

Rationing in Pandemics: Administrative and Private Law Challenges

by

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Abstract

Rationing of lifesaving resources in pandemics is likely to be an increasingly relevant issue. While the broad legal and ethical implications of pandemic preparedness have been explored at length, little attention has been paid to the legal issues associated with rationing. This thesis seeks to analyze the potential for administrative and private law challenges to governments' rationing of vaccines, ventilators and antivirals.

The wide variety of statutory authorities, and their associated conditions and discretionary limitations, that governments may rely on for mandating rationing protocols, makes them susceptible to administrative law challenges on the grounds of errors of jurisdiction. An analysis of the tort liability of governments, hospitals and physicians suggests that negligence suits will likely not be successful due to a lack of proximity required for a private law duty of care, the policy-making immunity of governments and a contextual standard of care.

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Table of Contents

Acknowledgments	iii
Table of Contents	iv
Chapter 1 Introduction	1
1.1. Types of Legal Challenges to Rationing.....	3
1.1.1. Administrative Law	3
1.1.2. Private Law	4
1.1.3. Constitutional Law.....	5
1.2. General Issues	7
1.2.1. Timing.....	8
1.2.2. Standing	9
Chapter 2 Rationing in Pandemics: Past Experience & Future Predictions	12
2.1. Introduction.....	12
2.2. The Necessity of Rationing.....	12
2.3. Pandemics	15
2.3.1. H1N1 Pandemic	16
2.4. Rationing Lifesaving Resources	18
2.4.1. Vaccines.....	19
2.4.1.1. <i>Supply and Demand</i>	19
2.4.1.2. <i>Prioritization of Vaccine Recipients</i>	22
2.4.1.2.1. Key Facets of Prioritization Systems.....	22
2.4.1.2.2. Jurisdictional Responsibilities	24
2.4.1.3. <i>Rationing Vaccines: The H1N1 Experience</i>	28
2.4.2. Ventilators.....	32
2.4.3. Antivirals.....	36
2.5. Conclusion	40
Chapter 3 Administrative Law Challenges	41
3.1. Introduction.....	41
3.2. Principles of Administrative Law	41
3.2.1. Jurisdiction & Grounds for Review	42
3.2.2. Standard of Review	46
3.2.3. Relief.....	47
3.3. Statutory Authority – Physicians & Hospitals	48
3.3.1. Regulated Health Professions	49
3.3.2. Public Hospitals	53
3.4. Statutory Authority – Public Health	54
3.4.1. Provincial / Municipal.....	55
3.4.1.1. <i>Boards of Health</i>	55
3.4.1.2. <i>Enforcement</i>	59
3.4.1.3. <i>Appeal</i>	61
3.4.1.4. <i>Provincial Public Health Powers</i>	62
3.4.1.5. <i>Procurement</i>	64
3.4.1.6. <i>Emergency Response & Planning: Declaration of Pandemic</i>	65
3.4.2. Federal.....	67

3.5.	Statutory Authority - Emergencies	69
3.5.1.	Provincial	70
3.5.1.1.	<i>Emergency Planning & Administration</i>	70
3.5.1.2.	<i>Emergency Declarations & Jurisdictional Issues</i>	72
3.5.1.3.	<i>Emergency Orders</i>	75
3.5.2.	Federal	80
3.5.2.1.	<i>Emergency Management Act</i>	80
3.5.2.2.	<i>Emergencies Act</i>	82
3.6.	Conclusion	86
Chapter 4 Private Law Challenges.....		88
4.1.	Introduction	88
4.2.	Key Elements of the Tort of Negligence	89
4.3.	Sovereign Immunity & Proceedings against the Crown	90
4.4.	Liability of Governments in Negligence for Pandemic Rationing	94
4.4.1.	Duty of Care	95
4.4.1.1.	<i>The Cooper-Anns Test</i>	95
4.4.1.2.	<i>Proximity</i>	96
4.4.1.3.	<i>Policy/Operational Dichotomy</i>	104
4.4.2.	Standard of Care	115
4.4.3.	Damages	118
4.4.4.	Causation	118
4.5.	Suing Hospitals & Physicians	120
4.5.1.	Hospitals	120
4.5.2.	Physicians	122
4.5.2.1.	<i>Standard of Care</i>	123
4.5.2.1.1.	<i>'Emergency' or 'Crisis' Standards of Care</i>	124
4.5.2.2.	<i>Cost Containment</i>	125
4.5.2.2.1.	<i>Budget Scarcity vs. Actual Scarcity</i>	128
4.6.	Conclusion	130
Chapter 5 Conclusion		131
Bibliography		133

Chapter 1

Introduction

Pandemics, while rare, are potentially catastrophic events, disrupting society and costing many lives. Given their largely unpredictable and widespread nature, it is likely lifesaving resources such as vaccines, ventilators and antivirals will be too scarce to provide to all who need them. Instead, they will need to be rationed. Past experience with the H1N1 pandemic, as well government response plans for future incidents, confirm this tragic reality. Regardless of the mechanism chosen to ration such resources, there will be some who will be denied care (and potentially a chance to live). If able, they or their representatives may turn to the courts for recourse. This possibility – citizens challenging rationing decisions through law suits in tort or through judicial review of executive action – and the success thereof, is the central concern of this thesis.

The ensuing discussion and analysis will show that opportunities for judicial review of delegated executive decision-making are substantial. However, barring bad faith, the consideration of irrelevant factors, or non-compliance with statutory conditions precedent, such actions are unlikely to be successful. Private law suits in negligence against provincial governments, hospitals or physicians are likewise unlikely to be successful due to courts' willingness to immunize public health policy actions from liability.

This will be a largely prospective analysis, as there have been no Canadian cases to-date challenging pandemic rationing on either administrative, private law or constitutional grounds. This should not subtract from the analysis, as many pandemic response plans and laws were crafted or revised after the H1N1 pandemic. Thus, the issues raised herein are likely to be applicable to any future pandemic-induced rationing.

The analysis will proceed as follows. First, the remainder of this introductory chapter will be a brief background on the three types of legal challenges likely to arise from rationing in the course of a pandemic, as well as common issues between them of standing and timing. The second chapter will involve a background review of what rationing is, why it will be necessary during a pandemic, how it has been done in the past (namely, the H1N1 pandemic), as well as an examination of how pandemic response plans propose to ration in the future.

The bulk of legal analysis begins with the third chapter, which opens with an overview of the administrative law of judicial review. This will precede an in-depth analysis of all relevant statutory powers that provincial (using Ontario as an example) and federal governments may rely in mandating rationing or otherwise controlling the distribution of scarce lifesaving resources during a pandemic. This review suggests that substantial opportunity for challenge exists, but barring bad faith or the failure of executive to abide by statutory conditions precedent, the chances of success are slim.

Finally, the fourth chapter will examine the potential liability of governments in negligence for crafting and implementing rationing protocols/guidelines. Brief consideration will also be given to the potential liability of hospitals and physicians. The analysis will show that the private law liability of governments for rationing in pandemics is a virtual non-starter, as courts have consistently refused to recognize a private law duty of care of public health authorities. In the event a private law duty of care were judicially recognized, policy concerns would militate against finding a government liable. Likewise, hospitals and physicians are unlikely to be found liable due to a lack of legal responsibility for non-negligent care and a contextualized standard of care, respectively.

