FRONTLINE PERSPECTIVES

Peer Reviewed

Ethical and Legal Considerations of COVID-19 in Canada

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Abstract

INTRODUCTION: The COVID-19 pandemic has presented novel ethical challenges to the Canadian healthcare providers. **METHODS:** Several bioethical frameworks proposed for public health interventions during pandemics are reviewed. We present fictionalized cases to review important ethical and legal perspectives of COVID-19 in Canada. **CONCLUSIONS:** The current pandemic highlights a lack of consistent legal authority to address breaches in public health recommendations across Canada; invoked legislation during COVID-19 has included the federal Quarantine Act, provincial mental health legislation, and municipal bylaws to enforce physical distancing in public spaces. **DISCUSSION:** Established laws designed to justify involuntary admission or testing and treatment for patients with mental illness should not be used as a justification to unlawfully admit or test patients with known or suspected COVID-19. Coercive measures that infringe on ethical norms during the COVID-19 pandemic – including testing, treating, and involuntary admission – threaten mutual trust between healthcare providers and patients. As such, decisions that infringe on such norms should be considered in the context of known social inequities and be attuned to mitigating stigma faced by patients.

Learning Points:

- The COVID-19 pandemic has presented healthcare workers with novel ethical dilemmas. An ethical framework used to manage challenging clinical scenarios should include consideration of threats posed to an individual's rights, social relationships, and political welfare, and community harm.
- Existing vulnerabilities and social inequities should be proactively considered in individuals for whom public health policies may present unique social/economic challenges.
- Provincial Mental Health legislations provide some legal justifications for coercive measures, but they are broadly not applicable to quarantine and self-isolation. The potential misuse of such laws during pandemic conditions should be mitigated.
- In Ontario, COVID-19 is considered a communicable but not virulent disease; as such, the powers to enforce mandatory isolation as outlined in the Health Protection and Promotion Act (HPPA) are not directly applicable.
- The Canadian federal Quarantine Act does not apply to domestic travel restrictions.

Introduction

The COVID-19 pandemic has presented enormous challenges to the Canadian healthcare system. Among them are novel ethical dilemmas faced by healthcare professionals (HCPs) who, as in any crisis, have had to make ethical decisions with imperfect information and limited guidance. Medical principlism is a common approach to biomedical ethics that considers decisions through the principles of autonomy, beneficence, non-maleficence, and justice. Western bioethics has historically emphasized the value of autonomy – free and informed decisions made without coercion – when juxtaposed with competing values (Azétsop & Rennie, 2010; Callahan, 2003). While principlism commonly provides an ethical framework for routine care, novel ethical dilemmas arising in pandemic conditions can interfere with an HCP's sense of good care (Hem et al., 2014). Decisions that may infringe on traditional ethical norms during atypical pandemic conditions should be anticipated.

The axiom of utilitarianism is frequently argued to justify public health interventions such as

quarantine (Doxiadis & Blaney, 1987), despite how these strategies may interfere with norms of autonomy, justice, and procedural due process (Gostin, 2006; Kinlaw et al., 2009). Following the 2003 SARS epidemic, the University of Toronto's Joint Centre for Bioethics (JCB) infectious disease and pandemic ethics framework presented ten 'substantive values' and five 'procedural values' to guide future decisions in pandemic conditions (Joint Centre for Bioethics, 2005; Rothstein, n.d.). Similar ethical frameworks used to inform public health response include that of Childress et al.'s five "justificatory conditions" (Childress et al., 2002) and the work of Upshur reviewing principles justifying public health intervention (Upshur, 2002) (see **Table 1**). Each framework, while unique, contains a common commitment to ethical principles of relevance to ethical dilemmas in COVID-19. We present fictionalized cases to review important ethical and legal perspectives of COVID-19 in Canada.

Table 1. Ethical values frameworks of public health interventions

Joint Centre for Bioethics, 2005	**Childress et al., 2002**	**Upshur, 2002**
Individual Liberty	Effectiveness	Harm principle
Protection of the public from harm	Necessity	Least Restrictive or coercive means
Proportionality*	Proportionality*	Reciprocity†
Reciprocity†	Least Infringement	Transparency^
Transparency^	Public Justification#	
Privacy		
Protection of community from undue stigmatization		

Duty to provide care		
Equity		
Solidarity**		

*Measures taken should not exceed what is necessary to address the actual level of risk / needs of the community

† Appropriate compensation or restitution should be provided for those disproportionately burdened by a public health measure. This includes patients, healthcare providers, and families who may be disproportionately restricted by such measures.

