INTRODUCTION

Many of our clients are asking important questions about legal issues related to the COVID-19 pandemic. This issue of our Newsletter, like the last issue, continues to address these issues.

As always, please feel free to contact us with any questions you may have in relation to any of the topics covered in this Newsletter.

A special thank you to all of your members who continue to work despite the challenges and risks to themselves and their safety and health.

We wish everyone good health.

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A. ONTARIO'S LONG-TERM CARE COVID-19 COMMISSION RELEASES FINAL REPORT

Raymond Seelen

The COVID-19 pandemic has resulted in untold suffering across the provinces, and nowhere has this been more deeply felt than in the long-term care sector. At the time of writing, there have been a staggering 3,764 resident deaths in the sector, as well as 11 staff deaths. These numbers measure only a fragment of the impact of this virus and do not show the emotional, mental and physical suffering endured by front-line health workers throughout the course of the pandemic.

In the context of this unprecedented public health disaster, the Province established the Ontario Long-Term Care COVID-19 Commission in July 29, 2020. The Commission's mandate was to investigate the spread of COVID-19 in the long-term care sector. The Commission issued its final report on April 30, 2021.

Caley Wray was retained by the Service Employees International Union, Local 1 Canada ("SEIU") to represent it before the Commission. The final report, while not without its flaws, lays out a pathway for systemic reform in the long-term care sector. It is our view that the majority of the Commission's recommendations, if implemented, will significantly improve working conditions for the frontline health care staff that SEIU and other trade unions represent and will thereby improve the quality of care that vulnerable seniors can expect to receive. SEIU's advocacy before the Commission was largely successful. SEIU issued 11 calls to action to the Commission. Of these 11 items, the Commission made recommendations linked to each call to action, endorsing them either in whole or in part. This success could not have been achieved without the hard work of numerous persons at SEIU, including Director of Governmental Relations Michael Spitale; Head of Strategic Research Matthew Cathmoir and his team; Sector Service Manager for Long Term Care Ricardo McKenzie; and the dedicated staff at all levels of the SEIU's organizational structure. SEIU's submissions to the Commission were supported by numerous brave frontline healthcare workers who put themselves at risk of retaliation from their employers by testifying before the Commission. Last, and certainly not least, advocacy before the Commission was significantly supported by SEIU's President Sharleen Stewart who personally testified before the Commission on both the struggles faced by SEIU as an organization and about her own personal experiences supporting frontline workers.

The Commission found in no uncertain terms that the long-term care sector had been neglected by successive provincial governments. The Province has, for decades, failed to adequately fund long-term care homes, failed to enforce the care standards that it has set and has failed to maintain the physical infrastructure of the buildings where care is provided. The Commission's recommendations, in many aspects, call for the Province to invest more resources into long-term care – that is, more funding, more integration and

more accountability. SEIU has pressed the Province to implement these measures for decades and the public recognition of these problems is welcome.

Against the background of this broad success, it is all the more important to consider where the Commission fell short. The following comments are not meant to diminish the important recommendations made by the Commission. Rather, they are intended to apply careful criticism in those areas where the Commission could have done better.

Two of the key recommendations which SEIU put forward to the Commission were that no new contracts for long-term care should be awarded to profit driven companies and that for-profit provision of long-term care should be phased out. The SEIU is well aware that existing long-term care home operators put profits margins ahead of quality of care. To its credit, the Commission did recognize that for-profit care providers were directly responsible for some of the worst outbreaks over the course of the pandemic and that care should not be provided by those whose only motive is profit. However, the Commission stopped short of recommending an end to for profit enterprise in long-term care.

First, the Commission recognized a category of "mission-driven" organizations. The Commission defines a mission-driven enterprise as one which "[focuses] on goals rather than commercial success as an end in and of itself." The Commission suggested that businesses which are considered "for-profit" for tax purposes may be mission-driven in practice and that there is no reason not to include mission-driven for-profit providers in the long-term care system.

