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"If all of this was about health, I'd still be working:" Lived experiences of healthcare workers under COVID-19 vaccine mandates in British Columbia, Canada

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Abstract

COVID-19 vaccine mandates for healthcare workers (HCWs) in British Columbia (BC) were implemented in October 2021 and remained effective until July 2024, despite public protests and opposition from some unions. This study explored HCWs' lived experiences under these mandates, focusing on decision-making processes, personal and professional impacts, and perceived consequences for patient care. We conducted a reflexive thematic analysis of qualitative responses from 90 HCWs, collected through one open-ended survey question and elaborations on closed questions. The survey, conducted in May–June 2024, recruited a convenience sample of 166 HCWs of varying vaccination status, professions, and demographics through social media and professional networks. Findings are reported in accordance with the consolidated criteria for reporting qualitative studies (COREQ) checklist (Table A1). Most respondents were unvaccinated and had lost employment due to non-compliance. Participants reported significant personal losses and expressed overwhelmingly negative views on mandates. Six key themes emerged: (1) conflict with scientific evidence and clinical practice; (2) violations of medical ethics, especially informed consent; (3) dismissed personal and economic hardships; (4) overlooked vaccine-related physical harms; (5) discrimination against unvaccinated HCWs and patients; and (6) negative impacts on patient care. Our findings suggest that vaccine mandates caused substantial social and economic harm, contributed to staffing shortages, degraded workplace morale, and compromised patient care. Drawing on respondents' experiences and the scientific evidence available at the time, we conclude that mandatory COVID-19 vaccination for HCWs lacked scientific justification and violated foundational ethical principles in health-care policy and practice.

Keywords: COVID-19; Workplace vaccine mandates; Healthcare workers; Thematic analysis; Informed consent

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1. Introduction

On September 01, 2021, thousands of people from across the Canadian province of British Columbia (BC)—including approximately 5000 in Vancouver—protested against

COVID-19 vaccine passports and mandatory vaccinations for healthcare workers (HCWs), gathering outside hospitals and city halls. The backlash and controversy surrounding vaccine mandates were not unique to the province; jurisdictions across North America witnessed similar protests over vaccine mandates for HCWs. These protests drew support from individuals working in the health-care sector, as well as from members of the public concerned about the expansion of vaccine requirements and surveillance (Bains, 2021; Shepert, 2021; Stahl, 2021). At the time of the protests, only one vaccine mandate had been introduced, targeting long-term care and assisted living settings (BC Ministry of Health, 2021; Office of the Provincial Health Officer, 2022b). However, shortly afterward, on September 12, another order extended this requirement to HCWs across all hospitals, mental health facilities, community care settings, and administrative roles under the provincial and regional health authorities. The mandate required HCWs to be vaccinated by October 26, 2021, as a condition of employment in the health sector (Office of the Provincial Health Officer, 2022a).

The protests in BC and other provinces in Canada were organized by the Canadian Frontline Nurses, a group that formed upon the declaration of COVID-19 as a pandemic, and described in a media report as "founded by two Ontario nurses who have promoted conspiracy theories about COVID-19" (Stewart, 2021). The demonstrations sparked widespread condemnation from political leaders and public health officials. For instance, Vancouver's mayor at the time, Kennedy Stewart, called the protesters "kooks" and "fringe lunatics," whereas Premier John Horgan and Health Minister Adrian Dix condemned the behavior of some protesters, who were accused of verbally and physically assaulting HCWs who complied with public health measures (Lindsay, 2021).

The President and CEO of the Canadian Nurses Association publicly stated that the actions and views of the Canadian Frontline Nurses did not represent the values of nursing, which he denounced as "anti-science." He wrote: "The reckless views of a handful of *discredited* people who *identify as nurses* have aligned in some cases with angry crowds who are putting public health and safety at risk. They have drawn [in] *anti-science, anti-mask, anti-vaccine*, and anti-public health followers whose beliefs align with theirs. For some reason, they would have us believe that millions of the best-educated health scientists, public health experts, physicians, and nurses globally have all missed something that they have not. Their outlandish assertions about science would be laughable were they not so dangerous" (Canadian Nurses Association, 2021) (emphasis added).

The letter further stated that "anti-public health disinformation threatens to confuse a tired and bewildered public by misrepresenting personal ideology as facts, and science as conspiracy," and finished by reiterating that the Canadian Frontline Nurses "represent everything that we don't." These conflicts underscore the polarizing nature of COVID-19 policies, especially vaccine mandates for HCWs in the province. They also highlight how government and public health representatives positioned themselves in contrast to those opposing the mandates, framing the latter as a discredited fringe minority—individuals identifying as, rather than being, legitimate health professionals—and as standing in opposition to the views of pro-science, pro-mandate health and medical experts.

Significantly, the comments of government and public health officials also reinforced media narratives in Canada and internationally, which attributed the persistence of the COVID-19 crisis to a minority of unvaccinated HCWs and members of the public (Anthes & Petri, 2021; BBC News, 2021; Pollard & Angus, 2021; The Editorial Board, 2021). For example, when the vaccine mandate for long-term care and assisted living facilities was implemented on August 12, 2021—about 2 months before the broader mandate—Dr. Bonnie Henry stated: "We now have eight outbreaks *introduced by unvaccinated people*…and we've seen spread both to residents and staff, causing illness but also disruption to the lives of people in long-term care" (Weichel & Daflos, 2021) (emphasis added).