^ Legitimate stakeholders should be involved in the decision-making process, have input into deliberations, and that decision-making should be as clear and accountable

The responsibility to explain and justify to the relevant parties any infringements of moral considerations that result from public health interventions

**Using collaborative approaches that set aside traditional values of self-interest or territoriality among health care professionals, services, institutions, or regions.

Case A

A 24-year-old single man experiencing homelessness presents to hospital during the COVID-19 pandemic with fever and cough. He has a previous diagnosis of schizophrenia and is stable on treatment. He is admitted to the medicine ward for work up and a SARS-CoV-2 swab is taken. He is asked to remain in hospital until the test results come back, but becomes angry when he cannot go out on a pass to smoke because of pandemic restrictions in place in the hospital. He insists on discharge against medical advice. His attending physician wonders if this is an appropriate use of the provincial Mental Health Act to enforce admission and consults psychiatry.

Case B

A 30-year-old female is admitted to the psychiatric inpatient unit for the treatment of manic relapse of her Bipolar Affective Disorder. She is admitted involuntarily under mental health legislation. She has a fever and sore throat on day 3 of her admission, but declines a SARS-CoV-2 swab recommended by the internist. She states that "this is all a scam to restrict our collective rights and freedoms". She states that she has the right to decline a test and that she will cooperate with the staff to minimize her risk of potentially spreading the virus if she has it, but will not comply with tests she deems unnecessary. The internist wonders if she is incapable to make decisions about her respiratory testing and management.

Figure 1. Box A Criteria (Subsection 20(5), MHA) is required to admit a patient on an involuntary basis (Ontario)

(a) The patient is suffering from mental disorder of a nature or quality that likely will result in,

(i) Serious bodily harm to the patient,

(ii) Serious bodily harm to another person, ***or***

(iii) Serious physical impairment of the patient,

unless the patient remains in the custody of a psychiatric facility;

And

(b) The patient is not suitable for admission or continuation as an informal or voluntary patient.

Ethical Considerations

Coercive Admission

Western biomedical ethical norms value an individual's right to self-determination and autonomy. While patients can decline testing and treatment, these norms may be called into question during pandemic conditions when an individual's refusal to adhere to clinical recommendations could result in harm to others.

Case A exemplifies several ethical tensions, including the primary opposing values of *autonomy* and *protection of the public from harm*. This individual's comorbid psychiatric condition does not justify use of mental health legislation for coercive admission (see *Provincial Mental Health Legislation*). Even if the case was confirmed COVID-19 positive, there is no link between this individual's illness and his mental state. The presumption that this patient's mental illness may justify coercive admission without clear evidence of impaired capacity is a form of discrimination. The value of *equity* should motivate HCPs to ensure that comorbid health/social status does not affect the quality of care for patients with COVID-19.

In this case, socioeconomic factors further complicate the risk of community harm; whereas individuals with a home may resolve such tensions by complying with quarantine orders, this individual's housing status precludes his ability to safely isolate from others. The ethical principle of *reciprocity* should be considered as far as individuals do not suffer unreasonable economic consequences of public health expectations at time of discharge. This does raise the questions of whether public health authorities that mandate self-isolation for communicable diseases have a duty to provide the necessary conditions (e.g. housing) for quarantine, and whether hospital facilities in which HCP and other patients are in close proximity are an appropriate setting for individuals with unstable housing. The suspicion of disease during a pandemic – even if unconfirmed – may carry social stigma that can infringe on the rights of individuals in the healthcare system and in the community setting.

Refusal of Testing and Treatment

In **Case B**, the patient's refusal to consent to the COVID-19 swab test highlights two important

considerations. First is the tension that arises when an individual's informed wishes do not align with the values or opinion of an HCP. Public health crises such as pandemics may exacerbate paternalistic tensions between patient *autonomy* and the HCP's intention to provide *beneficence* in caring for the community. Misaligned values can lead to forms of coercion: formal, informal, and perceived (Gilburt et al., 2008), the latter two of which are commonly overlooked. Where coercion exists, it should be legally justified and applied with consideration towards *necessity* and *proportionality* (Childress et al., 2002). The principles of *equity* suggest that individuals have equal opportunity to challenge the HCP's opinion, irrespective of diagnosis, comorbidity, or socioeconomic status. The second important consideration, relevant to **Case B,** is the issue of capacity (below).