1.1. Types of Legal Challenges to Rationing

The ability to legally challenge rationing decisions is important in a liberal democracy. If individuals disagree with the judgment of government decision-makers, the legal system may be their only recourse to have their concerns heard, and potentially upheld. As rationing lifesaving resources often involves difficult and tragic decisions, the potential for harm arising from wrongful, abusive or illegitimate conduct is great. Thus, legal review serves an important mediating role. As Nola Ries states, “[l]egal review obliges officials to defend their actions before courts or other quasi-judicial decision-makers who, in turn, must balance individual liberties and public health goals.”¹ As Chapter 3 will show, public health and public health emergency powers are oftentimes extreme (as may be needed to impose constricting rationing protocols). Thus, such powers are, “susceptible [to] abuse and law may be used in various ways to scrutinize and hold accountable the exercise of coercive power.”²

There are three primary areas for legally challenging government-mandated rationing – administrative, private, and constitutional law. This thesis is most concerned with the former two, though all three will be briefly outlined below in order to provide background knowledge of the primary issues.

1.1.1. Administrative Law

As Chapter 3 will show, governments and their actors can rely on a wide variety of statutory powers to impose rationing protocols. At the provincial level, legislation-granted powers cover the supervisory regulation of health professionals, pharmaceuticals, public hospitals, and actions in the broader public health. Both federal and provincial governments

¹ Nola M Ries, “Legal Issues in Disease Outbreaks: Judicial Review of Public Health Powers” (2007) 16:1 Health Law Review 11-16.

² *Ibid.*

are also empowered to make orders and regulations necessary to carry out resource rationing under emergencies legislation.

As will be seen, a vast arsenal of (sometimes extreme) statutory powers is accompanied by a great vulnerability to administrative law challenges. Affected persons, or those seeking redress in the public interest, can apply to courts for judicial review of any public decision, thereby challenging any rationing thereunder. Judicial review functions as a check on executive discretion by ensuring authority delegated by the legislature is respected, and not exceeded or abused. Delegated authority must only be exercised within the confines of the delegation. Any other actions are *ultra vires*, and thus unlawful as without legal authority. Courts will review delegated actions to ensure they operate within the boundaries of their enabling legislation, consistent with the objectives thereof and principles of natural justice.

1.1.2. Private Law

Chapter 4 will examine private law challenges to government-imposed resource rationing. Unlike administrative law, private law seeks not necessarily to hold public decision-makers to account, but also deter substandard actions and compensate harmed individuals.

In particular, the tort of negligence will be explored regarding three potential defendants: provincial governments, hospitals and physicians. As in any negligence action, the defendant will be held liable if they owed the plaintiff a duty of care, their actions fell below a standard of reasonable care, the plaintiff suffered actual damages or harm, and the defendant's negligence caused that harm. Such a case may arise if an individual is denied care due to the necessity of rationing, and suffers harm as a result. They may choose to sue

the government (which in most statutes examined herein, has waived their traditional sovereign immunity) in order to receive compensation for that harm. Any judicial consideration of liability will likely turn on (i) whether a public or private law duty of care is owed by the government authority; (ii) the decision was ‘policy’ or ‘operational’ in nature; and (iii) whether the standard of care should accommodate the extenuating circumstances of a pandemic.

1.1.3. Constitutional Law

While admittedly beyond the scope of this thesis, several constitutional issues may arise in the allocation of scarce resources during pandemics that bear mentioning.³

First, there are issues regarding the division of powers. In other words, what is the constitutional authority of each level of government to enact, promulgate or otherwise mandate rationing guidelines or priority sequences? As Nola Reis notes, public health powers are not explicitly enumerated in the *Constitution Act, 1867* and so both provincial and federal jurisdictions can legislate in that area within their enumerated powers.⁴ Specifically, the federal government has responsibility for matters relating to criminal law, quarantine, and ‘Peace, Order and Good Government’.⁵ Meanwhile the provinces have exclusive dominion over hospitals, property and civil rights and all local and private matters.⁶

In addition to jurisdictional issues, prioritizing certain classes of persons over others to receive lifesaving resources (and thereby implicitly denying care to some) raises several

³ For an excellent overview of how *Charter* rights are implicated in resource allocation decisions generally, see Nola M Ries, “Charter Challenges” in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 3d ed (Markham: LexisNexis, 2007) 539-570.

⁴ Nola M Ries, “Legal Foundation of Public Health in Canada” in Tracey M Bailey, Timothy Caulfield & Nola M Ries, eds, *Public Health Law & Policy in Canada*, 2d ed (Markham: LexisNexis, 2008) at 11.

⁵ *Constitution Act, 1867 (UK)*, 30 & 31 Vict, c 3, reprinted in RSC 1985, App II, No 5, s. 91.

⁶ *Ibid*, s. 92.

rights concerns under the *Charter of Rights and Freedoms*.⁷ Of important note, the *Charter* only applies to government and actors undertaking government functions, not private actors.⁸ The Supreme Court has held that the actions of public hospitals are only subject to *Charter* scrutiny to the extent they are carrying out government laws or policies.⁹

Of most relevance to pandemic rationing are sections 7 (protection of life) and 15 (equality), which respectively state:

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

15. Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.¹⁰

Clearly, section 7 may be implicated in rationing that has the effect of denying lifesaving treatment to persons that need it, jeopardizing their right to life in a manner inconsistent with the principles of natural justice.¹¹ The most (in)famous case on section 7 was the *Chaoulli* case, where the plaintiff successfully challenged the legal basis of the Quebec government's limits on the provision of private health care insurance and services, arguing a violation of their right to life and security of the person.¹²

Likewise, section 15 may be applicable to the extent priority sequences or protocols discriminate on the basis of a protected status, such as age or disability. To date, there has been no analogous case, though the courts have considered challenges of government

⁷ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982 (UK)*, 1982 c 11 [*Charter*].

⁸ *Ibid.*, s. 32(1).

⁹ See *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624; *Stoffman v Vancouver General Hospital*, [1990] 3 SCR 483.

¹⁰ *Charter*, supra note 7, ss. 7, 15.

¹¹ See e.g. the claims in *Flora v Ontario Health Insurance Plan*, 2008 ONCA 538; *Wynberg v Ontario* (2006), 82 OR (3d) 561 (CA); *R v Morgentaler*, [1988] 1 SCR 30; *Rodriguez v British Columbia* (1993), 107 DLR (4th) 342.

¹² *Chaoulli v Quebec (Attorney General)*, [2005] 1 SCR 791. For a more detailed analysis of the case see Colleen M Flood, Kent Roach & Lorne Sossin, eds, *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto, 2005).

decisions not to fund certain care, thereby resulting in a discriminatory effect.¹³ Similar reasoning may be applicable to pandemic *Charter* challenges, but as the next paragraph will outline, any impugned government action will still receive the benefit of a section 1 analysis.

Finally, an infringement of either of the foregoing sections as a result of pandemic rationing does not mean that a *Charter* violation *per se* has occurred that requires remedy under section 24(1). Instead, section 1 of the *Charter* states that rights and freedoms guaranteed thereunder are, “subject to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”¹⁴ The ‘reasonable limits’ clause of section 1 acts as a buffer in cases where individual rights must be sacrificed for communal interests.¹⁵ It is not difficult to contemplate a heated debate, and perhaps ultimate acceptance by courts that rationing, while potentially infringing certain *Charter* rights, is reasonably justifiable because it is designed to minimize overall morbidity and mortality.

