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

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Matter Commented On: COVID-19 in Alberta and Canada

Introduction

Coronaviruses are a large family of viruses that affect humans and animals and, in some circumstances, can pass between species. Coronaviruses cause illnesses ranging from the common cold to SARS. A novel coronavirus, SARS-CoV-2, which causes COVID-19, was first identified in Wuhan, China in December 2019. There have been over 1,250,000 cases worldwide, over 68,000 of which have been fatal. Actual infection rates are likely much higher, given the limited number of tests conducted in many jurisdictions, the backlog in receiving test results, and the prevalence of false negative tests. As of April 5, there have been 1181 cases in Alberta, including 20 fatalities.

People with COVID-19 commonly experience respiratory illness with symptoms of fever, cough, and shortness of breath, while a subset of patients develop pneumonia and multi-organ failure. COVID-19 is particularly difficult to contain, given that it spreads easily from person-to-person, often from people who are asymptomatic. Although estimates vary widely, one recent study that adjusted for undiagnosed cases suggested a mortality rate of 0.66%. There is currently no specific treatment or vaccine for the disease, although significant efforts are underway.

The ongoing COVID-19 outbreak raises several legal and ethical tensions, such as the ethical duty to treat patients vs. the right to refuse unsafe work and health care priority setting in the face of scarce resources. In this post, which is the first in a two-part series, I consider the tension between individual liberties and the collective good.

The Legal Context

Alberta's response to infectious diseases is governed by the *Public Health Act*, RSA 2000, c P-37. This legislation grants medical officers of health various powers in relation to communicable diseases such as compelling the production of information (section 19), conducting investigations (section 29(1)), entering premises (section 30), and compelling medical examinations (section 31). The legislation also broadly permits a medical officer of health to "take whatever steps" he or she "considers necessary" to combat the spread of communicable diseases (section 29(2)). When the Lieutenant Governor in Council declares a public health emergency, which occurred in Alberta on March 17, the medical officer of health "may take whatever other steps are…necessary in order to the lessen the impact" of that emergency (section 29(2.1)).

In an earlier post on ABlawg, Shaun Fluker addressed the powers of medical officers of health and their use in response to COVID-19. For example, pursuant to section 29(2.1), Alberta's Chief Medical Officer has made orders limiting gatherings to 15 people, prohibiting attendance at schools, requiring individuals with COVID-19 to isolate for 10 days, requiring those who have travelled or have been in close contact with someone with COVID-19 to quarantine for 14 days, and closing certain premises (such as recreational facilities and bars), which was later expanded to include all non-essential services.

The declaration of a public health emergency gives the Minister of Health several powers including acquiring or using any real or personal property, requiring qualified persons to render aid, and distributing essential health supplies (section 52.6). It also permits the Minister to "suspend or modify the application or operation of all or part of an enactment" (section 52.1(1)), which the government invoked to increase penalties for violations of the *Public Health Act*. Although the province has declared a public health emergency, they have not declared a state of emergency under the *Emergency Management Act*, RSA 2000, c E-6.8, which would provide additional powers, such as fixing the prices of goods or limiting movement within the province (section 19). Some other provinces have already moved in this direction. For example, Ontario declared a state of emergency and recently issued an emergency order to curb price gouging.

The relevant federal law on public health is the *Quarantine Act*, SC 2005, c 20, which authorizes the government to stop health threats from entering Canada. This legislation requires travellers to provide information (section 15) and authorizes the use of screening technology to detect communicable diseases (section 14). Quarantine officers may compel travellers to submit to health assessments, medical exams, treatment, or detention (sections 19-28).

The *Quarantine Act* also empowers the Governor in Council to make an order prohibiting or limiting entry into Canada "of any class of persons who have been in a foreign country or a specified part of a foreign country" if there is a communicable disease outbreak in that country that would pose an imminent and severe risk to Canadians (section 58). There have been several orders related to COVID-19, including those prohibiting foreign nationals from entering Canada (subject to exceptions) and requiring individuals (including citizens) entering Canada to isolate for 14 days. The government also announced that they are conducting spot checks to ensure that travellers comply with orders under the *Act*. Similar to Alberta, the federal government has yet to declare a state of emergency, but could do so under the *Emergencies Act*, RSC 1985, c 22 (4th Supp), which Shaun Fluker discusses here.