This is a very troubling position. Tax status is often used as a way to categorize long-term care homes because the determination of tax status is a clear and time-tested method based on established criteria which is used to assess the goals or purpose of the organization. There is a statutory definition of a non-profit organization and the status of non-profit organizations is regulated by the Canada Revenue Agency.

For-profit long-term care providers often describe themselves as mission-driven. This self-identification can be little more than marketing. No sane person wants to send a loved one to a facility that implies it is not driven by a desire to provide care. When the Commission states that only mission-driven organizations (for-profit or otherwise) ought to be involved in the provision of care, it is inviting profit-driven organizations to simply characterize themselves as mission-driven. The tax status guideline is a clear dividing line between those organizations which operate for a profit and those which do not. The mission-driven characterization is not and invites for-profit enterprises to continue to be involved in the long-term care sector.

Second, the Commission recommends that the Province turn to for-profit providers for capital to finance the construction of new facilities and the refurbishment of existing facilities. The Report envisages a process where the for-profit providers essentially lease,

sell or mortgage new buildings to the province for a profit. In the Commission's view, this practice will help the province meet the funding shortfall necessary to create new long-term care beds. While this process will limit the penetration of for-profit providers into the long-term care sector, it will not transfer existing homes that are operated on a for-profit basis to other ownership. It is not a plan to end for-profit provision of care, rather, it is a method by which to curtail its growth.

Moreover, it is important to note that for-profit long-term care providers largely escaped substantial criticism throughout the Report. It is acknowledged repeatedly through the Report that long-term care providers were largely unprepared for the pandemic. This is clear in relation to pandemic planning, PPE stockpiling, leadership and IPAC training. Much of these deficiencies are related to deficiencies in provincial funding, regulation and government guidance. The Report also notes that the sector was left out of the Provincial pandemic planning for months after the first cases in Ontario. In many ways, long-term care home operators are painted as victims of government negligence.

The Report does not address significant lobbying by for-profit operators in the long-term care sector. It is transparently clear that inadequate regulation played a role in the spread of COVID-19 in long-term care. However, the industry plays a role in the shaping of its own regulatory environment. The industry advocates for a lack of oversight and a lack of enforcement, which in turn enables homes to reduce operating costs. This is, in part, why countless reports and studies have recommended reforms to long-term care, but few of those reforms have been carried out. The Commission ought to have examined these lobbying efforts in depth.

The Commission also had very little to say about the role of the Ministry of Labour, Training and Skills Development ("MLTSD") in the pandemic. Among other things, the MLTSD is responsible for the enforcement of the *Occupational Health and Safety Act* ("OHSA"). Early in the pandemic, MLTSD inspectors rarely attended long-term care facilities in person and conducted most investigations over the phone. As the numerous reports from the armed forces and hospital management teams would later show, the conditions in many homes during the pandemic's first wave were horrifying. By failing to attend in person, MLTSD inspectors often failed to realize the severity of conditions. It took multiple applications to the Ontario Labour Relations Board by SEIU before the MLTSD would resume in-person inspections. It is concerning that the Commission did not recognize the role of the MLTSD in this pandemic and more concerning that there were no recommendations directed at the MTLSD.

In summary, while the Commission understood the magnitude of the challenge facing the long-term care sector, there remain substantial gaps in the Commission's recommendations. Historically, recommendations for reform in the long-term care sector have been left unimplemented. Implementing the Commission recommendations ought to be a priority for all stakeholders in the long-term care sector. However, in implementing these recommendations, the various gaps and short-comings of the recommendations

cannot be ignored. While the Commission Report is an excellent starting point, further systemic changes beyond what is contemplated by the Commission will be necessary to improve working conditions in this sector and to protect the health of both residents and workers in the next pandemic.

