengthy reflection. Common sense judgments had to be made without the security of scientific certainty or even broad interim consensus.

66. It is against this backdrop that the leadership at Quinte determined to introduce the Policy. Dr. Colin MacPherson, the Quinte Chief of Staff, was alert to the complexity of the problems and certainly aware of waning immunity and transmission issues early. For example, in a message sent on his behalf to all Quinte staff and physicians on August 23, 2021, he wrote the following:

> Recent experience in other hospitals have made clear that the Delta variant can cause serious trouble even in places with high vaccination rates. It can spread among vaccinated health workers, and although symptoms are typically relatively mild in vaccinated individuals, it can sideline staff from work and seriously compromise clinical services. Many of our patients, though vaccinated, have complex illnesses which can be severely complicated by infection with the Delta variant.

There was “research evidence/jurisdictional experience” material assembled by the provincial Research, Analysis and Evaluation Branch on all manner of topics being disseminated at the Hospital from time to time.

67. If Employer counsel meant to suggest that such issues were entirely unknown at the Hospital, she reaches too far. Even lay members of the public were becoming more and more aware of the importance of boosters.

68. The publication dates of the journal articles entered as exhibits lead me to question Dr. Rau's confident assertion that the 'transmission' issue was understood in the summer and fall of 2021. Almost every one of the articles he cites in support of his opinions were published after November 2021. And, in any event, as the expert reports of Dr. Loeb and Dr. Juni illustrate, there was considerable space for differing conclusions to be drawn about core issue, notably the effect of vaccines on transmission. In my opinion, the Hospital may not be reasonably criticized for being uninformed about the 'latest' or acting without waiting for more certainty.

69. Therefore, given what was generally known in the late summer and fall of 2021, I conclude that Quinte acted reasonably when it did even were it now to be found that Dr. Rau's current assessment of the issues should be preferred over that of Dr. Loeb, an assessment that is unnecessary to be made now. It was only after November that the research studies, relied upon and debated by the experts here, were coming to be published let alone more widely known.[11] At the time, there was general acceptance that COVID vaccines were safe, impaired transmission, and were effective in reducing the risk of severity of disease. Ms. Rowe's explanation – safety, first and foremost -- was credible and creditable.

70. Previous arbitrators, in some cases with the benefit of expert evidence, have reached he same conclusion for their own reasons. They have noted that management has the authority to impose workplace rules, that mandatory vaccination policies have a plausible foundation in the precautionary principle and the *Occupational Health and*

[11] By rough count close to 90% of the articles cited by Dr.Rau.

Safety Act obligation, and that Directive #6 should not be taken as any kind of determining guide or governing limitation. I also have no issue with Quinte preferring to stay in step with other area hospitals and patient expectations that were far from irrational.

71. On the facts before me, on the point of a mandatory vaccination requirement, Quinte did the right thing. The Hospital had good reason to do so when it did and might have been subject to legitimate criticism if it had not.

72. I take a different view of the Policy's approach to non-compliance and turn now to that issue.

The termination for non-compliance issue

73. For the reasons that follow, I conclude that the Policy was unreasonable in that it does not permit the placement of those nurses, who chose not to be vaccinated for COVID, on unpaid leaves of absence.

were they "automatic terminations"?

74. What does the Quinte Policy say and how has it been applied?

75. Whatever may have been the facts before previous arbitrators, there is no room for doubt here. The ASOF records the relevant language. The Policy speaks to considerations of "all options" for enforcement including "unpaid leaves of absence" at the front end and then moves to **"if at any time an employee advises QHC that they do not intend to comply with the terms of the Policy, even if for reasons important**

to them, that employee will be terminated for cause immediately". [bold in the Policy][12]

76. Ms. Rowe's testimony was unequivocal. She was unaware of the personal circumstances of any of the discharged employees because there was no need for her to become aware. There were no exceptions to automatic termination for any employee who chose not to be double vaccinated.