Legal Considerations

Provincial Mental Health Legislation

In Canada, mental health legislation varies across provinces and territories which have the jurisdiction to enact legislation relating to health. While there are differences among the various pieces of legislation, there are similarities when considering involuntary admission. To be involuntarily admitted to a psychiatric facility anywhere in Canada, a person must have a defined mental disorder which causes them to be likely to harm themselves or others, or to suffer serious impairment or deterioration (O'Reilly & Gray, 2014). As in **Case A**, the fact that the patient sought discharge against medical advice, despite a potentially positive test result in the context of symptoms and a diagnosed, but stable, mental disorder, does not imply that his mental disorder is causal. In Ontario, a person may also be detained under the Mental Health Act if they are found incapable of making decisions in the treatment of their mental disorder and are likely to suffer serious physical or mental deterioration (**Figure 1**).

Provincial legislation across Canada requires consent for any treatment in a patient who is deemed capable of making treatment decisions. Here, the issue of decisional capacity depends on assessing an individual's understanding of relevant information and appreciation of the reasonably foreseeable consequences related to a particular treatment. An individual may be incapable with

respect to some treatments and capable with respect to others[1]. As in **Case B**, the fact that a patient may be found incapable of decisions related to their mental illness does not imply failure of capacity in other domains. Disagreeing with the recommendations of a doctor is not determinative of incapacity to consent to treatment, but may trigger a reassessment of the assumption of capacity.

Therefore, in both **Case A** and **Case B**, the Mental Health Act would not be appropriately applied.

Federal Legislation

The **Quarantine Act** grants the federal government broad powers applicable to persons arriving in, or departing from, Canada for screening, health assessment, and medical examination. This act provides explicit constitutional authority to quarantine persons and conveyances (e.g. airplanes, shipping vessels) entering or leaving the country, and to fine and jail those who refuse to comply with directions. These federal powers do not extend to interprovincial travel, provincial quarantine orders, or involuntary hospital admission.

Health Protection and Promotion Act (HPPA)

Each province and territory in Canada has public health legislation that establishes the powers of public health officials to carry out various functions, including communicable disease control. This legislation encompasses the authority to issue isolation and quarantine orders. In the province of Ontario, the HPPA empowers a medical officer of health (MOH) to order a person who is, or may be, infected with a communicable disease to: “isolate himself or herself and remain in isolation from other persons”; otherwise “conduct himself or herself in such a manner as not to expose another person to infection”; submit to a medical examination and report the outcome to the MOH; and to immediately place himself or herself under medical care and treatment for a communicable disease which is also virulent.[2]

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[1] Health Care Consent Act, 1996, S.O. 1996, c. 2, Schedule A, s. 4, s. 15.

[2] *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, ss. 22(4)

The definitions of "virulent" and "communicable" disease are specified by regulation made by the Minister of Health[3], and as such defined by the designation of disease. Common definitions of communicable disease (able to be transmitted from one sufferer to another) and virulent (extremely severe or harmful in its effects) are afforded distinct legal consideration under the Health Protection and Promotion Act (HPPA).

If a person fails to comply with an order of the MOH in Ontario, a judge of the Ontario Court of Justice may make an order that the person be taken into custody, admitted, and detained in a hospital for purposes of examination and treatment by a physician for a communicable disease which is also virulent.[4] Diseases caused by the novel coronaviruses (including SARS and MERS) are defined as communicable, but not virulent as per the Designation of Diseases under the Health Protection and Promotion Act.[5] Therefore, these types of court orders cannot be relied upon to detain or treat.

Canadian Charter of Rights and Freedoms

The Canadian Charter of Rights and Freedoms applies to federal, provincial, and municipal laws. All laws and actions taken on the part of the government and its agents to address COVID-19 need to be consistent with the Charter. Even the declaration of an emergency, at any level, does not suspend its operation. However, under the Charter, no rights and freedoms are absolute; many may be in conflict. Enshrined rights and freedoms can be infringed by laws that "are demonstrably justified in a free and democratic society"[6]. During the COVID-19 pandemic, various measures being taken by governments need to be proportionate to the objective of protecting public health, and must be justified. Due to the unprecedented nature of these conditions, many of these measures have not yet been tested at law. Care must be taken not to unduly override the rights and freedoms of the

[3] R.S.O. 1990, c. H.7, s. 1 (1); 1997, c. 30, Sched. D, s. 1; 1998, c. 18, Sched. G, s. 55 (1); 2000, c. 5, s. 14 (1); 2001, c. 25, s. 477 (1-3); 2006, c. 19, Sched. L, s. 11 (2, 3).