B. CAN EMPLOYERS ENFORCE MANDATORY VACCINATION POLICIES FOR COVID-19?

Erin Carr

The question of whether an employer can require employees to be vaccinated against COVID-19 has attracted considerable attention over the past several months. The debate puts trade unions in a difficult position, with memberships split between those who support mandatory vaccination as a means to ensure workplace health and safety, and those who oppose mandatory vaccination on the premise of preserving the right to privacy, bodily integrity, and individual choice. Requiring an employee to receive a vaccination is, after all, asking that they undergo a medical procedure, and is therefore highly invasive.

The short answer is, in the absence of legislation, an employer cannot force an employee to be vaccinated. However, certain high-risk employers may be able to implement policies which impose restrictions on employees who refuse the vaccine, such as masking, frequent COVID-19 testing, or taking a leave of absence, possibly without pay.

Mandatory vaccine policies generally

While this precise issue has yet to be the subject of a legal challenge, a number of adjudicators have already demonstrated a willingness to err more on the side of workplace safety in the context of mandatory vaccination policies for the seasonal flu. In those cases, mandatory vaccine policies have been upheld in healthcare contexts based on a finding that the employer's interest in workplace and public safety outweighed any violation of employee rights. Several other arbitrators have also ruled *against* mandatory vaccine policies, finding that they amount to coerced medical treatment, a form of assault. For several reasons, the objections of those arbitrators are unlikely to carry much weight in the context of the current pandemic.

First, we know COVID-19 is far deadlier than the seasonal flu, particularly in vulnerable populations. We also know that COVID-19 is much more infectious than the seasonal flu, and further, we know that COVID-19 vaccines are up to 95% effective—a stark difference when compared to the seasonal flu vaccine, which ranges between 40%-60% effectiveness.

Given these key differences, mandatory vaccination policies for COVID-19 are likely to be upheld in high-risk settings depending on the nature of each particular workplace. For instance, in healthcare contexts, such as hospitals and long-term care homes, an appropriately drafted and reasonably implemented mandatory vaccine policy would likely be seen as both necessary and reasonable. The answer is less certain in non-healthcare congregate work settings, where there is a heightened safety risk from COVID-19 transmission (e.g., meat packing plants, warehouses, construction). Finally, in low-risk contexts, where the risk of transmission may be mitigated by workplace measures such as masks, physical distancing, and regular testing, mandatory vaccination policies will likely be considered unenforceable.

Ontario government introduces vaccine education for LTC workers who refuse the vaccine

On May 31, 2021, Ontario became the first province to announce that all long-term care homes in the province will be required to put into place COVID-19 vaccine policies for all staff. The policy will require each staff member to do one of the following by July 1, 2021:

- Provide proof of vaccination of each dose;
- Provide a documented medical reason for not being vaccinated; or
- Participate in an educational program about the benefits of vaccination and the risks of not being vaccinated.

So far, the only exception arises where the worker provides a documented medical reason for not being vaccinated. This opens the possibility for a legal challenge by individuals who cannot be vaccinated due to other human rights grounds, notably, those who refuse the vaccine based on sincerely held religious beliefs.

The government has yet to comment on whether employers will be permitted to require the vaccine; it merely set out the minimum requirement of employers to implement an educational program. The government also did not comment on whether time spent completing the educational program will be paid. The usual rule states that employers must pay employees for training when it is required by the law or by their employer.

Important caveats

In any event, there are several important caveats to consider if and when employers introduce mandatory vaccine policies.

The first caveat is that employers will not be permitted to force employees to be vaccinated against their will, but rather, to impose restrictions on employees who refuse the vaccine. For example, an employer may direct an employee who refuses the vaccine to work remotely, wear a face mask, adopt different work conditions to ensure physical distancing, undergo regular COVID-19 tests, and/or take a leave of absence, possibly

without pay. If the policy is challenged, employers will likely need to explain why alternative, less invasive measures would be inadequate in the circumstances.