1.2. General Issues

There are two practical limitations that are substantially common between private law and administrative law challenges to rationing decisions. The first is timing. That is, the judicial system and its built-in procedures may simply not be fast enough to deliver a meaningful remedy to a wronged party during a pandemic, where rationing may only be a temporary measure. Second, there is the question of standing – who can challenge government-mandated or recommended rationing decisions?

¹³ See e.g. *Eldridge*, *supra* note 9; *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, [2004] 3 SCR 657, [2004] SCJ No 71.

¹⁴ *Charter*, *supra* note 7, s. 1.

¹⁵ See e.g. *R v Oakes*, [1986] 1 SCR 103, [1986] SCJ No 7.

1.2.1. Timing

A limitation of any potential statutory, common law or constitutional challenge is that by the time it reaches a court for decision, it will likely be too late. Any challenge to government statutory authority for rationing, negligence suit relating to such, or *Charter* challenge that seeks to remedy any potential inequity, will take time after statements of claim and pleadings are exchanged.

This assumes that the pandemic will not have negatively impacted court operations, a possibility acknowledge at least by the Alberta pandemic response plan.¹⁶ Even if special quick-access courts are implemented during pandemics, it is possible that by the time the case reaches a judge, the second wave of a pandemic may have subsided. More importantly, any supply shortages or demand spikes may have ebbed, eliminating the need for rationing and priority groups altogether. This was seen during the 2009-2010 H1N1 pandemic where priority sequencing for vaccines only lasted a few weeks until immunization clinics were opened to the general public.

Timing issues may also deter legal challenge, as may the reality that rationing and sequencing guidelines are applicable to everybody, and not just certain groups. In this regard,

Ries notes:

If public health interventions ... are imposed on a widespread, but temporary, basis, individuals may be less likely to seek legal recourse if they see that others face similar restrictions and that limits on personal freedoms will end well before they ever have an opportunity to appear before a judge to argue a challenge.¹⁷

Even if courts are able to hear proposed challenges quickly, and provide injunctions or other forms of speedy remedies, such solutions may be meaningless due to factors outside

¹⁶ Alberta Health and Wellness, *Alberta's Plan for Pandemic Influenza* (Edmonton: Alberta Health and Wellness, 2009) at 23 [APPI].

¹⁷ Ries, *supra* note 1.

the defendant governments' control. For example, an injunction or court order to halt rationing or revise priority groups would not necessarily allow a plaintiff or injured party to receive the scarce resource in question because of supply limitations, as will be discussed in Chapter 2. If there are simply not enough vaccines due to manufacturing delays, any order to provide the resource will be hollow.

With that said, a legal challenge to rationing may still have a meaningful impact on government policy for future pandemic responses. As well, any lawsuit alleging government negligence in rationing must, by necessity occur *a posteriori*. That is, it cannot be brought until after rationing has occurred. Therefore, if the goal of the claim is compensatory – as most tort negligence claims are – such purpose will not be negatively impacted by timing difficulties.

1.2.2. Standing

A second issue common to all three types of potential legal challenges, is that of standing. Who is able to challenge the decisions and what qualifications must they have?

For *Charter* challenges, section 24(1) provides that anyone whose rights or freedoms are infringed may apply to a court for a remedy. An infringement would obviously have to be proven in court and therefore it is fairly wide open as to who may challenge government decisions on the basis of the *Charter*.

In private law, any party can file suit against government, hospitals or physicians if they feel they have been harmed by the defendant's negligent actions. Whether that will be borne out in court is a different matter. The stumbling blocks in this regard (to be expanded upon in Chapter 4) would be whether the parties are sufficiently proximate so as to find a duty of care. Any alleged negligence also would have to be found to be causative of the

plaintiff's actual damages or harms. If a prospective plaintiff has suffered no legally cognizable harm, seeking a private law remedy would be useless.

The matter of standing is most complicated in cases of administrative law – judicial review of executive action. However, while issues of standing are important, they likely will not represent a significant hurdle to parties seeking judicial relief.¹⁸ Generally, anyone directly affected (via a 'sufficiently personal interest') by a decision of a public actor has standing to seek administrative law remedies. Clearly, in cases of rationing this would include patients (or their representatives) offered or denied treatment on the basis of prioritization or sequencing decisions.¹⁹ Patient advocacy organizations may also bring suit, as could health care practitioners (or their organizations), public health workers and organizations, pharmaceutical manufacturers and distributors, hospitals, and others.²⁰

In addition to personal interest standing, there are cases where courts may grant discretionary standing. For example, Cherniawsky notes that, "standing is unlikely to be a great barrier for groups who cannot establish that they have a direct interest which has been affected."²¹ This is the result of a ruling of the Supreme Court of Canada that held that citizens have the right to seek a judicial declaration that governments enforce their own laws.²² In such cases, direct standing does not exist, but discretionary standing does. Courts may grant such standing in circumstances where, "the issue is serious and justiciable; the party has a genuine interest in the issue; and, there is no other reasonable and effective means

¹⁸ Katherine Cherniawsky, "Enforcement of Health Care Rights and Administrative Law" (1996) 4 Health LJ 35-61 at para 36.

¹⁹ *Re Doctors Hospital and Minister of Health et al* (1976), 68 DLR (3d) 220 (Ont Div Ct); *Finlay v Canada (Minister of Finance)*, [1986] SCR 607, [1986] 2 SCJ No 73.

²⁰ Cherniawsky, *supra* note 18 at para 38.

²¹ *Ibid.*

²² See *Finlay*, *supra* note 19.

to bring the issue before the court.”²³ Thus, if for example, a medical officer of health mandates certain forms of resource rationing that exceeds their statutorily granted powers, any person may apply to the court for a declaration of *ultra vires*.

Similarly, as will be seen in the subsequent chapter on private law duties of governments, public health authorities have been held to owe a public law duty to the community at-large. Thus, if governments are arguably not living up to their public law duties under the legislation, this could lead to patient advocacy groups and other public interest organizations gaining standing.²⁴

Ultimately, the question of standing will have to be judicially considered (assuming it is challenged by the defendant), and such a determination will rest solely on the peculiar facts of that case.

²³ *Ibid*; Cherniawsky, *supra* note 18 at para 38.

²⁴ Cherniawsky, *supra* note 18 at para 38.

Chapter 2

Rationing in Pandemics: Past Experience & Future Predictions

2.1. Introduction

This chapter will examine why rationing in pandemics is necessary, how it has been handled in the past, and how governments propose to do so in the future. The focus will be on three potentially lifesaving resources – vaccines, antivirals and ventilators – each of which will be shown to be scarce due to unique issues. Given the potential scarcity of these three resources, governments have plans to ration them where necessary, and during the 2009-2010 pandemic implemented some of those plans, often through the use of priority sequencing groups. The background information contained in this chapter will inform and allow a more fulsome discussion of prospective legal challenges.

