

The Effects of COVID-19 on the Health System: Legal and Ethical Tensions Part II

By: Lorian Hardcastle

Matter Commented On: COVID-19 in Alberta and Canada

Since it appeared in Canada at the end of January, the number of cases of COVID-19 has steadily increased. Despite considerable efforts to contain the spread of the disease, Canada has seen [over 1000](#) new cases per day since late March, with this number reaching 1600 new cases in a single day on April 5. On April 7, [58 people](#) succumbed to the disease in one day. The ongoing COVID-19 outbreak raises numerous pressing legal and ethical tensions. In a previous [ABlawg post](#), I examined the trade-offs that governments have made between individual liberties and protecting the public good. In this post, I consider two additional legal and ethical tensions: health care priority setting in the face of scarce resources and the disproportionate effects of public health measures on vulnerable people.

Health Care Priority Setting with Scarce Resources

Although there are significant limits on the available data, [one model](#) predicts that COVID-19 will peak in Alberta in mid May, with as many as 800,000 infections and between 400 and 3000 deaths. A more serious but less likely model predicts that infections will peak in early May, with up to 1,000,000 infections and between 500 and 6600 deaths. According to modelling, at the disease's peak, about [250 Albertans](#) will require intensive care beds. An estimate of the worst case scenario would require 1200 intensive care beds and 925 ventilators (Alberta currently has 509 with more on the way). Canadian governments are working quickly to create capacity within the health system. For example, [several provinces](#) are constructing makeshift hospitals or [issuing](#) temporary medical licenses to internationally-trained doctors. However, our health system could still become overwhelmed, given that Canada has [relatively few](#) hospital beds per capita (Italy has 34% more).

Provincial governments have already made difficult decisions in light of COVID-19. For example, Alberta has postponed nearly [7500](#) surgeries. While reallocating hospital beds is necessary to prepare for an onslaught of COVID-19 patients, postponement will undoubtedly have significant quality of life and mobility implications for some of those awaiting surgery. Provincial governments are also making priority-setting decisions by [rationing](#) limited testing supplies. For instance, while some provinces continue to test returning travellers and contacts of those diagnosed with COVID-19, others don't. Alberta [currently tests](#) patients who are hospitalized with respiratory illnesses, symptomatic individuals living in continuing care or other group living settings, and symptomatic individuals aged 65 years or older. Testing is also offered to symptomatic individuals who are healthcare workers, first responders, group home or shelter

workers, individuals involved with COVID-19 enforcement (such as police and bylaw officers), and correctional facility staff.

As illustrated by the experiences of countries that have been hardest struck by COVID-19, the decisions on rationing of health services faced by Canadian governments and health care professionals could become increasingly ethically fraught. According to a group of [Italian doctors](#), “[t]he situation here is dismal” and “[o]lder patients are not being resuscitated and die alone without appropriate palliative care, while the family is notified over the phone, often by a well-intentioned, exhausted, and emotionally depleted physician with no prior contact.”

In anticipation of conditions worsening, governments across the world are developing guidelines for prioritizing patients should their health care systems become overwhelmed. Alberta’s criteria are [under development](#). How to prioritize patients is a difficult question, given that in Canada we tend to think about rationing care in terms of waiting lines rather than actually denying patients treatment. However, because of a possible surge in the number of COVID-19 cases, these criteria are a necessity. It would not be defensible to ask health care providers to decide which of their patients to treat, given their ethical and legal responsibilities to all patients. It could be particularly devastating, for example, if a doctor had to [withdraw lifesaving treatment](#) from a stable or improving patient to prioritize one with a better prognosis. Therefore, policy-makers must develop clear and transparent criteria, which should be applied by triage committees who do not have a clinical relationship with patients being assessed for treatment.

Most criteria tend to take a utilitarian approach, giving priority to otherwise healthy people who are the most likely to fully recover. Some jurisdictions rely on tools developed prior to COVID-19 to evaluate patients, such as the [Sequential Organ Failure Assessment](#) (SOFA), which measures the functioning of different body systems like the heart, lungs, kidneys, and liver. Given that our knowledge of COVID-19 is still evolving, predicting prognosis and the applicability of pre-existing tools may be limited. Some advocate [prioritizing](#) the treatment of health care workers, which recognizes the sacrifices they make in treating patients and is also utilitarian, in that treatment may help them return to work sooner. Finally, some physicians and policy-makers are encouraging those who do not want life-saving interventions to develop [advance directives](#) now, so that resources they do not want are not wasted on them.

The Toronto Star obtained a copy of Ontario’s [triage protocol](#), which indicates that those who do not receive treatment will be patients “who are very likely to die from their critical illness, and people who are very likely to die in the near future even if they recovered from their critical illness.” Patients who no longer meet the triage criteria may be removed from treatment (like ventilators) but will receive the “highest priority for palliative care.”

Although utilitarian priority-setting may seem fair, many health conditions have socio-economic disadvantage embedded into them, which may be exacerbated by the application of seemingly neutral criteria. For example, in [Washington State](#), doctors can consider withholding care from patients with “severe congestive heart failure”, “severe chronic lung disease”, or “severe cirrhotic liver disease with multiorgan dysfunction”. Heart, lung, and liver disease may be caused or worsened by tobacco and alcohol consumption. Although these conditions may result in an objectively poorer prognosis, the social determinants of health (such as income and social status

– which are themselves connected to factors such as gender, race, Indigeneity and disability) are often at the [root](#) of substance use and these individuals may have struggled with equitable access to health care services to treat these conditions prior to COVID-19. Similarly, patients with chronic health conditions such as [diabetes](#) have been denied treatment in Italy. If Canadian provinces similarly denied care, this would disproportionately affect Indigenous people, given [significantly higher](#) rates of diabetes in these communities and the challenges with accessing health care services to manage this condition.