Ultimately, the vaccine mandates led to the termination of an estimated 2500 HCWs in the province for non-compliance—over half of them were from the Interior and Northern Health regions, where labour shortages have resulted in ongoing emergency room closures (DeRosa, 2023b). Some sources have reported higher numbers, estimating over 4000 HCWs were placed on unpaid leave, with hospitals compelled to cut services due to staff shortages (Government of Canada, 2025). The orders remained active until July 26, 2024, when BC's Provincial Health Officer officially declared the end of the public health emergency and related emergency powers (BC Ministry of Health, 2024b). Notably, this was over a year after the World Health Organization, in May 2023, had declared that COVID-19 was no longer a global health emergency. As the last jurisdiction in North America to maintain vaccine mandates for HCWs, BC replaced the requirement with a new policy obliging HCWs to report their immunization or immune status for COVID-19, influenza, and other "critical vaccine-preventable diseases" (BC Ministry of Health, 2024a).

By the time mandates were implemented, most HCWs in BC had already been vaccinated. As Health Minister Adrian

Dix stated, "99% of full-time HCWs (were) vaccinated for COVID-19, so the number unable to work because they're unvaccinated" was, according to him, "relatively small" (DeRosa, 2023b). It was also the case that only a minority of HCWs openly challenged the policy. However, the proportion of vaccinated HCWs who may have chosen otherwise had their employment not been at stake remains unknown. Equally underexplored is HCWs' experience of the policy—experiences understood on their terms, and not merely through the lens of the policy's perceived need.

To help fill this gap, we assessed the nature and rationale of HCWs' vaccination decisions and their views on mandatory vaccination policies in BC. This analysis was based on qualitative data drawn from responses to one open-ended question and open-text options within closed-ended questions in a cross-sectional survey exploring these decisions and views (Chaufan *et al*., 2025a). Our study is part of a broader project appraising the impact of the COVID-19 policy responses on HCWs and health systems (Open Science Frame registration[1]), which in turn contributes to a larger project examining geopolitics, medicalization, and social control in the COVID-19 era (Open Science Frame registration[2]). This article is presented in accordance with the consolidated criteria for reporting qualitative studies checklist.

2. Methods

We conducted a qualitative, reflexive thematic analysis of responses to a single open-ended question ("Are there any other issues that you believe would help us to further understand the impact of the policies on health workers and patient care? If so, please elaborate") and open-text responses within closed-ended questions. This subset comprised 90 respondents drawn from a convenience sample of 166 HCWs in BC.

The research team consisted of three female investigators with a joint experience of over four decades in medical sociology and health services research. The lead author is a non-practicing medical doctor with a Doctorate in Sociology and a Notation in Philosophy, currently employed as a professor of health policy. The first co-author is a health researcher with a Master of Arts in Anthropology, and the second co-author is a health researcher pursuing a Master of Arts in the Health Sciences.

Eligible survey participants included individuals with current or past healthcare employment in BC during the Covid-19 period, whether they remained employed, were dismissed due to vaccine mandates, or left the workforce for other reasons (e.g., early retirement). All HCWs in BC, regardless of vaccination status, profession, age, gender, years of experience, socioeconomic status, or race/ethnic background, were invited to participate. The study was promoted via social media and the principal investigator's professional networks, using a snowball sampling approach that encouraged participants to share the invitation with other eligible HCWs. Invitations were redistributed at 7-day intervals throughout May and June 2024. Further methodological details and quantitative survey results are reported elsewhere (Chaufan *et al*., 2025a).

Our analysis was guided by themes identified in a prior qualitative analysis on HCWs' experiences with vaccination mandates in the province of Ontario (Chaufan *et al*., 2025b). We employed both inductive and deductive approaches, seeking to confirm or disconfirm formerly identified themes while attempting to identify new themes. Data from open-ended responses were extracted from the original Google Forms and transferred into a Word document. Qualitative analysis was assisted by Dedoose software (version 9.0.107, Socio Cultural Research Consultants, USA). The study was approved by the York University Office of Research Ethics (No. 2023-389).

3. Results

The textual dataset comprised responses from 90 survey participants—78 who replied to the open-ended question and 12 who only elaborated through open-text fields in closed-ended questions. Most respondents reported being unvaccinated or not fully compliant with COVID-19 vaccination requirements. Those who experienced employment termination as a result of vaccine mandates described a range of personal, social, and economic hardships. Irrespective of vaccination status or current employment, participants overwhelmingly expressed negative views toward vaccination mandates for HCWs. Respondents recounted numerous adverse effects of these mandates, including detrimental impacts on themselves, their colleagues, and their patients. Many conveyed frustrations with policies they perceived as inconsistent with their medical education and practice, institutional protocols, and foundational bioethical principles.