Another crucial component of any mandatory vaccine policy is that it must accommodate employees who refuse the vaccine based on protected grounds under human rights legislation. For example, employees who cannot be vaccinated because of religious beliefs, medical conditions, or disabilities are entitled to reasonable accommodation up to the point of undue hardship. What constitutes reasonable accommodation and undue hardship will depend on the specific circumstances of each case. For instance, if an employee's work can be completed remotely, a work-from-home accommodation may be reasonable. If working from home is not possible, a reasonable accommodation may include daily COVID-19 assessments before entering the workplace, maintaining appropriate physical distances, and wearing a mask. However, if the employer can demonstrate that such measures would be extremely onerous, costly, or unsafe, the employer may be permitted to exclude the employee from the workplace until the pandemic is contained on the basis of undue hardship.

Further, while an employee is never required to disclose a diagnosis, an employer may be permitted to request documentation from the employee to support their accommodation request (e.g. a physician's note stating that the employee cannot be vaccinated due to a medical condition). As noted above, the Ontario government announced that LTC employees who refuse the vaccine based on medical grounds will be required, in all cases, to provide the employer with supporting medical documentation.

Similarly, mandatory vaccination policies may include the requirement to provide proof of vaccination, triggering privacy protections for employees. Privacy legislation requires that any information collected by an employer must be used and stored purely to serve the narrow purpose for which it was collected. In other words, an employer can only use the information to enforce the mandatory vaccine policy.

A final consideration is that, for unionized employees, collective agreements may already contain provisions that address whether the employer is permitted to require mandatory vaccination. In those cases, the collective agreement will likely govern the issue.

Ultimately, if trade unions decide to challenge a mandatory vaccine policy, they may do so on the basis that they are contrary to the collective agreement, human rights legislation, and the *KVP* principles (*Lumber & Sawmill Workers' Union, Local 2537 v. KVP Co*). Challenges may arise in the form of a policy grievance, an individual grievance against discipline or termination for not following the policy, or an individual grievance concerning an accommodation that was not granted under the policy.

C. ARBITRATOR CONFIRMS UNIONIZED EMPLOYEES' RIGHT TO PERSONAL LEAVE UNDER SECTION 206.6 OF THE *CANADA LABOUR CODE* IN *UNIFOR LOCAL 6007 V. BELL CANADA (MALGI)*, 2021 CANLII 46942

Maeve Biggar

On September 1, 2019, Bill C-86 brought a number of significant changes to the *Canada Labour Code* ("the *Code*") into effect, including the new section 206.6 of the *Code* which provides federally regulated employees with paid personal leave. This new statutory entitlement raised questions regarding the interaction between paid leave under s. 206.6 of the *Code* (which we will refer to as "*Code* leave days") and paid leave entitlements arising out of a collective agreement.

The new section 206.6 provides up to five days of personal leave for employees to take in prescribed circumstances including, among other things, treating illness or injury, carrying out responsibilities related to the health or care of family members, and addressing urgent matters for themselves or family members. If the employee has completed three consecutive months of continuous employment, they are entitled to be paid for the first three days of the leave at their regular rate of pay.

Unifor Local 6007 v. Bell Canada (Malgi) is one of the first arbitration awards to address the relationship between the new *Code* leave days and personal days under a collective agreement. In this case, the collective agreement at issue provided employees in a certain classification, including the Grievor, with four personal days, only one of which was paid. These personal days could be taken for any reason, subject to the scheduling needs of the Employer. When the Grievor requested to book a *Code* leave day to take an ill family member to a medical appointment, the Employer refused and advised her that she must first exhaust her personal leave days under the collective agreement. The Grievor ultimately chose to make other arrangements and did not take the day off work.

The Union took the position at arbitration that the Grievor was rightfully entitled to a paid *Code* leave day in the circumstances and that she was not obliged to make use of her allotted personal days under the collective agreement before accessing a personal leave day under the *Code*. The Union argued that the *Code* leave days and the collective agreement personal days were separate legal entitlements serving different purposes and the Employer was improperly conflating the two. The Employer argued that it was permitted to combine the two entitlements and that there was no violation of the collective agreement because the Employer had given the Grievor the opportunity to take the day off with pay, albeit at the expense of her sole paid personal day under the collective agreement.