Legal and Ethical Tensions: Individual Liberties vs. the Collective Good

Since the arrival of COVID-19 in Canada, there have been significant restrictions on individual liberties, such as orders to shut down many businesses and isolation orders for travellers and individuals who are symptomatic. Bill 10, *Public Health (Emergency Powers) Amendment Act, 2020*, 2nd Sess, 30th Leg, Alberta, 2020, which received royal assent on April 2, increases monetary penalties for those who violate public health orders and enhances the role of peace officers in enforcing the *Public Health Act*. Governments across the country are similarly moving towards the criminalization of public health. For example, Quebec police arrested an

individual for violating quarantine, while those in Newfoundland arrested a traveller who did not self isolate. Several provinces have set up police checkpoints at provincial borders (see e.g. here and here).

Despite already having significant restrictions in place, some critics say that governments must go further if we are to reduce the spread of COVID-19. For example, some argue that the provinces should order people to shelter-in-place, limiting contact to members of the household and only permitting movement outside the home for essential purposes such as procuring groceries and other supplies. Others support the federal declaration of a state of emergency and the use of individuals' cell phone data to monitor their compliance with isolation orders, which would raise privacy issues.

Given the unpredictable manner and pace at which public health emergencies can unfold and the dangers associated with failing to take decisive actions, it is clear that governments require significant legal powers to protect the public. These restrictions come at significant cost to individual liberties, including *Charter*-protected rights, and must be exercised with restraint. For example, the power of public health inspectors to enter premises can engage the protection against unreasonable search and seizure (*Charter* section 8), the unprecedented restrictions on inter-provincial movement engage mobility rights (*Charter* section 6), while isolation orders may violate the right to liberty and the freedom from arbitrary detention (*Charter* sections 7 and 9). However, the context in which these rights are engaged differs from the usual cases considered by the courts. For example, being quarantined in one's home (along with large swaths of the population) does not come with the same stigma, restrictions on liberty, or long-term employment effects as the criminal law imposes.

Public health powers have seldom been adjudicated before Canadian courts, but the limited cases tend to show significant judicial deference to government. This is consistent with Supreme Court of Canada jurisprudence noting that while violations of life, liberty and security of the person will normally be difficult for governments to justify under section 1 of the *Charter*, they may be able to make such justifications in times of emergency. For example, in *Re BC Motor Vehicle Act*, 1985 CanLII 81 at para 85, the Court recognized that justification may be possible in "exceptional conditions, such as natural disasters, the outbreak of war, epidemics, and the like."

In *Toronto (City, Medical Officer of Health) v Deakin*, [2002] OJ No 2777, the Ontario Court of Justice upheld a four-month extension on the detention of a tuberculosis patient. Mr. Deakin was detained in a locked room in the hospital, was physically restrained and escorted by security guards to smoke outside, was shackled to a bed when he became violent, and "moral persuasion" was used to convince him to take medication. Although his liberty interest was engaged by these acts, the Court concluded that his request for a two-month detention with no compulsory treatment was "unrealistic and impractical" and said that there was "simply no other, realistic method to deal with the problem" other than to extend his detention and treatment by four months (at paras 29-30).

In *Canadian AIDS Society v Ontario*, 1995 CanLII 7116 (Sup Ct J), aff'd 1996 CanLII 1139 (CA), the Red Cross conducted AIDS tests on frozen blood samples without the knowledge or consent of donors. The applicant challenged legislation that required the reporting of test results

to public health officials and donors. While the Court accepted that the disclosure of medical information would engage the right to security of the person, this deprivation was not contrary to the principles of fundamental justice because "the law strikes an appropriate balance between the goal of the state to promote public health, and the privacy rights of the individual" (at 3). The Court also found there was an expectation of privacy in the blood samples but said there was not an unreasonable search or seizure because of "the importance of public health" in releasing that information (at 25). With respect to the state's interest in protecting health, the Court commented that "considerable power is given to the health authorities to respond to the presence of communicable disease" (at 15).