As in the Ontario case, we identified six key themes: (1) Policies at odds with scientific evidence, medical training, and professional practice; (2) policies at odds with medical ethics; (3) unaccounted or dismissed personal hardships; (4) unaccounted or dismissed physical harms; (5) discrimination based on vaccination status; and (6) negative impacts on patient care. The subsequent subsections provide an in-depth elaboration and interpretation of each theme, supported by selected

[1] Accessible at https://osf.io/z5tkp

[2] Accessible at https://osf.io/84kbr/

verbatim quotations (slightly edited for clarity and coherence) to reflect participants' perspectives.

3.1. Policies at odds with scientific evidence, medical training, and professional practice

Respondents described the COVID-19-related policy responses as conflicting with their medical training and professional standards. Many also reported that they believed that vaccine mandates were unsupported by scientific evidence—particularly the lack of evidence for the ability of vaccination to prevent disease transmission, as well as concerns over insufficient long-term safety data. One respondent commented:

> "Data on transmission post-vaccination is limited and does not fulfil the logic behind the mandates, nor does the current situational data regarding (COVID-19) in the community validate 'emergency orders'" (unvaccinated HCW).

Some respondents also expressed frustration that the mandates continued to treat two vaccine doses as adequate for maintaining employment, even after emerging evidence—including from vaccine manufacturers—suggested that this level of protection waned after a few months. For example, an unvaccinated respondent explained that their health authority required "two doses of the vaccine for a variant that is long gone," concluding that "this has nothing to do with our health." Another unvaccinated respondent referred to evidence they had identified showing higher COVID-19 case rates and more missed workdays among vaccinated and boosted HCWs compared to those unvaccinated HCWs. The scientific rationale was also questioned in cases where the mandates applied to remote workers. One respondent who worked from home noted:

> "(I did not provide) any patient care (…), did not come in contact with patients or other employees who worked with patients (and) worked remotely from home, in a different town and different province than where my office was, (yet) was still required to be vaccinated" (Partially vaccinated HCW).

Another respondent, who inspired the title of this article, compellingly stated:

> "2.5 years later, I still don't have my job back. I worked from home. Apparently, my union is still in arbitration. I think it's a total joke. If all of this was about HEALTH, I'd still be working" (unvaccinated HCW).

Respondents also lamented what they perceived to be the lack of evidence-informed policy regarding vaccine safety. For example, one respondent stated:

> "There are no long-term studies, and pregnant women were told to get vaccinated with this new vaccine; did everyone forget about thalidomide or (diethylstilbestrol)?" (unvaccinated HCW).

Another unvaccinated HCW explained that they had received a question-and-answer document explicitly noting the lack of long-term safety data, yet vaccination remained a requirement for continued employment.

Respondents also criticized how natural immunity acquired from previous infection was ignored in vaccination policies. For example, one respondent noted:

> "BC does not believe in natural immunity. There is no other option to work as a health-care professional - you must have two COVID-19 vaccines" (unvaccinated HCW).

Another unvaccinated respondent described the "denial of naturally acquired immunity" as a "concerning departure from (evidence-informed) policy." Another described how they sought an exemption from the vaccine mandate based on natural immunity, but ultimately were denied:

> "I sought exemption from mRNA vaccines as I had already obtained superior natural immunity. I agreed to the protein-based Novavax that I determined (still) unnecessary, but a safer platform. I was granted an unpaid 6-month (leave of absence) prior to mandate by (my) employer. Despite this, when public health denied my exemption request, I was then given 2 weeks to receive (the) mRNA vaccine or be terminated" (unvaccinated HCW).

Many respondents commented that they did not request exemptions despite wishing to, as they expected them to be denied. Finally, respondents called attention to the inconsistency in maintaining the mandate in BC when other provinces, such as Alberta and Ontario, had already rescinded theirs as no longer necessary. One respondent asked:

> "BC is still the only province holding this mandate. What makes them different than Alberta or across Canada, where there is no mandate?" (unvaccinated HCW).

3.2. Policies at odds with medical ethics

A common theme expressed by respondents was the violation of core bioethical principles, particularly informed consent, which they viewed as compromised by coercive measures that undermined individual autonomy and the right to make voluntary health decisions. Notably,

respondents concerned about vaccine safety reported being assured by employers that the COVID-19 vaccines were safe and effective, even though no evidence to back those claims was ever provided. For example, one unvaccinated respondent asserted that "safe and effective" were mere claims that are not enough to make an informed decision. They also reported that their questions or concerns regarding vaccines were ignored or dismissed. Another unvaccinated respondent asked, "What happened to informed consent and bodily autonomy?". Yet another reported having witnessed patients hospitalized with COVID-19 being administered vaccines without consent. Respondents also noted a loss of patient privacy upon the introduction of mandates, with hospital visitors required to disclose their vaccination status to gain entry:

> "Patient privacy and confidentiality were thrown out the window as BC implemented a vaccine pass to enter the hospital. The person at the entrance of the hospital would ask for your full name and exactly which department you were going to. No one in the public, nor a random person at the door, needs to know your business" (unvaccinated HCW).