Arbitrator Matthew Wilson agreed with the Union's analysis of s. 206.6 and the collective agreement and allowed the grievance. According to Arbitrator Wilson, there was nothing in the collective agreement or the *Code* that permitted the Employer to commensurately deduct personal days under the collective agreement whenever an employee elected to use a *Code* day. Importantly, Arbitrator Wilson accepted the Union's argument that the personal leave days under the collective agreement were negotiated as days "akin to vacation days, floater days or lieu days", and as such were not the same as *Code* leave days, which can only be used for the specific reasons enumerated under s. 206.6 of the *Code*. Arbitrator Wilson stated that comparing the two entitlements was like comparing "apples and oranges" and concluded that the Employer had no right to unilaterally convert what was negotiated with the Union to be a rest day into a *Code* leave day. Accordingly, Arbitrator Wilson issued a declaration that the Employer had violated both the *Code* and the Collective Agreement by denying the Grievor the ability to take a *Code* leave day.

While this decision does not address all scenarios that can arise out of the interaction between *Code* leave days and collective agreement entitlements, it undoubtedly represents a positive development for trade unions in the emerging area of arbitral case law regarding section 206.6 of the *Code*.

D. INFECTIOUS DISEASE EMERGENCY LEAVE REGULATION DOES NOT PRECLUDE CONSTRUCTIVE DISMISSAL AT COMMON LAW

Sukhmani Virdi

In the summary judgment of *Cutinho v Ocular Health Centre* 2021 ONSC 3076 (CanLII), the Ontario Superior Court of Justice found that the Infectious Disease Emergency Leave Regulation, O. Reg 288/0 ("IDEL") did not preclude a non-unionized employee from pursuing a civil remedy for constructive dismissal at common law.

In response to the economic uncertainty during the COVID-19 pandemic, the Ontario Government passed the IDEL Regulation. Section 7 of the Regulation provides that the temporary reduction or elimination of a non-unionized employee's hours or wages for reasons related to COVID-19 does not constitute constructive dismissal.

In this case, the Defendant operated two ophthalmic clinics – one in Kitchener and one in Cambridge. There were a number of disputes between the doctors practicing at the Cambridge clinic and the two principals of the Defendant. One of the disputes involved the principals' concern that the Cambridge doctors were not adhering to physical distancing guidelines in their clinic as part of their response to COVID-19.

As a result of these disputes, the principals decided to close down the Cambridge clinic. At first, the Plaintiff was told that the office was closed down but she would continue to be paid. A month later, the Plaintiff was advised that as a result of the Cambridge clinic closure, there would be a temporary reduction of the workforce and that the Plaintiff was being placed on a temporary layoff.

While the parties disagreed as to whether the reason for layoff was "COVID-19 related," Justice Broad found that regardless of the reason for layoff, the IDEL regulation did not apply. Notably, Justice Broad found that Section 8(1) of the *Employment Standards Act, 2000* did not prevent an employee from pursuing a civil remedy by virtue of the *Act.* Accordingly, the application of Section 7 of the IDEL regulation was constrained by Section 8(1) of the *Act.*

Justice Broad also reviewed the corresponding webpage of Ministry of Labour, Training and Skill Development and found that the Ministry Guide expressly stated that the IDEL regulation established that where an non-unionized employee's wages or hours were temporary reduced or eliminated for reasons related to COVID-19, there was no constructive dismissal under the *ESA.* Thus, the IDEL regulation did not apply to a civil action.

The Court's analysis of the applicable damages deserves some attention. In this case, the Plaintiff mitigated her common law damages. However, the Court reviewed the jurisprudence on damages for constructive dismissal and found that a dismissed employee could not mitigate their statutory entitlements. As such, the Plaintiff was entitled to her statutory termination pay – even though under the *ESA*, her layoff did not constitute a constructive dismissal.