Prioritization criteria may also be ableist, given that individuals with certain disabilities may be less physically able to fight COVID-19 or may have conditions that increase their chances of mortality even with treatment such as ventilation. Furthermore, even if prioritization criteria seem objective, there are concerns that physician bias towards patients with disabilities, which has been observed in other contexts, may affect their application (see e.g. [here](#), [here](#), and [here](#)).

The determination of who will get care is already giving rise to legal challenges in the US. For example, [lawsuits](#) alleging that these criteria discriminate on the basis of disability have been filed in Washington and Alabama. The latter’s controversial [criteria](#), which have since been [amended](#), stated that “persons with severe mental retardation, advanced dementia or severe traumatic brain injury may be poor candidates for ventilator support”. The Office for Civil Rights at the US Department of Health and Human Services, which is responsible for enforcing anti-discrimination laws, issued a [bulletin](#) to ensure that health providers are mindful of regulations prohibiting denials of treatment on grounds such as disability and age.

Although no COVID-19 related discrimination lawsuits have been reported in Canada, they may be forthcoming as governments release details on how they will ration health care resources. Provincial criteria may be vulnerable to legal challenge if they are based solely on prohibited grounds of discrimination. One doctor involved with drafting ethical guidelines in Italy [reported](#) saying “scarce resources for those patients who have the greatest chance of survival, which means prioritizing younger, otherwise healthy patients over older patients or those with pre-existing conditions.”

Excluding people solely on the basis of age is problematic, since it does not necessarily correlate with prognosis at the individual level (even if older people are statistically more likely to have co-morbidities affecting prognosis in the aggregate). Saskatchewan has [announced](#) a plan to form triage committees that will determine who to treat on the basis of considerations such as age, frailty, chronic illness, likelihood of recovery, and the patient’s pre-expressed wishes. The Chief Medical Officer of the Saskatchewan Health Authority has said that its system is not discriminatory, noting that age is not considered in isolation but in conjunction with “other patient-level circumstances” such as frailty or the presence of a chronic illness.

The Disproportionate Effect of Public Health Measures on Vulnerable People

Individuals with vulnerabilities may not only be affected by rationing criteria but by current efforts to contain the spread of COVID-19. As discussed in my previous [ABlawg post](#), provincial governments have passed various restrictions including mandating individuals who are symptomatic to self-isolate, limiting the size of gatherings, and requiring individuals to distance

from one another, all with the increasing threat of sanction and police enforcement. However, abiding by public health rules and recommendations disproportionately affects certain groups.

For example, cell phone [data](#) from the US unsurprisingly show that wealthier people are struggling less with distancing rules. It is also easier for children of those with higher incomes to keep up with schoolwork due to better access to the internet and other resources. Access to educational resources may also be difficult for children with special needs, in light of the government's [recent layoff](#) of educational assistants. Similarly, isolation requirements may put those living with domestic violence in [dangerous situations](#). Governments have also sometimes failed to account for the effect of their business closures on particular groups. For example, the mayor of Windsor has come under fire for his [decision](#) to stop the bus service. Critics argue that this shut-down makes it difficult for lower-income people to access grocery stores and pharmacies and to get to jobs in essential services.

Rules prohibiting visitors from care facilities and hospitals, while arguably [necessary](#) to limit the spread of disease, will undoubtedly affect the residents of those facilities, many of whom rely on family members for help with medical decision-making, health and personal care, and psychological wellbeing. Spagnuolo and Orsini [argue](#) that for those with intellectual disabilities, “[d]enying the vital supports provided by trusted people, including family and friends who may assist with decision-making and communication, constitutes not only a disruption or inconvenience, it creates an impossible situation for many.”

Another group that is disproportionately affected by public health restrictions are individuals who struggle with homelessness. Provinces have been slow to provide housing for this population, which would both facilitate their compliance with provincial laws and public health orders and would help prevent the spread of COVID-19, which could devastate homeless communities. Calgary's [Telus Centre](#) is set up as an emergency shelter for 300 people. However, [pictures](#) show that individuals staying in these facilities will not be able to maintain the recommended physical distancing. Furthermore, provinces have been slow to [provide](#) laundry and shower facilities to individuals staying in these shelters. For those who are symptomatic, Alberta is working to retrofit hotel rooms.

Conclusion

Governments are making various difficult trade-offs in response to COVID-19. Although isolation rules, business closures, and other public health measures may contain the spread of disease and protect the population as a whole, they may disproportionately affect other groups, such as those who struggle with homelessness, domestic violence, or have lower incomes. Governments responding to COVID-19 have often been slow to anticipate and mitigate inequities and are instead left scrambling to address the challenges faced by these groups, despite the fact that these issues were largely foreseeable.

One particularly vexing issue that governments face is the development of rationing criteria in anticipation of a shortage of health care resources. Although utilitarian guidelines may have an intuitive sense of fairness, they can be inherently discriminatory and ableist. Given their hasty

development in anticipation of an onslaught of COVID-19 cases, the appropriate transparency and interdisciplinary consultation with affected groups has tended to be truncated or non-existent. It is essential that governments evaluate the extent to which their policies disproportionately affect certain groups and take steps to mitigate inequities both as these policies are developed and in drafting pandemic preparedness plans in anticipation of future public health emergencies.

This post may be cited as: Lorian Hardcastle, “The Effects of COVID-19 on the Health System: Legal and Ethical Tensions Part II” (April 9, 2020), online: ABlawg, http://ablawg.ca/wp-content/uploads/2020/04/Blog_LH_Covid2.pdf

To subscribe to ABlawg by email or RSS feed, please go to <http://ablawg.ca>

Follow us on Twitter [@ABlawg](https://twitter.com/ABlawg)