Concerns about the lack of privacy and confidentiality of personal medical data extended to HCWs themselves. One respondent explained:

> "Although annually, you needed to manually report your flu vaccination status, with COVID-19, the health authority just went into your personal records and looked it up. No confidentiality for healthcare workers" (unvaccinated HCW)

3.3. Unacknowledged or dismissed personal hardships

Another salient theme was the lack of recognition—or outright disregard—by the authorities imposing the mandates of the personal hardships and struggles faced by HCWs. Respondents described being terminated for non-compliance with mandatory vaccination, often without any acknowledgment of how deeply such decisions impacted their lives, and often after years of dedicated service. Many identified a wide range of personal and economic setbacks due to the mandates and shared stories of severe financial strain that followed their implementation. These included losing access to severance or employment insurance, depleting lifelong savings, and becoming dependent on financial help from family members or friends to survive. Many respondents reported being "forced into retirement" due to the pressure of vaccination or losing employment, with unvaccinated HCW noting that the "number of those that retired early to avoid vaccination-or-termination is not reported or understood" and that "current gaps in health care are bigger based on those unreported numbers."

One unvaccinated HCW said that the policy of mandated vaccination had been an "absolutely indescribable disaster affecting every area of one's life." Examples of these life-altering circumstances were provided by another respondent, who explained:

> "People I know sold homes, moved to different provinces or even to the United States - making major life alterations because of government policy" (unvaccinated HCW).

Another described their experience of being placed on unpaid leave, losing access to health benefits, and needing to take on contract work to earn an income:

> "My ex-husband was dying during all of this, and I had to leave my position as an addictions counsellor or risk termination for not being vaxxed. I have been on unpaid leave since October 2021 and continue to do contract work in order to have an income. My contract work used to be my side gig. Now it is my income. I have to pay for my own benefits in order to maintain even dental for myself" (unvaccinated HCW).

Many respondents also reported being terminated with cause—meaning for reasons considered legally valid, and for which the employee is made responsible—thus making them ineligible for employment insurance benefits. One unvaccinated HCW explained their experience of this dilemma: "There were no layoffs, no access to (employment insurance); it was immediate termination with cause. I was breastfeeding my toddler." Others reported being no longer interested in remaining in the health sector due to feelings of distrust, loss of respect, and personal hurt. For instance, one respondent reported having experienced "moderate depression and anxiety" over losing their nursing career, *yet al*so stated they would not want to return to their previous role "due to the prejudice" they experienced from colleagues "for not being vaccinated." Another unvaccinated respondent described the wider impacts they had witnessed, such as "loss of income resulting in loss of homes, separation of marriages, distrust in the health-care system." Another compelling description was how mandates had left a "permanent scar:"

> "What 'public health' did during the pandemic changed me as a person for life. I have managed to find a new way, but this has left a permanent scar (in me). I now don't trust our health system; I now see and understand the relationship pharmaceutical companies have with our medical system" (fully vaccinated HCW).

Similarly, another unvaccinated respondent reported that while they were doing better at the time of the survey than when mandates were in effect, they still "grieved" their job and remained "emotionally distraught" over how they had been treated at the height of the mandated vaccination period.

3.4. Unacknowledged or dismissed physical harms

Another prominent theme was the strong belief held by many respondents that the increase in illness and disability among vaccinated patients—often ignored, dismissed, or denied—was linked to the COVID-19 vaccine. For example, one respondent noted the silence surrounding adverse events among patients and HCWs:

> "People are being diagnosed with myocarditis and pericarditis and various cancers, and there is no mention of the vaccines probably causing this. This deceit is very stressful to health workers and very damaging to patients, who no longer know whom to trust in health care" (unvaccinated HCW).

Respondents also observed health issues among patients that they believed were linked to the COVID-19 vaccine and expressed frustration that these concerns were either not investigated or quickly dismissed by most colleagues as unrelated to vaccination. For example, one participant reported both directly caring for and knowing of patients who were vaccine-injured, yet still pressured into receiving additional vaccine doses:

> "I worked with rehab patients who were injured as a result of the shot, and it was documented, yet I was muzzled to give them information that would help them get better, and the unit continued to coerce patients to get more shots despite their injury. The rehabilitation doctors and (general practitioners) did not consider some injuries to be due to the shot, or were not allowed to even consider (the vaccine to be the cause) if they thought so. One doctor had a vaxx injury himself but could not give a recommendation to a patient on not taking another shot, even though she herself had sustained a vaxx injury" (unvaccinated HCW).

Similarly, another HCW reported witnessing adverse effects among patients following vaccination:

> "I saw our patients being adversely affected when they rolled out the vaccine, and encouraged nurses to document the adverse effects. We witnessed stable patients fail and die rapidly post-vaccine, but no one did anything about it" (Partially vaccinated HCW).

In addition, some vaccinated respondents experienced adverse effects post-COVID-19 vaccination, including one respondent who was refused an exemption despite experiencing an adverse reaction. Another respondent described their severe adverse reactions following each dose of the COVID-19 vaccine:

> "After the first dose, I had severe nosebleeds and blood clots passing through my nose for about 2 weeks. I thought I was going to have a stroke and die. So, to me, it was a life-threatening reaction at the time! I do have an autoimmune disease" (Partially vaccinated HCW).