2.2. The Necessity of Rationing

Rationing in health care is not a new concept and exists to some extent in every health care system around the world, regardless of economic status as public or private. Rationing can be described as, “the withholding of a commodity from, or limiting its supply for, some individuals.”²⁵

Essentially, demand for certain health care resources far outstrips supply and therefore decisions must be made as to who receives the limited supply, necessarily leaving some demand unsatisfied. In a market economy, prices are a mechanism to bridge gaps between supply and demand. However, due to the *sui generis*-like nature of health care resources, particularly lifesaving resources, price is often not a feasible, moral, or ethical

²⁵ Henry A Shenkin, *Current Dilemmas in Medical-Care Rationing: A Pragmatic Approach* (New York: University Press of America, 1996) at iv.

option to equilibrate supply and demand. In cases of lifesaving technologies or treatments, the 'demand' is a demand to live, such that rationing will result in deaths that may not have occurred had rationing not been required. In other words, "[a]ll rationing mechanisms imply the eventual denial of useful medical care to relatively few patients in favor of containing total costs of medical care for an entire society."²⁶

There are two subgroups of rationing: macro and micro. Macro-rationing covers system-wide decisions made at a high level, typically involving global budgetary allocations and is generally a function of cost limitations. Some scholars contend that every element of civil society is predicated on allowing people to die when it costs too much. For example, economic allocation analysis factors into decisions about the extent of safety regulations and precautions in such areas as road and workplace safety.²⁷ The essential question of macro-rationing allocation decisions is: if given a finite pool of funds (tax revenues), how is that pool distributed to varying societal priorities and goals? Once a budget has been allocated to health care through macro-rationing decisions, the next question is: how do we collectively best spend that money within the health care sphere? Such decisions are still not made at the individual level and, for publicly-funded systems, often encompass choosing which range of services to include in the public Medicare basket (also known as priority setting).

Micro-rationing is arguably the more tragic of the two, as it often involves making decisions that directly impact identifiable patients, as compared to budget allocations where, as tragic as it is to condemn individuals to certain death, the emotional impact is lessened due to its abstract nature. Micro-rationing decisions are those about whether to grant or refuse

²⁶ *Ibid* at 35.

²⁷ John McKie et al, *The Allocation of Health Care Resources: An Ethical Evaluation of the 'QALY' Approach* (Aldershot: Ashgate Publishing, 1998) at 1.

care made at the individual patient level.²⁸ As Caulfield notes, most rationing is conducted by physicians because, “their clinical discretion leaves them with the bottom line decision making power as the ‘micro’ allocators.”²⁹

Decision-making processes around both micro and macro rationing can also be broken down into two broad subgroups: implicit and explicit. Explicit rationing, covering most macro-rationing or allocation decisions, are those performed openly by government regulation or legal pronouncements.³⁰ Decisions in such systems are often based on well-publicized rules of entitlement such as ranked lists of covered procedures.

In contrast, implicit rationing decisions are not legally mandated and are made by the nature or structure of the health care system, such that certain conditions or individuals are excluded from care. This often involves the exercise of gatekeeper discretion.³¹ For example, bedside rationing whereby individual physicians determine what services or treatment a patient is to receive is a form of implicit rationing. This form of micro-rationing is invisible to the public, as a multitude of factors such as patient age, prognosis, quality-of-life, likelihood of success, and availability of resources, to name but a few, enter into the gatekeeper’s decision about whether or not to grant care and therefore access to the resource in question. As John Butler summarizes, “[d]iscretion is to a greater or lesser degree, cloaked in secrecy.”³² As will be seen, pandemic rationing involves both implicit and explicit decision-making, dependant on the level of operational guidance in pandemic response plans.

²⁸ Shenkin, *supra* note 25 at 23.

²⁹ Timothy A Caulfield, “Health Care Reform: Can Tort Law Meet the Challenge?” (1994) 32 *Alta L Rev* 685 at 687.

³⁰ Shenkin, *supra* note 25 at 24.

³¹ John Butler, *The Ethics of Health Care Rationing* (New York: Cassell, 1999) at 13.

³² *Ibid* at 16.

2.3. Pandemics

Public health pandemics are particularly apropos to the rationing debate. Panic, fear and the prospect of wide-spread indiscriminate morbidity and mortality all serve to create tremendous demand for scarce health care resources. Furthermore, often unlimited government budgets cannot avoid rationing in a pandemic, as there are numerous factors that could limit supply of lifesaving resources that an immediate influx of cash could not solve.³³

Pandemics also represent a unique challenge to traditional rationing models, as implicit micro-rationing is often abandoned in favour of centrally-imposed macro-rationing. This is likely the case for two reasons: efficiencies in central planning and administration, and physician conflict-of-interest. Current thinking holds that large-scale emergencies require central planning and administration for efficient distribution and optimal success. For example, centrally-controlled vaccine procurement and distribution is far more efficient than requiring individual practitioners or health care sites to purchase their own stocks. Likewise, screening and distribution can be more efficiently provided in central locations than through regular health channels. Second, physicians have a general legal duty to patients to optimize their success and act in their best interests. However, in an emergency, it may be inappropriate for that standard of care to remain firmly in place, as denying resources to certain patients or patient groups may benefit a far greater proportion of the public, thus causing a conflict in ethical and legal obligations.

³³ It should be noted that unlike ventilators which will likely always be lifesaving, vaccines and antivirals will not necessarily be lifesaving at the time rationing decisions are made.

2.3.1. H1N1 Pandemic

Influenza pandemics have occurred four times in the last hundred years: Spanish Influenza (1918-1919); Asian Influenza (1957-1958); Hong Kong Influenza (1968-1969); and most recently the H1N1 pandemic (2009-2010).³⁴ The worst – the Spanish Flu – killed over 20 million people worldwide, including an estimated 30,000 to 50,000 Canadians.³⁵

The H1N1 pandemic originated in Mexico in early 2009.³⁶ On June 11, 2009, the World Health Organization (WHO) declared a global pandemic of the highest level (Phase 6). The pandemic was eventually terminated by WHO on August 10, 2010.³⁷ The first Canadian case of pandemic H1N1 was reported on April 26, 2009, and the first death on October 27, 2009 in Ontario.³⁸

Canada experienced two waves of pandemic H1N1: the first between April 12 and August 29, peaking in June; and the second peaking in November 2009 and ending on January 27, 2010.³⁹ The Canadian Institute for Health Information noted that, “[t]wo-thirds of all hospitalized H1N1/influenza cases occurred during a five-week period in the second wave (October 25 to November 28).”⁴⁰ However, hospitalized pandemic influenza patients only represented approximately 3% of all acute care cases seen by hospitals. In total, “H1N1/influenza patients accounted for only ... 0.4% of ICU patients, and 0.7% of patients

³⁴ APPI, *supra* note 16.

³⁵ Public Health Agency of Canada, *The Canadian Pandemic Influenza Plan for the Health Sector* (Ottawa: Her Majesty the Queen in Right of Canada, 2006) and *Annex D: Appendix: Vaccine Prioritization Framework*, online: <<http://www.phac-aspc.gc.ca/cpip-pclcpi/vf/index-eng.php>> at Background-3 [CPIP].

³⁶ The outbreak of influenza-like-illness was first reported in Veracruz on April 12, 2009.

³⁷ Public Health Agency of Canada, *Lessons Learned Review: Public Health Agency of Canada and Health Canada Response to the 2009 H1N1 Pandemic* (np: Public Health Agency of Canada, 2010) at 2 [Lessons].