77. There are management rules/policies that give employees notice that non-compliance may lead to discipline up to and including discharge. Depending upon the rule, such notice may be said to be required. It is quite a different thing to publish a rule that provides for summary discharge in the event of breach. In this latter situation, absent a specific penalty provision negotiated with a union, automatic termination would appear to conflict with typical just cause protections: *Toronto Firefighters*, at para. 311.

78. I find that it does so here. Whatever the case may have been in Central West, there is no room here to conclude other than that automatic discharge was intended to be a fundamental element of the Policy. The Policy was indeed intended to be "coercive" as explained in *Central West* and *Lakeridge*. Refusal to vaccinate was intended to result in termination.

79. On the Quinte fact pattern, to conclude that the Policy could be interpreted to entail a second phase in this arbitration, to consider individual circumstances on a conventional just cause standard, would be to embrace a fiction.

[12] See para. 8 above, found in ASOF at para.36

why not unpaid leaves of absence

80. The only evidence on this point came from Ms. Rowe and it was minimal. She explained that indefinite unpaid leaves were discussed but rejected for two reasons: "we did not foresee any short or mid-term change for a vaccine requirement, a core layer of COVID response"; "the other challenge was the recruitment issue, we would have to hold positions open, we would only be able to backfill temporary roles".

81. With the greatest of respect, I do not agree with the following comments of the prominent arbitrator in *Central West*:

> The alternative proposed by the Union – that the Employers be required to place all employees who do not wish to be vaccinated, while the vaccinated continued working, on **indefinite leaves of absence** – leaves that would last until the Employers could *demonstrate* harm to their legitimate business interests, or until there was no longer a need for the requirement, or until those who did not wish to vaccinate changed their minds – **is, in my opinion, presumptively unreasonable. And it requires no specific evidence to establish. It is plain and obvious**.
>
> [at para. 157]
>
> [italics in the original/ bold added]

82. If these observations were said to apply to ONA and the very few registered nurses terminated by Quinte, I would say there is absolutely nothing plain and obvious about such a conclusion.

83. The evidence adduced here proves otherwise.

84. First, the safety issue.

85. In effect, ONA complains that the Hospital made the wrong selection in a binary choice between the termination of employees and their placement on unpaid leaves. The possibility of equivalent, alternative, less intrusive measures was not actively pressed by ONA at the hearing. I have fully credited the Hospital's action in requiring mandatory vaccination by nurses on the basis of what it knew, and reasonably should have known, at the time the Policy was introduced and applied. Removal of unvaccinated employees was justified having regard to the perceived well-being of patients, other staff, the public, and the nurses themselves. As other arbitrators have said, the precautionary principle and the *Occupational Health and Safety Act* also stand in support of that decision.

86. What *is* plain and obvious is that the removal of unvaccinated nurses would have served the same safety objectives as terminations, given the Hospital's concerns. If nurses had been placed on indefinite unpaid leaves, they were gone.

87. In this vein, the booster question should not be overlooked. No expert was even asked about the benefit of boosters at the hearings. The benefit was taken for granted. If safety had at that point been the paramount, indispensable ("first and foremost") consideration, one might have expected the acquisition of mandatory boosters to have been added as an essential requirement for continued employment. This did not happen.

88. The possibility of amending the Policy was discussed in November, but Ms. Rowe testified that it was decided that the benefits of the booster shot did not outweigh

the risk of losing further staff to terminations. There is no evidence that Dr. Evans was asked for his opinion.

89. Quinte was certainly at liberty to make that labour relations assessment, an internal management balancing exercise if you like. Safety first and foremost but not quite so first and foremost as before. Unboosted employees, vaccinated many months before, remained at work before and after acquiring COVID infection. Yet this Employer election did not trigger a rethink of the need to discharge the very few remaining unvaccinated nurses, when the benefit of double vaccinations had been reduced by that time on any view of the matter.