3.5. Discrimination according to vaccination status

Many respondents vividly described the discrimination they experienced from employers, the larger society, and even colleagues due to their vaccination status. Some respondents commented that they were fired for non-compliance with vaccine mandates, even though they had worked with patients—including those infected with COVID-19—through 2020 (before vaccines were available) and into 2021 (before they were mandated). For example, one respondent described what they saw as the irrationality of vaccine mandates for HCWs, even when they had been repeatedly exposed to the virus while working during the pre-vaccine and pre-mandate era:

> "You work through the first 2 years of a pandemic with limited knowledge of the virus and continually see patients in person, and then once the vaccine mandates come out and you don't take the vaccine, you're a monster and an uneducated healthcare worker" (unvaccinated HCW).

Many respondents felt that the discrimination they experienced or observed was too much to bear, causing them to not only lose trust in the system but also to leave their profession. For example, an unvaccinated HCW reported that they would not return to work in health care because of the "prejudice" they experienced from colleagues. Another respondent explained:

> "The health-care system has lost many highly skilled professionals due to them being terminated…and has degraded significantly as a result; coercive policies have made the industry undesirable to participate in" (unvaccinated HCW).

A related theme was the increased hostility and loss of camaraderie within the profession due to vaccine mandates. An unvaccinated HCW shared: "These policies really divided everyone in a very negative way. HCWs often need to work as team members (mandates) did not

help anyone." Another respondent reported how vaccine mandates contributed to a toxic and discriminatory environment for both patients and HCWs:

> "The divide it created in the hospital was sickening—witnessing nurses and doctors, and other medical staff make fun of unvaccinated patients and saying things like they don't deserve to be seen before anyone else was sickening. To be part of the ostracization and witness it felt like the Holocaust. One of our RN's (registered nurse) went on early mat (maternity) leave because she was constantly being harassed by one of the doctors to get vaccinated while being pregnant. This doctor also made it known she did not want to see unvaccinated patients" (unvaccinated HCW).

One seemingly aggrieved respondent observed that "Dr. Henry's constant use of the phrase 'an unvaccinated HCW represents a public health hazard' and the language used to portray the unvaccinated as 'selfish, ignorant, and backward' created significant animosity" within the profession and among the public toward unvaccinated persons more broadly. Many respondents also observed serious discrimination against patients who were unvaccinated, which, in their view, significantly impacted the quality of patient care. For example, an unvaccinated HCW described some colleagues' behavior as "completely unprofessional," noting that "many nurses should lose their license for how they talked about their patients' choice to not vaccinate." Another unvaccinated respondent observed that the "discrimination against the unvaccinated was extreme, with many clinics turning away patients, even as they received young adults who were suicidal because the route to education in their desired health profession closed unless they were vaccinated."

Finally, respondents chronicled how unvaccinated people were denied access to visit loved ones in hospital care, negatively impacting the quality of care for patients of all vaccination statuses. They also cited other practice changes that they considered unnecessary and inhumane, such as mandating masks during delivery or banning unvaccinated partners from being present at the moment of birth:

> "Humanity was lost. Women were told to wear a mask while delivering their babies; spouses/partners were not allowed in for deliveries if they did not have a vaccine pass" (unvaccinated HCW).

3.6. Negative impacts on patient care

In addition to observing physical harm and serious instances of discrimination suffered by patients, respondents also reported that vaccine mandates exacerbated staffing shortages, as HCWs were either placed on extended unpaid leave or dismissed—ultimately degrading the quality of patient care. For example, one respondent was aware of "a few local nursing friends" who would soon lose their licenses because they were unable to meet their hours requirement "because they are unemployable due to their unvaccinated status." The same respondent also described the case of HCWs who were barred from working as caring and eager to work, noting that "some of these nurses had another 20+ years left in them to work, and loved their jobs and those they cared for."

Another unvaccinated respondent expressed shock that the Ministry of Health had "completely failed to assess the risks posed by understaffing and service closures because of the mandates." Yet another unvaccinated HCW remarked that "the impact trickles down to ordinary citizens" because "the fewer healthcare workers, the fewer staff will be available to address the health-care needs of patients." Finally, one participant wrote that: "Health care in BC is poisoned," with many HCWs resenting their employers "for being coerced" to be vaccinated against their will, which they believed "can only reflect on the care they provide."

Importantly, many respondents described how health-care priorities had shifted entirely toward COVID-19, to the neglect or dismissal of other health concerns. For example, one respondent, a radiographer, described how COVID-19 policy changes caused patients requiring imaging to use portable machines, which exposed them to more radiation and unnecessary risks, stating that "it felt like EVERYTHING was about COVID, when it didn't need to be (…); it burned our staff our very quickly and degraded patient care." Another respondent also observed the excessive attention to COVID-19 to the detriment of multiple pressing health issues in the province—such as substance use and addictions—either predating, exacerbated by, or resulting from the COVID policy response itself:

> "The spike in overdose deaths in Vancouver (the most populated BC city) directly relates to the service restrictions initiated by COVID protocols prioritizing one group over all others. I am certain more overdose deaths have happened than COVID deaths. We were told pre-COVID, there was no money for anything to improve care for substance users—then boom, COVID happens, and suddenly we have all the money in the world (but only) for COVID and nothing else. Hypocrisy" (fully vaccinated HCW).