³⁸ Alberta Health and Wellness & Alberta Health Services, *Pandemic (H1N1) 2009: The Alberta Experience* (np: Government of Alberta, 2010) at 11 [Alberta Experience].

³⁹ Lessons, *supra* note 37 at 2.

⁴⁰ Canadian Institute for Health Information, *The Impact of H1N1 Pandemic on Canadian Hospitals* (Ottawa: Canadian Institute for Health Information, 2010) at 8 [CIHI].

requiring invasive mechanical ventilation.”⁴¹ Approximately 25 - 35% of patients with H1N1 required hospitalization, and 1,130 required mechanical ventilation in Canada.⁴² Between April and December 2009, over 10,400 identified pandemic influenza cases were discharged from acute care facilities in Canada.⁴³ This is a small fraction of the over 400,000 laboratory-confirmed during the entire pandemic.⁴⁴ In total, 426 patients died from H1N1 in Canada.⁴⁵ That is three times less mortality than during seasonal flu, which was virtually non-existent during the H1N1 pandemic.⁴⁶ In Alberta, 96% of the deaths from pandemic H1N1 were among those with underlying chronic conditions, while 77% of those hospitalized had such conditions.⁴⁷ While this number seems significant, it was not of a scale sufficient to require the rationing of critical care resources or ventilators.

The wave-like action of influenza pandemics is important from a resource rationing perspective, as vaccines will likely not be available during the first wave, which may last eight to ten weeks. Furthermore, if vaccines are distributed prior to or during the second wave, mortality and morbidity can be significantly reduced, as the second wave tends to be more virulent and devastating. For example, “Canada’s second wave resulted in four to five times more hospitalizations and deaths compared with the first wave.”⁴⁸ Part of this spike may be due to the slow rollout of mass vaccination campaigns, typically not beginning until

⁴¹ *Ibid* at 10.

⁴² *Ibid* at 16.

⁴³ *Ibid* at 4.

⁴⁴ Lessons, *supra* note 37 at 16.

⁴⁵ *The H1N1 Pandemic – How Ontario Fared: A Report by Ontario’s Chief Medical Officer of Health* (Toronto: Ministry of Health and Long-Term Care, 2010) at 1 - 2 [CMOH].

⁴⁶ *Ibid* at 10.

⁴⁷ Health Quality Council of Alberta, *Review of Alberta’s Response to the 2009 H1N1 Influenza Pandemic* (np: Alberta Health and Wellness, 2010) at 40 [HQC].

⁴⁸ Lessons, *supra* note 37 at 2.

near the end of the second wave.⁴⁹ In Toronto, “most of the infections that led to severe illness and mortality in wave 2 occurred before significant levels of immunity occurred.”⁵⁰

Unlike seasonal influenza, younger cohorts of the population suffered significantly more illness as result of H1N1 infection.⁵¹ For example, “[d]eaths were lower than expected in the 65 years and over age group, but higher in younger age groups.”⁵² Indeed, school-aged children accounted for the largest number of confirmed cases and hospitalizations.⁵³ For a baseline example of a seasonal influenza distribution, approximately 90% of deaths occur among elderly individuals with underlying medical conditions.⁵⁴ This is consistent with most previous pandemics, where the greatest incidence of death occurred in those under the age of 60.⁵⁵ The median age of death from pandemic H1N1 was 50 years old.⁵⁶ The median age of those with laboratory-confirmed H1N1 infection was 12 years old, with the highest rate of infection prevalence in the cohort of 5-24 years old. Among those 65 and over, infection incidence was lowest.⁵⁷

2.4. Rationing Lifesaving Resources

The following potentially lifesaving resources are likely to require rationing during pandemics: vaccines, antivirals and ventilators.

⁴⁹ Alberta Experience, *supra* note 38 at 11.

⁵⁰ Toronto Medical Officer of Health, *2009-2010 pH1N1 Influenza Pandemic Summary Report* (Staff Report to the Toronto Board of Health) (Toronto: no publisher, 2010) at 18.

⁵¹ CIHI, *supra* note 40 at 2.

⁵² Alberta Experience, *supra* note 38 at 5.

⁵³ *Ibid* at 13; CIHI, *supra* note 40 at 14.

⁵⁴ Lessons, *supra* note 37 at 12.

⁵⁵ CPIP, *supra* note 35 at Background-3.

⁵⁶ Alberta Experience, *supra* note 38 at 5.

⁵⁷ This deviation from typical seasonal influenza age distribution is similar to that experienced during the 1918 influenza pandemic where healthy young adults were at the greatest risk for death and severe hospitalization. This was likely because it is thought that older adults had some level of immunity with previous exposure in their lifetimes. See e.g. California Department of Health Services, *Pandemic Influenza Preparedness and Response Plan: An Annex to the CDHS Public Health Emergency Response Plan and Procedures* (np: California Department of Health Services, 2006) at 110.

2.4.1. Vaccines

2.4.1.1. Supply and Demand

Targeted vaccines and widespread immunization are well-recognized as the best chance for public health authorities to mitigate the impact of pandemic influenza, followed by the use of antiviral pharmaceuticals.⁵⁸

The Canadian Pandemic Influenza Plan (CPIP), and most plans in the US, UK and Europe, call for the production and procurement of sufficient vaccine to eventually immunize the entire population.⁵⁹ However, past experience suggests that because the vaccine will likely not be mandatory (no response plans call for forced immunization), prudent planning would be to prepare for a 75% demand rate. Such a rate is variable depending on the, “public perception of the risk and the severity of the disease.”⁶⁰

In 2001, a ten-year contract was signed between the federal government and a manufacturer (which would eventually come under the umbrella of GlaxoSmithKline (GSK)) to guarantee sufficient domestic manufacturing capacity of a strain-specific pandemic influenza vaccine. To this end, 50% of Canada’s seasonal influenza vaccine requirements were awarded to the manufacturer to secure capacity.⁶¹ The manufacturer was also paid a ‘pandemic readiness fee’. Maintaining domestic manufacturing is vital to an effective response, as it is likely that any internationally-manufactured vaccines will be embargoed and unavailable for import into Canada.⁶² Likewise, the procurement contract provided that

⁵⁸ See e.g. CPIP, *supra* note 35 at Introduction-1.

⁵⁹ *Ibid* at Preparedness-8.

⁶⁰ *Ibid* at Preparedness-10; British Columbia, Ministry of Health & Centre for Disease Control, *British Columbia Pandemic Influenza Preparedness Plan: Guidelines for Planning, Response and Recovery* (Vancouver: British Columbia Centre for Disease Control, 2005) at 92.

⁶¹ Standing Senate Committee on Social Affairs, Science and Technology, *Canada’s Response to the 2009 H1N1 Influenza Pandemic* (Ottawa: Senate of Canada, 2010) at 31 [Senate].

⁶² See e.g. Ontario Ministry of Health and Long-Term Care, *Ontario Health Plan for an Influenza Pandemic* (np: Ontario Ministry of Health and Long-Term Care, 2008) at 3-5 [OHPIP].

any vaccine production from Canadian facilities is first to be provided domestically, against Canada's bulk order, prior to being exported internationally.