90. This brings me to staffing.

91. Second, the alleged recruitment issue.

92. This is the only area of Ms. Rowe's testimony that gave me pause as it is not mentioned in the comprehensive 'risk' list that she prepared at the time. [13] Given her admirable attention to detail, if recruitment or staffing had then been seen as any kind of real concern, flowing from anticipated COVID terminations, it would surely have been noted.

93. It is impossible to ignore that *Lakeridge* is the only COVID arbitration decision to date arising from a hospital. And the *Lakeridge* outcome turned heavily on this point. That decision was released while this case was being case managed. With respect, Ms. Rowe's reference to "recruitment" in her testimony has more the look of a convenient

[13] QHC Vaccination Policy: Risk Review, September 16, 2021

attempt to echo that award without fitting the facts. I do not accept that “recruitment” was on the Quinte radar when the automatic termination decision was adopted.

94. In actual fact, the Hospital was facing serious nursing staffing problems exponentially greater than any posed by placing 9 nurses on leave. The Hospital was having difficulty recruiting nurses at all as Ms. Rowe conceded. The COVID situation had nothing to do with Quinte’s serious staffing problems. Albeit statistically insignificant, the automatic terminations only added to the problem.

95. In *Central West*, a different environment, it was said that there was no need for evidence of this kind to make the “plain and obvious” point that backfill positions are hard to fill. But the statistical evidence in this case is undeniable. There were approximately 350 vacancies for ONA positions between November 2020 and March 2023 and none were due to terminations due to the Policy as Ms. Rowe confirmed.

96. Third, the explanation that the Hospital did not foresee any short or mid-term change for a vaccine requirement (presumably making indefinite leaves untenable).

97. I have no doubt that Ms. Rowe accurately described Hospital’s belief at the time if there was a collective belief at all. But was this reasonable?

98. I see no need to consider the question of whether the Policy, in these circumstances, could be considered *per se* unreasonable without a specific internal reference to possible change. Whether or not the Policy could or should have formally provided for constant review and possible amendment given the unique COVID

situation, there was surely no reason for the Employer not to allow for that possibility on its own volition. Employer rules and policies are routinely subject to review.

99. This Award accepts that Quinte could not reasonably have been expected to be alive to the latest research as it became available. But what the Employer did know was that this pandemic was fluid and constantly evolving. And it did know that more research advice was becoming available almost continuously. Dr. MacPherson was advising his professional staff accordingly. Further, the waning immunity issue was certainly coming into full view, even for lay people, with the contemporary public attention to boosters. Public health advisories were subject to change and there were amended Directives coming from the Chief Medical Officer of Health. There was nothing certain at all and everyone knew it.

100. So did Quinte, of course. The Hospital's Weekly Bulletin of September 2, 2021, under the "QHC Covid-19 Vaccination Policy" bullet point said the following: "Based on an ongoing assessment of risk, this policy may be revised at any time to include increased testing or mandatory vaccination requirements for existing staff and physicians." And the Policy itself referred to all enforcement options being available for consideration – before that statement was undercut by its following warning about immediate termination for cause.

101. There is no indication that the Hospital ever thought at this point to leave its downstream options open and to balance the interests of the unvaccinated nurses *qua* employees. For all Ms. Rowe knew, the Hospital was terminating a senior nurse who had provided dedicated service to patients throughout the pandemic and long before.

Regardless of any personal circumstances, length of service, possible discipline free record, no matter where she worked in the Hospital. And doing so automatically.

102. There is always a small cohort of employees on short and long term disability leaves in hospitals and employers are required to cope with the inconvenience. It would have cost the Hospital next to nothing, perhaps nothing, to place a few unvaccinated nurses on leave, even indefinite leave. Instead, they were summarily discharged. There was no reason for Quinte to adopt a rigid Policy position on unvaccinated terminations, fettering itself to their mechanical application, and blinding itself in advance to change that was almost certainly coming. To my mind, that is the antithesis of what is contemplated by just cause review, a right that may not be appropriated by an employer through a policy, whether or not it be otherwise well intended.