As this was a summary judgment decision, Justice Broad found that there was still a genuine issue for trial. Specifically, Justice Broad directed the matter proceed to trial for a determination of the Defendant's alternate position that it had just cause to dismiss the Plaintiff, thereby potentially relieving the Defendant from providing the Plaintiff with her statutory entitlements.

This is the first decision to interpret the IDEL Regulation and undoubtedly, it will not be the last. Until and unless there is an amendment to the Regulation or Act, or an appellate court decides otherwise, it is clear that COVID-related reductions or layoffs could still leave employers vulnerable to civil actions where an employee could recover damages for constructive dismissal at common law in addition to their statutory entitlements under the *Act*.

E. PAID INFECTIOUS DISEASE EMERGENCY LEAVE

Nick Ruhloff-Queiruga

In response to growing pressure to incorporate paid sick days into its fight against COVID-19, the Ontario government has introduced Bill 284 to implement three paid days of Infectious Disease Emergency Leave ("IDEL") for Ontario workers. The Bill, called the *COVID-19 Putting Workers First Act, 2021*, received Royal Assent on April 29, 2021.

In order to qualify for paid IDEL, s. 50.1(1.2) of the *Employment Standards Act, 2000* lays out a number of reasons triggering entitlement to the leave including:

(1) the employee being under medical investigation, supervision or treatment related to COVID-19;

(2) the employee is acting in accordance with an order under the *Health Protection and Promotion Act* related to COVID-19;

(3) the employee is in quarantine or self-isolating from COVID-19;

(4) the employee is directed by his employer in response to a concern that the employee may expose other individuals to COVID-19 and;

(5) the employee is providing care or support to an enumerated person in relation to COVID-19.

Employees will be entitled to paid IDEL from April 19, 2021 to September 25, 2021.

Critically, under the new subsection 50.1(1.4), employees who are already entitled to paid leave for any of the 5 reasons listed above under their own employment contract lose their entitlement to paid IDEL proportionally. For example, if a worker has 3 paid sick days under their own employment contract that can be used for any of the five COVID-related reasons listed above, they will be entitled to zero paid IDEL days. If a worker has two paid sick days under their own employment contract that can be used for any of the five COVID-related reasons listed above, they will be entitled to 1 paid IDEL day. If a worker does not have any paid sick days, they will be entitled to all 3 paid IDEL days. In practice, this provision means that only employees who work for employers that provide 2 or fewer paid sick days will qualify for the new paid IDEL days.

Where an employee is entitled to IDEL pay, an employer is required to pay the employee the lesser of $200.00 and the employee's regular pay that the employee would have earned if they had not taken the leave. If the paid leave falls on a day that the employee would normally be entitled to receive overtime pay, shift premium pay or premium pay for working on a public holiday, the employee is not entitled to any of those premiums.

Employers are entitled to be reimbursed for payments made to an employee for taking paid IDEL leave up to a maximum of $200.00 per day, per employee. The reimbursement provisions ensure that employers that already provided equal or better paid sick leave prior to April 19, 2021 will not be entitled to reimbursement, regardless of how they change their employment contracts after that date.

In summary, workers in Ontario are now eligible to qualify for 3 days of paid IDEL (to a maximum of $200.00 per day) if their current employment contracts do not contain equal or better paid sick leave provisions. For employers that did not provide equal or better paid sick leave as of April 19, 2021, they are entitled to reimbursement (to a maximum of $200.00 per day) for any IDEL payments made to employees under the new legislation.

F. CASE COMMENT: CYBULSKY V. HAMILTON HEALTH SCIENCES, 2021 HRTO 213

Robert Whillans

Dr. Irene Cybulsky was a cardiac surgeon and the Head of Cardiac Surgery Service at HHS from 2009 to 2017. She held the position of Head of Cardiac Surgery Service for over 15 years on an annual renewal before Dr. Michael Stacey, the Surgeon-in-Chief, decided not to re-appoint Dr. Cybulsky to her position.