As the 2001 contract was set to expire on March 31, 2011, a new contract was awarded on March 25, 2011, again to GSK, for \$425.9 million for an additional ten year commitment.⁶³ Any vaccine required under the new contract will be manufactured at the company's plant in Ste-Foy, Quebec. The company will also continue to manufacture half of the seasonal influenza vaccine used in Canada. In addition, a new \$33.1 million contract was awarded to Sanofi Pasteur Ltd. to ensure vaccine availability for vulnerable populations, such as pregnant women and those with chronic conditions, who will likely be unable to receive an adjuvant-boosted immunization.

Despite general consensus on the importance of vaccination and a guaranteed domestic manufacturer, it is acknowledged that the development and production timeline of any pandemic vaccine will likely necessitate an immunization program that involves prioritization – or sequencing – into target groups.⁶⁴ This is the case because vaccine will not be immediately available, being produced in batches and not at the onset of the pandemic. This occurred during the H1N1 pandemic and is expected to occur in future pandemics. Shortage of critical supplies, including vaccines, may also occur due to supply line interruptions or insecurity, an issue addressed in most pandemic readiness plans.

Several main issues contribute to the development delay of an effective pandemic vaccine. First, the world medical and virology community must isolate seed strains of the particular viral strain, which will not be known until the pandemic begins. The identification

⁶³ "\$425.9M pandemic flu deal awarded by Ottawa" *CBC News* (March 25, 2011). The decision-making processes surrounding these contracts bring up many issues such as political concerns (geographic plant location), value-for-money, bidding processes, etc. that are beyond the scope of this thesis.

⁶⁴ CPIP, *supra* note 35 at Preparedness-8, Annex D-6.

and distribution of the seed strain by WHO is estimated to take between six and eight weeks.⁶⁵ From that point, the approximate manufacturing lead time to the production of the first vaccine lot is 48 days.⁶⁶ That first vaccine lot will be used as a master seed lot for further production. The estimated time for receipt of the first vaccine batches for mass immunization is 10 to 12 weeks after the seed strain is received. This includes time for expedited and small-scale clinical trials for safety and effectiveness before the product is widely distributed.⁶⁷ In total, the first publicly-available vaccine will be ready four to five months after the pandemic influenza strain is discovered and vaccine work begins. Once the vaccine manufacturing process begins, not all can be produced at once, with an anticipated production rate of 2 million monovalent (single) doses per week, further necessitating sequencing to population groups matching the production rate.⁶⁸ Even after individuals, in the priority groups or otherwise, receive the complete vaccination dosing, it takes approximately fourteen days for their immune response to be at a sufficient level to consider them immunized.

Fortunately, from a supply-maximization standpoint, the use of adjuvant can stretch the supply of any vaccine. For pandemic H1N1, the use of adjuvant reduced the amount of antigen required in each dose from 15ug to only 3.8ug.⁶⁹ Therefore, the adjuvant results in a relatively equal immune response but using roughly 75% less antigen.⁷⁰ However, adjuvant may not be safe to use in certain vulnerable populations. As the original 2001 pandemic vaccine manufacturing contract between the federal government and GSK was sole-sourced, and two versions of the vaccine could not be manufactured simultaneously, a delay occurred

⁶⁵ *Ibid* at Annex D-13, D-14.

⁶⁶ *Ibid* at Preparedness-9.

⁶⁷ *Ibid* at Annex D-13, D-14.

⁶⁸ *Ibid* at Annex D-14.

⁶⁹ *Ibid*.

⁷⁰ HQC, *supra* note 47 at 33.

when the decision was made to switch to a unadjuvanted version in the middle of the adjuvanted production process.⁷¹ This will hopefully be avoided in future pandemics due to the addition of a second supplier for non-adjuvanted production.

2.4.1.2. *Prioritization of Vaccine Recipients*

2.4.1.2.1. Key Facets of Prioritization Systems

As pandemic vaccine supply will likely not be sufficient to meet the initial demand, rationing of available batches to certain groups or persons is required. In most pandemic response plans, this entails the creation of priority groups that will serve to guide such rationing decisions. The creation of priority groups is extremely controversial and touches on many ethical, political and legal tensions beyond the scope of this paper. In fact, the inclusion of priority lists in earlier versions of the CPIP prompted their removal in the current version, as they apparently distracted from operational activities and responses.⁷²

The goals of any pandemic response set the tenor to which actionable rationing guidelines must accord. The Canadian plan, and all provincial plans with stated goals, has two objectives: one primary, the other secondary. First, minimize morbidity and mortality. Second, minimize societal disruption.⁷³ These goals are but one approach, albeit the most dominant. There is significant bioethical literature on different rationing schemes, including those that prioritize based on societal worth and continuity, equality (first-come-first-served, lottery), and others, the analysis of which is beyond the scope of this thesis.

Stated objectives must still be translated into actionable and distinct items – rationing guidelines. Priority groups are designed to reduce, “morbidity and mortality through

⁷¹ Lessons, *supra* note 37 at 73.

⁷² CPIP, *supra* note 35 at Annex D-3.

⁷³ *Ibid* at Introduction-3.

maintaining the health services response and through individual protection of high risk groups ... this will help minimize societal disruption by maintaining ... essential services.”⁷⁴

Priority groups are typically sensitive to the strain and epidemiology of the particular pandemic virus, and it will not be possible to identify with any high degree of certainty prior to the pandemic those persons peculiarly susceptible to infection and serious illness or death.⁷⁵ Modeling based on the H1N1 experience reveals that vaccinating high risk groups first has beneficial results on mortality rates and health care utilization costs.⁷⁶ However, the same research also showed that had vaccine been available significantly earlier than was the case – that is, prior to the peak – children, as highly virulent vectors, perhaps should have been vaccinated first.⁷⁷ This data illustrates the requirement that in order to reach the primary pandemic planning goal of minimizing mortality and morbidity, the nature and epidemiology of the particular influenza strain must be factored into rationing/prioritization decisions.

A further limitation in any plans to identify priority groups before the onset of the pandemic is the fact that in order to maximize use of the limited vaccine supplies the size of proposed priority cohorts and anticipated vaccine uptake rates within those cohorts must be factored into any deliberative process. As noted in the CPIP: “[f]inal allocation decisions ... may not be made until the pandemic is under way and the vaccine becomes available.”⁷⁸

Emphasis is also made that priority groups should be as uniform as possible. For example, the CPIP states that, “[e]fforts should be made to encourage all jurisdictions to adopt the national recommendations on priority groups at the time of a pandemic in order to

⁷⁴ British Columbia, *supra* note 60 at 71.

⁷⁵ CPIP, *supra* note 35 at Annex D-4.

⁷⁶ HQC, *supra* note 47 at 40.

⁷⁷ *Ibid.*

⁷⁸ CPIP, *supra* note 35 at Annex D-16.

facilitate equitable access and consistent messaging.”⁷⁹ The adoption of consistent priority groups within and across jurisdictions will likely help to increase acceptance and public confidence in the immunization program, thereby maximizing its effectiveness. Cross-jurisdictional consistency may also play a role in *Charter* challenges, in particular equality claims.