103. The decision to automatically terminate a nurse returning from a parental leave only underlines the point. Quinte discharged that nurse in *April 2023*.

104. Fourth, the case law.

105. I see no purpose here in purporting to canvas the many COVID arbitration awards that have preceded this one. They contain many useful insights into a difficult problem where the exigencies of a genuine medical emergency have come to test traditional labour relations values. This issue has surfaced strongly held differing medical opinion and it should be no surprise that labour arbitrators, presented with various fact patterns, have not responded with one voice either.

106. For what it may be worth however, in my view, the very recent decision in *Consumers' Cooperative Refineries Ltd.* does an outstanding job in synthesizing the differing arbitral approaches taken to date.

107. Arbitrator Ish, a senior western arbitrator, noted that:

> the analysis in the cases have tended to bifurcate the overall reasonableness of a COVID policy and the enforcement of the policy. With respect to the latter, which is the issue in the present case, the "COVID decisions" have taken one of two routes.
>
> [at para.116]
>
> The result of many of these decisions is that while the policy itself was found to be reasonable, its enforcement mechanisms and their application were not considered to be reasonable.
>
> {at para.120}

108. The Arbitrator identified *Lakeridge* and others as offering one route and *Toronto Firefighters*, *BC Hydro,* and others, a second.

109. Arbitrator Herman, in *Lakeridge*, could not have explained his opinion (that it was reasonable to include terminations of unvaccinated employees as a component of a policy), any more directly or sweepingly than he did. There is no chance of his opinion being misconstrued:

> Typically, the individual circumstances of employees being disciplined, such as length of service, discipline record, or reasons for the employee's conduct are generally considered before discipline is imposed. This case does not arise, however, in a typical disciplinary context. The customary right of an employee to have personal circumstances considered in determining the justness of discipline or discharge has significantly less applicability, if any, in a context where placing

an employee on leave or termination, because the decline to get vaccinated, is justified on the basis that it is necessary for them to be vaccinated in order for the Hospital to be able to continue provide its core services.

[at para.187]

110. Arbitrator Ish preferred the second line of authority, as do I.

111. He observed that the cases make the following points:

- The discipline imposed must be necessary to meet the employer's health and safety concerns.
- There must be consequences for an employee's refusal to comply with a health and safety policy found to be reasonable. However, the consequences must also be reasonable and, if disciplinary, must meet the standard of just cause.
- There must be a balancing of interests between the employer and the affected employees, including evidence of any necessity or operational effect to the employer by imposing the enforcement discipline. As set out in Irving…
- Multiple warnings do not change the fundamental nature of coercive or threatened serious discipline…
- Insubordination, by refusing to follow the policy, is not determinative of just cause for termination without reference to any exceptions or answers to the offence of insubordination recognized in arbitral jurisprudence or to circumstances that might militate against an arbitrator's upholding the discharge decision, such as a lengthy, faithful service and a record of compliance with all other employer policies and procedures. The typical justification for discipline in response to some forms of insubordination (obey now and grieve later) do not fit well with COVID policies which involve the irreversible intrusion of an employee's privacy and bodily integrity associated with the policy's compliance…A policy or enforcement mechanism cannot presume insubordination with no basis for an assessment of an individual's intention, manner, or attitude.