4. Discussion

All respondents in this study opposed vaccine mandates—many describing emotional, social, and financial

hardships following the implementation of the policy. Most respondents chose not to comply and, as a result, experienced job loss, financial strain, conflict with colleagues, friends, and family, as well as mental and emotional distress. Respondents who were terminated felt alienated from their profession and the institutions they once trusted and served. They also criticized the mandates for disregarding conflicting scientific data, particularly regarding viral transmission, vaccine safety, and naturally acquired immunity, and felt that their clinical expertise and safety concerns had been routinely dismissed in favor of a narrative that promoted the vaccine as universally "safe and effective." In addition, many respondents observed how such policies compromised both accessibility and quality of care, fostering discrimination against unvaccinated HCWs and patients. Finally, many reported that mandates violated the core ethical principle in medicine of informed consent. All these findings echoed those in a similar survey conducted with HCWs in the province of Ontario, where vaccination mandates were implemented across health-care settings (Chaufan *et al*., 2025c).

In alignment with the current qualitative findings, our quantitative analysis of the data that this article draws from revealed that of 166 survey respondents of mixed vaccination status, a large majority (81%) experienced anxiety or depression due to mandated vaccination, and close to one-fourth (23.5%) reported suicidal thoughts (Chaufan *et al*., 2025a). As well, a large majority (73%) experienced a decrease in their income due to vaccination policies (a combination of layoffs, resignations, and early retirements), and most (84%) reported that their personal relationships had suffered. About one-third (34%) reported negative impacts on their physical health, and over half (58%) experienced deterioration of their mental health.

Significantly, most (93%) respondents were offered no accommodations or alternatives to vaccination, whether for medical, conscience, or religious reasons and most (90%) reported feeling unfree to choose whether or not to be vaccinated. In relation to the potential impact of the policy on patient care via the exacerbation of the staffing crisis in the province, close to half (45%) of respondents were no longer interested in remaining in the industry. In summary, our survey indicates that vaccination policies had an overall negative impact on the physical, emotional, and social well-being of HCWs—particularly, albeit not only, those who did not comply with mandates—as well as on health services and, concomitantly, patient care.

While the Provincial Health Officer of BC rescinded the COVID-19 public health emergency and the vaccination mandate in health-care settings, challenges remain. For instance, the provincial government has now introduced a requirement for all HCWs in public health-care settings to report their vaccination status for COVID-19 and influenza, as well as their immune status—through vaccination or naturally acquired—for measles, mumps, rubella, hepatitis B, whooping cough (pertussis), and chicken pox (varicella) (BC Ministry of Health, 2024a). As per BC authorities, the government's move "requires the immune status of HCWs to protect both patients and workers (and is) part of a system that can help to prevent outbreaks and manage them when they do happen quickly and effectively" (BC Ministry of Health, 2024a).

HCWs in BC have voiced strong concerns about the Health Professions and Occupations Act (HPOA), formerly Bill 36, passed in 2022 and set to take effect in 2025. The legislation draws on a 2018 report by regulatory consultant Harry Cayton, often described as an "independent expert," who called for an overhaul of provincial health regulation. Cayton cited the circulation of an "anti-vaccine video" by a College of Chiropractors board member as evidence of governance failure (Cayton 2018), a framing that equates dissent with a threat to public trust. The HPOA builds on this logic by consolidating 15 health colleges into six and transferring board appointments to government appointees, half of them non-licensed public members (BC Government News, 2022)—a shift that may expand control rather than rebuild trust.

Nevertheless, the government has defended the bill, with the BC Health Minister asserting that it was developed through one of the "most extensive consultation processes in the government's history" (DeRosa, 2023a), claiming it will "streamline the process to regulate new health professions, provide stronger oversight (and) protect patient care" (BC Government News, 2022). Critics, however, have warned that the bill is a top-down, undemocratic measure that risks further undermining patient care. Only 233 of the bill's 645 sections were discussed, and many HCWs—including the Doctors of BC organization—have warned that it will exacerbate recruitment challenges amid ongoing labor shortages (Hsiang, 2024). In the words of one physician, "nurses are (…) actually leaving our community to go elsewhere, and physicians, same thing... We need to make the grounds amenable to healthcare workers so they will want to stay" (Kingston, 2024). Another HCW argued that the HPOA fosters mistrust, creating an environment that will not "attract doctors or other health-care professionals to BC" (Lush, 2023).

So far, there has been a petition and calls for the repeal or delay of the HPOA, though the government insists that the changes it will implement are essential for improving patient safety and restoring public confidence in health care (Oral Health, 2025). However, the new reporting and

regulatory requirements may be replicating the policy tensions and HCWs' experiences observed with COVID-19 vaccination mandates—top-down countermeasures that ignore significant pockets of resistance among HCWs, greater public distrust in health authorities, eroded informed consent and confidentiality between HCWs and patients, and discouraged many from maintaining or pursuing health-care practices in the province (BC College of Family Physicians, 2023; DeRosa, 2023a; Hsiang, 2024; Kingston, 2024; Lush, 2023; Oral Health, 2025). While the orders restricting unvaccinated HCWs from employment have been rescinded, the broader infrastructure of health surveillance appears to be expanding—with likely negative effects on the ongoing shortage of physicians and nurses (BC Nurses Union, 2023; Judd & Stanton, 2025; Li *et al*., 2023).