[4] Health Protection and Promotion Act, R.S.O. 1990, c. H.7, ss. 35(3)

[5] Ontario Regulation 135/18: DESIGNATION OF DISEASES under the Health Protection and Promotion Act, R.S.O. 1990, c. H.7

[6] *Canadian Charter of Rights and Freedoms*, s 1, Part I of the Constitution Act, 1982

vulnerable and marginalized in society, including the mentally ill.

As in **Case A**, if the physician applied the Mental Health Act to detain the homeless patient who presented with symptoms of a suspected COVID-19 infection, but not of a mental disorder, the question arises as to whether the patient's section 7 right to life, liberty, and security of the person under the Charter has been breached. As in **Case B**, if the physician applied the Health Care Consent Act to find the patient incapable of consenting to treatment, and to obtain consent to the unwanted SARS-CoV-2 swab with positive results being reportable and attached to consequences, the question arises as to whether the patient's section 8 right to be secure against unreasonable search and seizure under the Charter has been breached.

Discussion

Public health emergencies present unique ethical dilemmas. The complex considerations of the Canadian public health response to COVID-19 can be contextualized within previous global health infectious disease emergencies such as the 2003 SARS outbreak and the 2014 Ebola crisis (Rothstein, n.d.). Multiple, ethical frameworks have been proposed for justifying public health interventions during a pandemic (Childress et al., 2002; Joint Centre for Bioethics, 2005; Rothstein, n.d.; Singer et al., 2003). Importantly, some of the most well-established values of autonomy, liberty, community protection, and privacy may be called into question during periods of crisis – especially when knowledge about an emerging health threat (e.g. virulence, mortality) is limited. In all such cases, the ethical framework used to justify intervention must be supported by legislative authority that clarifies infringement on both individual rights and community protections. The current pandemic highlights the lack of clear legal authority to address public health and safety in any consistent manner across Canada. Instead, a patchwork of law from every level of government has been enlisted to fill the gap; federal quarantine for those coming into and out of Canada, provincial public health orders with limited powers for communicable disease, and municipal by-laws to close various public areas to "enforce" physical distancing.

Both fictionalized cases present patients with psychiatric comorbidity. Individuals with mental illness experience increased rates of social isolation, stigmatization, and human rights violations under typical conditions (Baumann, 2007); this stigma is an important potential source of bias during

decisions in times of public health crisis. Therefore, protections for vulnerable populations, including those experiencing housing instability, should be anticipated in public health preparedness.

In **Case A**, the HCP was challenged to make a decision regarding involuntary discharge for a patient with suspected COVID-19. This case was complicated by housing instability and implicit bias, rather than the patient's comorbid illness. Balancing the values of autonomy, community protection, reciprocity, and equity, and least coercion, one appropriate response may have included working with a local public health officer to provide temporary accommodation (e.g. motel) for the duration of recommended quarantine. The legal authority to enforce isolation is inconsistent across Canada.

Case B case highlights the potential ethical limitations of universal COVID-19 testing, as has been suggested as a strategy to resolve national lockdowns (Peto et al., 2020). Whereas testing may alleviate some burden of individual liberty being restricted in those with negative test results, these measures should be balanced with protecting the community from undue stigmatization by perpetuating privilege and class structures (Manderson & Levine, 2020). The assumption of public consent for universal testing remains unsubstantiated.

Every person in Canada maintains rights under the Charter of Rights and Freedoms. Coercive admission and testing threatens basic rights not to be arbitrarily detained or searched. Established laws designed to justify involuntary admission or testing and treatment for patients with mental illness should not be used as a justification to unlawfully admit or test patients with known or suspected COVID-19. Coercive measures that infringe on ethical norms during the COVID-19 pandemic – including testing, treating, and involuntary admission – threaten a sense of good care and mutual trust that we collectively rely upon in times of crisis.

The legal and ethical implications of the COVID-19 pandemic will continue to evolve. As society adapts to the reality of prolonged pandemic conditions, so too will HCPs become more accustomed to confronting challenging ethical dilemmas. It is our hope that these cases highlight important considerations to provide a more nuanced and comprehensive understanding of processes that can be used during times of global uncertainty.

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Acknowledgements: None

Funding Source: None

Competing Interests: None

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Publication Date: August 31, 2020