Dr. Cybulsky was the only female cardiac surgeon at HHS for the entirety of her career. She was the only female Head of Cardiac Surgery Service in all of Canada. Nearly all of her interactions with others in comparable roles were with males.

Dr. Cybulsky's evidence spoke to the challenges of this dynamic. She explained the difficulty in forming bonds with her male coworkers as the only female cardiac surgeon. Evidence before the Tribunal established that Dr. Cybulsky was perceived to be an outsider. For example, she was excluded from a very popular men's ski trip among her colleagues.

The Tribunal found that a 2014 review of the Cardiac Surgery Service, and Dr. Cybulsky's role as Head, breached Dr. Cybulsky's human rights under the *Code*.

The review was prompted by complaints from Dr. Cybulsky's male colleagues, which the Interim Surgeon-in-Chief did not discuss with Dr. Cybulsky prior to the initiation of the review. The Interim Surgeon-in-Chief suggested that an outcome of the review might lead to Dr. Cybulsky adopting a more "fuzzy" manner.

During the course of the review, Dr. Cybulsky explained her concern that traditional leadership qualities – assertiveness, directness – are associated with males, and are

viewed as negative traits in females who are expected to be nurturing and "fuzzy". The Tribunal found that the reviewer essentially dismissed these concerns, although the comments from other interviewees included observations such as that Dr. Cybulsky was "like a mother telling her children what to do", and that her colleagues "don't see the soft side of her".

The final report form the review included a confidential section which stated that there was a large group which felt that Dr. Cybulsky should not continue as Head, because, among other things, she was "like a mother telling her children what to do", and had destroyed the collegiality within the group.

During a review of the report's findings, the reviewer candidly admitted that some of the issues "may well be because you are a woman and they're men".

The Tribunal concluded that HHS failed to consider Dr. Cybulsky's sex/gender in context. Dr. Cybulsky raised various challenges for female leaders, and the review did not consider or address those. The Tribunal found that even though the reviewers were aware of the concerns raised by Dr. Cybulsky, and even though the reviewers recognized that these concerns could be a factor in the way Dr. Cybulsky's male colleagues perceived her, the review did not address these concerns in any meaningful way.

In short, HHS did not take Dr. Cybulsky's concerns seriously.

Following the review, the male Surgeon-in-Chief determined "with her as the leader, there is a lot of friction in the group" and that he intended to open up the Head position to determine if others could perform that role. He did not explain to Dr. Cybulsky why he had reached that decision, despite never having met with her nor giving her any negative feedback about her leadership skills.

The Tribunal determined that the review, which was discriminatory, was a factor in the Surgeon-in-Chief's decision, and that his reliance on that review constituted further discrimination against Dr. Cybulsky. It was not relevant that there may have been other factors in Dr. Stacey's decision. In order for a decision itself to be discriminatory, discrimination against an individual on a protected ground need only be a factor, not the only factor in a decision.

Dr. Cybulsky then requested that HHS's human rights official mediate to resolve the issue of the Surgeon-in-Chief's decision. The Tribunal found that although Dr. Cybulsky had raised gender bias, HHS's human rights official did not address this concern.

Consequently, the Tribunal concluded that HHS had discriminated against Dr. Cybulsky in the conduct of the review, the decision not to renew her position as Head, and its investigation of her concerns regarding that decision.

This decision represents a landmark in recognizing what too many professionals who are members of a marginalized community know to be true. Discrimination is often not overt. It is hidden in little biases and confidences which can eventually build walls and ceilings to keep out people who are not part of the majority crowd.

The Tribunal's nuanced examination of the evidence and the context of Dr. Cybulsky's experience is to be commended.

Note: *The information contained in this Newsletter is not intended to constitute legal advice. If you have any questions concerning any particular fact situation, we invite you to contact one of our lawyers.*

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