Meanwhile, HCWs in BC have continued to challenge COVID-19 vaccine mandates, largely on ethical grounds—citing infringement of constitutional rights, including freedoms of conscience, religion, and personal security. However, to date, courts have largely sided with the government and public health officials, justifying mandates based on the scientific evidence available at the time (Hoogerbrug v. British Columbia, 2024; Notice of Civil Claim: Jedediah Ferguson and Terri Perepolkin vs. Dr Bonnie Henry, 2023). Nonetheless, the courts have requested Provincial Health Officer of BC, Dr. Bonnie Henry, to reconsider the mandate for HCWs who worked remotely and did not provide patient care (Hoogerbrug v. British Columbia, 2024). In response, Dr. Henry issued a reconsideration decision on August 28, 2024, confirming her position not to approve exemptions for remote and administrative workers based on three reasons: (1) during a public health emergency, remote workers could be required to be physically present, including through formal deployment; (2) COVID-19 vaccination "was and remains" effective in preventing severe illness and is needed to protect the health-care system; and (3) making exceptions for remote workers would have been impractical given the limited public health resources at the time (Office of the Provincial Health Officer, 2024).

At this point, it is important to acknowledge the problematic assumptions underlying government claims, which omit important scientific counter-evidence. For example, it was well established early on that COVID-19 vaccines did not prevent viral transmission (Shrestha *et al*., 2023; Singanayagam *et al*., 2021), including among fully vaccinated people in health-care settings (Mateos-Nozal *et al*., 2021; Park *et al*., 2022; Public Health Agency of Canada, 2022). This undermines the fundamental scientific rationale underlying mandate implementation. Moreover, mandate policies have also dismissed accumulating scientific evidence of vaccine-related adverse events—ranging from mild to life-threatening and even fatal—available from early in the vaccination campaign (Bareiß *et al*., 2022; Faksova *et al*., 2024; Farah *et al*., 2023; Filippatos *et al*., 2021; Ponticelli *et al*., 2021; Seneff *et al*., 2022; Yamamoto, 2022). Importantly, as reported by our respondents in this study, mandated vaccination infringes upon the right to informed consent—a right enshrined in seminal ethical documents (Shuster, 1997; UNESCO, 2005; World Medical Association, 1964). Informed consent entails the right to be fully informed of the risks, benefits, and alternatives to any medical intervention—including the alternative to refuse treatment, free from coercion or threat.

This study has limitations inherent to exploratory and qualitative research. First, we employed a non-probability, convenience-based snowball sampling strategy, which limits the generalizability of our findings. However, generalization is not the aim of qualitative research. Rather, we aimed for transferability—the extent to which findings resonate with or inform other contexts—which we supported through thick description and contextual detail (Drisko, 2025). Second, although HCWs of all vaccination statuses were invited, more unvaccinated respondents chose to participate. Therefore, there is no evidence that our results reflect the experiences of all, or even most, HCWs in the province—most of whom were vaccinated. One might conclude that the high vaccine uptake among HCWs indicates broad support for mandates.

However, we propose a more likely explanation: While only a minority of HCWs openly challenged the policy, many accepted vaccination under coercion, to avoid consequences they could not afford—such as unpaid leave and eventual termination, often with no compensation or unemployment benefits, as reported by several respondents in our study. Indeed, independent evidence supports this interpretation. A national, cross-sectional survey of 5,372 HCWs—conducted by the Canadian polling company Ipsos for the Public Health Agency of Canada—found that the threat of job loss was a major reason for vaccination. Specifically, 53% of health-care professionals, 46% of allied health workers, and 47% of auxiliary health workers cited the mandate as a key motivator (Ipsos & Public Health Agency of Canada [PHAC], 2023). Similarly, an Italian study found that most HCWs shifted their stance from rejecting to "accepting" vaccination in response to the threat of work restrictions (Costantino *et al*., 2022).

Despite its methodological limitations, our study fills an important gap, as most existing studies on the impact of vaccination mandates have been conducted with primarily vaccinated HCWs, thus excluding dissenting voices by design. For example, a systematic review investigating HCWs' attitudes toward mandatory vaccination reported

potential bias due to high vaccination rates among study participants (Politis *et al*., 2023). In contrast, we recruited outside traditional medical institutions—where only vaccinated HCWs remained employed—and used social media to reach unvaccinated HCWs, those most affected by mandated policies and therefore more eager to share their perspectives and experiences.

5. Conclusion

Our findings indicate that COVID-19 vaccination mandates contributed to a discriminatory health-care system in BC, Canada, particularly toward HCWs who did not receive the two doses required to be considered "fully vaccinated" to retain employment (Wong, 2022). Proponents of these mandates have argued that the differential treatment of unvaccinated HCWs was justified and necessary to protect patients, colleagues, and even the dissenting workers themselves. Legal challenges to these mandates have largely failed on similar premises. However, we have reported substantial scientific evidence challenging these assertions. We have also documented significant social, emotional, and economic harms inflicted by the policies—including worsening labor shortages, deteriorating workplace morale, diminished patient care quality, and violations of informed consent. In light of these findings, and supported by our analysis of publicly available medical literature, we conclude that the mandatory COVID-19 vaccination policies in health-care settings lack a sound scientific basis and violate fundamental ethical principles in health-care practice and policymaking.