2.4.1.2.2. Jurisdictional Responsibilities

In Canada, it is the responsibility of the Public Health Agency of Canada to distribute and allocate national stockpiles of all pandemic-relevant resources.⁸⁰ The national pandemic distribution agreement calls for the distribution of available vaccines to the provinces on an equitable per capita basis, in the absence of specific epidemiological details.⁸¹ However, as a report from the Senate of Canada noted, these agreements on the distribution of vaccine and priority groups are not legally binding.⁸²

Under CPIP, priority groups are determined by the Pandemic Vaccine Working Group of the Pandemic Influenza Committee, consisting of federal, provincial and territorial representatives and health experts and advisors.⁸³ Reflecting the pan-national agreement, most provincial pandemic response plans state that nationally-recommended priority groups will be followed. However, significant leeway has been reserved by lower jurisdictional levels to vary from nationally-agreed upon recommendations contained in guidance

⁷⁹ *Ibid* at Preparedness-7.

⁸⁰ See e.g. Saskatchewan Ministry of Health, *Saskatchewan Pandemic Influenza Plan for the Health Care System* (np: Saskatchewan Ministry of Health, 2009) at 7. The federal government is also responsible for providing health care services, including public health services, to select groups under their direct constitutional jurisdiction, such as prisoners incarcerated in federal penitentiaries; armed forces service personnel; and First Nations residing on reserves.

⁸¹ CPIP, *supra* note 35 at Annex D-9.

⁸² Senate, *supra* note 61 at 24.

⁸³ CPIP, *supra* note 35 at Annex D-9.

documents.⁸⁴ The CPIP recognizes that nationally-agreed upon priority lists may be modified based on local conditions.⁸⁵ No direction is provided as to who will modify the lists or to what extent they may be manipulated. The Quebec Pandemic Influenza Plan states: “[p]riority groups are a provincial Ministerial decision but with input from the federal level.”⁸⁶ Likewise, the Ontario plan states:

[T]he province is responsible for ensuring that there is a supply of vaccines/medications available at the provincial level, identifying any priority groups for Ontario, making allocation plans based on information gathered at the local level, and for distributing vaccines/medications and any provincially-held supplies to a designated location within each health unit jurisdiction.⁸⁷

Use in accordance with the agreement is also not guaranteed in the future, and official Canadian policy (in the CPIP) is that there is no policy and uncertainty reigns: “[a]t this time there is no policy decision regarding distribution of the first doses of vaccine across Canada ... perhaps the first doses should be sent to the area where activity is escalating in an effort to mitigate the impact of the first wave in those locations.”⁸⁸ As the CPIP suggests, additional flexibility should be built into the system, as per-capita distribution may not best meet the pandemic response goals of minimizing morbidity and mortality. While equitable distribution has its virtues, if the stated pandemic response goals are to be met, lifesaving resource distribution must be responsive to regional disparities in infection, virulence and demand. For example, demand is likely to vary depending on jurisdiction and even at different vaccine administration clinics within the same region, as demand is influenced by how the public reacts to the risk.

⁸⁴ See e.g. OHPIP, *supra* note 62 at 9-4.

⁸⁵ CPIP, *supra* note 35 at Response-20.

⁸⁶ Ministry of Health and Social Services, *Quebec Pandemic Influenza Plan – Health Mission* (np: La Direction des communications du ministère de la Santé et des Services sociaux, 2006) at 41 [Quebec].

⁸⁷ OHPIP, *supra* note 62 at 9A-3.

⁸⁸ CPIP, *supra* note 35 at Annex D-15.

The refinement and operationalization of priority guidelines appears to rest with the provinces, based upon the particular epidemiology of the pandemic.⁸⁹ According to provincial pandemic response plans, most provincial health ministries plan on allocating the vaccines available to them to each regional authority or health board on a per capita basis of those in priority groups. For example, if there is only enough vaccine to immunize 10% of the first priority group, each region will receive that set quotient, depending on how many people in their region falls into that priority group. The regional public health authorities are then responsible for administration of the vaccine according to priority groups. For example, the Newfoundland and Labrador provincial pandemic plan explicitly notes that the identification of priority group members and vaccination operational procedures are the responsibility of regional health authorities.⁹⁰ Generally, the Chief Medical Officer of Health will be responsible for allocating publicly-funded vaccine and antivirals within the province.⁹¹

Administration of publicly-procured vaccines and verification and tracking of priority groups is a power that generally lies with local public health units.⁹² However, significant variation and confusion reigned during the H1N1 pandemic, particularly regarding the priority groups. As the joint Health Canada and Public Health Agency of Canada H1N1 lessons-learned review concluded: “the implementation of sequencing recommendations varied across the country ... [t]his resulted in confusion ... about the different priority

⁸⁹ See e.g. British Columbia, *supra* note 60 at 20, 133.

⁹⁰ Newfoundland and Labrador, Department of Health and Community Services, *Pandemic Influenza: Planning Guidelines, Roles and Responsibilities for the Health Sector* (Newfoundland and Labrador: Department of Health and Community Services, 2007) at 7-3.

⁹¹ New Brunswick Department of Health and Wellness, *New Brunswick Pandemic Influenza Plan for the Health Sector* (np: Department of Health and Wellness, 2005) at 22 - 23.

⁹² *Ibid* at 9A-4.

groups.”⁹³ In his report, the Chief Medical Officer of Health for Ontario enunciated this challenge: “I did not know ... who or how many were getting immunized ... I do not know if all the ... populations in our priority groups received their vaccines.”⁹⁴

Even clear priority groups do not automatically translate into effective rationing. There must be some form of verification, particularly in public health clinics where medical directives stipulate to whom vaccines can be administered. For example, in order for public health nurses to administer vaccines, a medical directive signed by a physician is required (in the case of mass immunizations, the Chief Medical Officer of Health signs). The medical directive will provide what client conditions and situations are to be met prior to inoculation.⁹⁵ At the clinics, verification should be performed to ensure that the directive is properly followed. To this end, some jurisdictions have suggested using occupational documentation for those in priority groups by virtue of their occupation. For example, Ontario’s plan suggests that ID and documentation from the employer could be used to verify priority group status.⁹⁶ Toronto Public Health calls for the use of employee badges and health cards to authenticate priority group status.⁹⁷ However, administration cannot rely solely on job title or affiliation, as it should be based on who is actually performing the job, as volunteers or others may step into the role without formal affiliation.⁹⁸ Even in clinics dedicated to healthcare workers, few measures exist to verify occupational status. For example, a review of Alberta’s pandemic response noted that the immunization rates for

⁹³ Lessons, *supra* note 37 at 73.

⁹⁴ CMOH, *supra* note 45 at 12.

⁹⁵ OHPIP, *supra* note 62 at 9A-35.

⁹⁶ *Ibid* at 9A-6.

⁹⁷ Toronto Pandemic Influenza Planning Steering Committee, *Toronto Pandemic Influenza Plan* (Toronto: Toronto Public Health, 2005) at 128.

⁹⁸ CPIP, *supra* note 35 at Annex D-4.4.2.

health care workers are likely inaccurate because it was confirmed that staff clinics administered vaccine to non-staff members.⁹⁹

To summarize, the federal government is responsible for procuring the vaccine, equitably distributing it to the provinces and providing guidelines for dosage and priority groups. The provinces are responsible for operationalizing the guidelines, modifying them if necessary, and distributing and administering the vaccines. In those provinces with regional health authorities, some or all of the functions may be delegated from the provincial level to local authorities or boards of health.