  [at para.121]

112. In the result, Arbitrator Ish set aside the terminations before him for the following reasons:

- There was no evidence that an unpaid leave of absence would jeopardize the employer's health and safety obligations.
- There was no evidence that the grievors' absence from the workplace affected or would have affected the employer's operations.
- The employer's focus was solely on compliance with the policy and ultimately determined that the dismissal was the only option given the grievors' objection to the policy because of their personal choice reasons.
- The "main reason for this conclusion is that the employer's response ignored a fundamental finding of the Court in Irving…."
- The employer's interest could have been addressed by removal from the workplace without resort to dismissal.
- It is difficult to see prejudicial impact on the employer.
- The financial impact on the grievors was the same with an unpaid leave as a termination, but less than the ultimate impact of dismissal.
- When the interests of these two employees are balanced against the interests of the employer, they tilt in favour of the employees because they ultimately would sacrifice considerably more than would the employer.
- While it is correct that it was not known how long the restrictions would continue, they were perceived to be temporary.
- If the grievors were allowed to remain on an unpaid leave, that decision could be revisited at any time if circumstances changed.

  [at paras.129-132]

113. *All* of these reasons resonate with the Quinte case. I agree with Arbitrator Ish, that decisions such as *Lakeridge* should not be followed on this point.

114. I conclude where I might have begun. Arbitrator Mitchell set out the employee interest, in cases such as this, very well in *Elexicon*. That interest is material and substantial:

> Whatever may constitute irreparable harm in an application for injunctive or interim relief, in the context of an assessment of the reasonableness of a mandatory vaccination policy, it would be inaccurate and disrespectful to the legitimate interests of employees in maintaining their income and employment in my view, to ignore the genuinely coercive nature of a policy which threatens their income and their employment…..The coercive impact of the threat of loss of income, benefits, and employment and the impact on stability and careers is very real. In my view, of course employees have a choice, but saying that choices are hard is insufficient when it comes to determining the reasonableness of the Policy. In my view, arbitrators should take into account in the balancing exercise the deep dilemma of employees who strongly do not wish to be vaccinated whatever their motives, and who may have few or no other realistic choices to work elsewhere or who will have to give up a significant amount of earned benefits and stability if they choose not to get vaccinated. Just because there are hard choices as opposed to no choice at all, does not make the Policy not coercive, or make it more reasonable.
>
> [at para.92]

breach

115. The Hospital's adoption of its Policy in September 2021 was well motivated, driven as it was by genuine safety concerns. But that focus overwhelmed its obligation to balance employee interests as *Irving* commands. Nurses intent on remaining

unvaccinated are a small minority everywhere but their employee rights may not be ignored. The evidence led in this case demonstrates clearly that automatic termination of non-compliant nurses was fundamental to the design of the Quinte Policy and was unreasonable. The decision of the Hospital to dismiss the nurses failed the *Irving* balancing test entirely.

remedy

116. It follows from this finding that the Policy must be set aside insofar as it required and resulted in the termination of the individual grievors. They should have been offered the option of an unpaid leave of absence and must, therefore, be reinstated as Quinte employees if that be their wish.

117. The question then arising is what, if any, further remedy might be appropriate. The Union submits that the grievors' leaves of absence should have ended on January 31, 2022, or on such further date as the Arbitrator determines to be appropriate. Compensation is sought.

118. There has been a lot of water under the bridge since November 2021.

119. The experts relied upon here by the Hospital do not themselves agree upon when the mandatory vaccination policy should have been lifted, if at all. The discharged nurses will have carried on with their personal and professional lives independently.

120. Before any further litigation steps are taken, the parties should meet to discuss their respective positions in light of these reasons and the current situation.

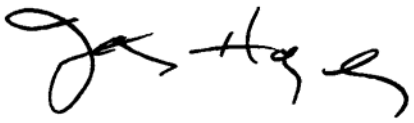
DISPOSITION

121. I find and declare that the Quinte COVID-19 Policy must be set aside to the extent that it requires the automatic dismissal of any non-compliant member of the ONA bargaining unit.

122. Any further remedial issue, including that applicable to the individual grievors is referred back to the parties.

123. I remain seized with respect to any issues related to the implementation of this decision.

Dated at West Vancouver, British Columbia, February 28, 2024.



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James Hayes
Sole Arbitrator