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Conflict of interest

The authors declare that they have no competing interests.

Author contributions

Conceptualization: Claudia Chaufan
Formal analysis: All authors
Investigation: Claudia Chaufan, Natalie Hemsing
Methodology: Claudia Chaufan, Natalie Hemsing
Project administration: Claudia Chaufan, Natalie Hemsing
Writing–original draft: Claudia Chaufan, Natalie Hemsing
Writing–review & editing: All authors

Ethics approval and consent to participate

The study was conducted following the Declaration of Helsinki (as revised in 2013). The study was approved by the York University Office of Research Ethics (No. 2023-389). Potential study participants were provided an information letter and consent form, including details on the study aims, methods, potential benefits and risks, and information about confidentiality and consent. They were informed of their right to withdraw consent at any time without consequences. The online survey questions were only accessible to participants after providing their freely informed consent. All efforts were made to conceal any identifying information about participants whose responses are quoted.

Consent for publication

Respondents consented to the publication of their data.

Availability of data

Data are available from the corresponding author upon reasonable request.

Further disclosure

The paper has been uploaded to MedRxiv (doi: 10.1101/2025.05.22.25328161).

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Appendix

Table A1. Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/descriptions	Reported on page number/line number	Reported on section/ paragraph
		Domain 1: Research team and reflexivity		
		Personal characteristics		
1	Interviewer/facilitator	Which author(s) conducted the interview or focus group?	p.8	Methods
2	Credentials	What were the researcher's credentials? *e.g., PhD, MD*	p.8	Methods
3	Occupation	What was their occupation at the time of the study?	p.8	Methods
4	Gender	Was the researcher male or female?	p.8	Methods
5	Experience and training	What experience or training did the researcher have?	p.8	Methods
		Relationship with participants		
6	Relationship established	Was a relationship established before study commencement?	N/A	N/A
7	Participant's knowledge of the interviewer	What did the participants know about the researcher? *e.g., personal goals, reasons for doing the research*	p.8	Methods
8	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? *e.g., bias, assumptions, reasons, and interests in the research topic*	p.8	Methods
		Domain 2: Study design		
		Theoretical framework		
9	Methodological orientation and theory	What methodological orientation was stated to underpin the study? *e.g., grounded theory, discourse analysis, ethnography, phenomenology, content analysis discourse analysis, ethnography, phenomenology, content analysis*	p.7	Methods
		Participant selection		
10	Sampling	How were participants selected? *e.g., purposive, convenience, consecutive, snowball*	p.8	Methods
11	Method of approach	How were participants approached? *e.g., face-to-face, telephone, mail, email*	p.8	Methods
12	Sample size	How many participants were in the study?	p.8	Results
13	Non-participation	How many people refused to participate or dropped out? Reasons?	p.8	Results
		Setting		
14	Setting of data collection	Where was the data collected? *e.g., home, clinic, workplace*	p.8	Methods
15	Presence of non-participants	Was anyone else present besides the participants and researchers?	Not an in-person study	Methods
16	Description of sample	What are the important characteristics of the sample? *e.g., demographic data, date*	p.8	Methods
		Data collection		
17	Interview guide	Were questions, prompts, or guides provided by the authors? Was it pilot-tested?	p.7	Methods
18	Repeat interviews	Were repeat interviews carried out? If yes, how many?	Not an in-person study	Methods
19	Audio/visual recording	Did the research use audio or visual recording to collect the data?	Not an in-person study	Methods

(Cont'd...)

Table A1. ***(Continued)***

No	Item	Guide questions/descriptions	Reported on page number/line number	Reported on section/ paragraph
20	Field notes	Were field notes made during and/or after the interview or focus group?	Not an in-person study	Methods
21	Duration	What was the duration of the interviews or focus group?	Not an in-person study	Methods
22	Data saturation	Was data saturation discussed?	N/A, based on survey	Methods
23	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	Not an in-person study	Methods
		Domain 3: Analysis and findings		
		Data analysis		
24	Number of data coders	How many data coders coded the data?	p.8	Methods
25	Description of the coding tree	Did the authors provide a description of the coding tree?	p.8	Methods
26	Derivation of themes	Were themes identified in advance or derived from the data?	p.8	Methods
27	Software	What software, if applicable, was used to manage the data?	p.8	Methods
28	Participant checking	Did participants provide feedback on the findings?	Not an in-person study	Methods
		Reporting		
29	Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? *e.g. participant number*	p.10-21	Results
30	Data and findings consistency	Was there consistency between the data presented and the findings?	As per the quotations	Results
31	Clarity of major themes	Were major themes clearly presented in the findings?	p.10-21	Results
32	Clarity of minor themes	Is there a description of diverse cases or a discussion of minor themes?	p.10-21	Results

Source: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349-357.