Although Canadian courts have been receptive to government arguments justifying rights violations in the public health context, there may still be successful challenges to restrictions related to COVID-19. For example, the government may struggle to justify some of its infringements on mobility rights. On March 24, the Minister of Transport issued an Interim Order requiring air carriers to deny boarding to symptomatic travellers, including Canadians, for a period of 14 days. Specifically, an air carrier is prohibited from allowing a person to board an aircraft if that person reports having either a) a fever and cough, or b) a fever and breathing difficulties. Even if travellers do not self-report these symptoms, they cannot board if airline staff observe them. However, air carrier staff lack medical training and symptoms such as fever and cough could be indicative of a variety of relatively innocuous illnesses, particularly if the traveller is coming from a country with no known cases of COVID-19. Therefore, a court may conclude that the risk to public health does not justify leaving a Canadian citizen stranded in a country with limited access to health care services and an inability to return to Canada due to the dwindling availability of commercial flights.

Furthermore, onerous travel restrictions may run afoul of Canada's international obligations, such as the requirement under the *International Health Regulations* not to adopt public health measures that unduly interfere with international traffic or the obligation under the *International Covenant on Civil and Political Rights* not to discriminate on the basis of race, colour, sex, language, religion, or social origin, even in the context of a public emergency.

Apart from constitutional review by the courts, restrictions on liberty will be more ethically and legally defensible if governments are transparent in their decision-making processes and are willing to accept accountability for their response to COVID-19. Transparency and accountability are important for both democratic and public health reasons.

In light of the significant threat posed by COVID-19, governments are making sweeping decisions that significantly affect individual liberties through orders from ministers of health or chief medical officers of health, which effectively sidestep the usual democratic processes. Given the lack of democratic debate preceding many of these orders, it is imperative that governments are transparent about the reasons for their decisions and the evidence relied on to justify them in order to legitimize those decisions. Because governments are taking actions with limited opportunity for

discussion and analysis beforehand, it is also essential that they are open to scrutiny after the emergency has subsided (albeit with the recognition that hindsight is 20/20).

Transparency and accountability also further the goal of protecting the public's health. Although there are now enhanced penalties associated with contravening public health laws or orders, there are limits on enforcement capabilities, meaning that public buy-in and voluntary compliance are still crucial to public health efforts. In many ways, governments have been very transparent, with daily briefings from provincial and federal leaders and chief medical officers of health, which have likely helped to build public trust and increase compliance. However, there have been transparency-related concerns, such as Ontario's underreporting of cases due to test rationing, backlogs, and flawed test results. Similarly, governments have been criticized for refusing to release their models or projections showing how the virus might play out. These lapses in transparency may undermine public trust, which is essential to ensuring ongoing compliance with public health recommendations.

Public health decisions are not merely based on medical evidence but must balance a plethora of concerns and interests. For example, while some argued for strict shelter-in-place restrictions and sweeping travel bans before there were a significant number of cases in Canada, it may be more effective to gradually ramp up containment efforts so that people are not fatigued by restrictions and become non-compliant just as the disease peaks. Given this delicate balance and the hasty decisions that policy-makers have had to make during this emergency, they are undoubtedly and understandably getting some things wrong. Following SARS, governments were largely held accountable for their decisions through independent commissions of inquiry (one provincial and one federal). These reports revealed both the successes and shortcomings of the response to the disease outbreak, which policy-makers used to make substantial improvements to Canada's public health system. Interestingly, Nova Scotia's *Health Protection Act*, SNS 2004, c 4, s 6(1)(i) states that within one year of the declaration of a public health emergency, the Minister must provide a report to the House of Assembly on the measures implemented in response to the emergency. Given that it is only a matter of time before governments face another public health crisis, they must be prepared to own the mistakes they make during COVID-19 and to learn from them so that we are better prepared for the next emergency.

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