2.4.1.3. Rationing Vaccines: The H1N1 Experience

Guidance on vaccine sequencing/prioritization was released by the federal government on September 16, 2009, and the adjuvanted vaccine was formally approved by Health Canada for widespread use on October 21st.¹⁰⁰ There was a slight delay in vaccine rollout due to repackaging, as the vaccines from the manufacturer arrived packaged in 500 dose boxes, too large for family physicians and other smaller service providers.¹⁰¹ Permission was required from Health Canada in order to re-package the vaccine, further contributing to the delay.

The priority sequencing guidelines were developed in consultation with the provinces and territories and medical and public health experts. As indicated by the titles, these documents were guidelines only and not binding on lower tier jurisdictions, which had the

⁹⁹ HQC, *supra* note 47 at 50.

¹⁰⁰ Lessons, *supra* note 37 at 15.

¹⁰¹ CMOH, *supra* note 45 at 13.

flexibility to implement them as they thought best.¹⁰² In fact, one document explicitly stated that is was for ‘information purposes’.¹⁰³

Based on best available evidence, priority groups were identified according to their members’ susceptibility to mortality or serious morbidity resulting from infection.¹⁰⁴ In other words, those in the first priority groups were those who would benefit most from immunization, and their caregivers. The minimization of mortality and morbidity is consistent with the goals of all Canadian pandemic response plans. The recommendation for immunizing vulnerable populations and caregivers was premised on mathematical modeling that suggested immunizing that population would decrease overall mortality and morbidity more than immunizing vectors or groups with high infection rates, such as children.

Specifically, the first priority group encompassed those with cancer, cardiac or pulmonary disorders, metabolic disease or other chronic conditions under 65 years of age; pregnant women; children under 5 years of age but older than six months; residents of remote or isolated communities; healthcare workers involved in pandemic response or the delivery of essential health services; household contacts of infants under six months and immunocompromised patients; and populations otherwise identified as high risk. The latter group is extremely open-ended, and one can only suppose designed to allow local flexibility and rapid response to shifting epidemiological conditions. Pregnant women, those with conditions susceptible to complications from infection, children under five, and those living in remote or isolated communities (including First Nations) all were shown to have experienced high rates of hospitalization. In order to reduce overall mortality and morbidity, H1N1 vaccine was

¹⁰² Senate, *supra* note 61 at 34.

¹⁰³ Public Health Agency of Canada, *Guidance Document on the Use of Pandemic Influenza A (H1N1) 2009 Inactivated Monovalent Vaccine* (np: Government of Canada, 2009) at 4 [PHAC Guidance].

¹⁰⁴ *Ibid*; APPI, *supra* note 16 at 54 - 56.

‘strongly recommended’ for persons in those groups or individuals who care for such persons.¹⁰⁵

It was emphasized that caregivers for high-risk populations should be prioritized for the vaccine, regardless of the immunization status of the person under their care. This was done to, “provide indirect protection for high-risk persons who cannot be immunized or may not respond to vaccine.”¹⁰⁶ This group includes health-care workers engaged in pandemic response or the delivery of essential health services (including support personnel) as well as household contacts for children less than six months of age or immuno-compromised patients.¹⁰⁷ The rationale for including healthcare workers in a priority group are mainly three-fold: preventing the infection of vulnerable populations; protection of workers who are placed at greater risk of infection due to their occupation in the aid of others (reciprocity); and the protection of critical health response infrastructure.¹⁰⁸ Those involved in vaccine manufacturing and delivery were also included, a clear necessity for the successful deployment of any mass vaccination campaign.

While children between 6 months and 2 years of age are at greater risk of hospitalization from infection, operationally it was easiest to expand the group to include those up to 5 years old, as that covers the entire pre-school cohort. The vaccine was not approved for use in children less than 6 months in age. Residents of remote and isolated communities were targeted because of the logistical ease with which to immunize an entire community, the high concentration of those with chronic conditions that make them more

¹⁰⁵ PHAC Guidance, *supra* note 103 at 6, 10.

¹⁰⁶ *Ibid* at 13.

¹⁰⁷ *Ibid*.

¹⁰⁸ APPI, *supra* note 16 at 56.

susceptible to mortality or morbidity, as well as the limited access of those residents to medical care should they become ill.

In Alberta, immunization was initially offered to anyone who sought it, with special encouragement given to those in high risk categories.¹⁰⁹ In hindsight, this was recognized as a mistake and the plan was abandoned when a shortage became apparent, causing the closure of all immunization clinics and their eventual re-opening five days later to only those in identified priority groups.¹¹⁰ Priority groups were expanded every few days throughout the province for three weeks until vaccines were made available to the general public. This contrasts with responses in Ontario, Saskatchewan and British Columbia where immunization sites were initially restricted to those in priority categories.¹¹¹

Unlike the static, one-size fits all pandemics Canadian plan, the United States' pandemic response plan is scalable, with different modeling and priority groups depending on a pandemic's severity.¹¹² The U.S. Department of Health and Human Services national vaccine priority guidance contains four broad categories covering the entire population: people who (i) maintain homeland and national security; (ii) provide health care and related services; (iii) maintain critical infrastructure; and (iv) the general population.¹¹³ Each tier of the prioritization plan includes subgroups from each of the four broad categories, such that the more severe the pandemic, the less tiers are included in the priority vaccination groups. For example, Tier 1 (which is the same regardless of pandemic severity) contains those engaged in maintaining critical societal needs, thus drawing on individuals from groups (i)

¹⁰⁹ HQC, *supra* note 47 at 38.

¹¹⁰ *Ibid* at 37.

¹¹¹ *Ibid* at 70.

¹¹² United States, Department of Health and Human Services & Department of Homeland Security, *Guidance on Allocating and Targeting Pandemic Influenza Vaccine* (Washington: U.S. Department of Health & Human Services, 2008) at 4 - 5.

¹¹³ *Ibid* at 4.

through (iii), as well as high-risk pregnant women and infants from group (iv).¹¹⁴ In contrast, California has developed a scoring tool for use in evaluating groups based on vaccination criteria, resulting in a numerical score that can then yield a rank-ordered list.¹¹⁵

2.4.2. Ventilators

The rationing and allocation of ventilators falls into the general category of hospital ‘surge’ capacity plans.¹¹⁶ Surge capacity can be defined as, “the ability to expand provision beyond normal capacity to meet transient increases in demand.”¹¹⁷ Surge capacity has three elements, the latter two of which have interest to this thesis: creating extra spaces through physical measures; releasing capacity; and prioritizing clinical interventions to limit demand.¹¹⁸ Surge capacity triage involves categorizing patients into those who could benefit from treatment and those who would not, and further grouping the former into those who could benefit the most with the least resources and most rapidly. This appears consistent with the stated pandemic response plan goals of minimizing mortality and morbidity.

American pandemic projections, using the CDC FluSurge modeling program, suggest that close to 30% of admitted critical care patients would require mechanical ventilation.¹¹⁹ In addition to ventilators, ICU beds (and the care and supplies that go with them) will also be scarce during a pandemic-induced surge. This is likely to be the case in Canada as well, as the utilization rate of ICU beds in Ontario hospitals is already over 90% of capacity.¹²⁰

¹¹⁴ *Ibid* at 8.

¹¹⁵ California, *supra* note 57 at 120.

¹¹⁶ No surge capacity plans were reported as being used during the H1N1 pandemic.

¹¹⁷ United Kingdom, Department of Health, *Pandemic Influenza: Surge Capacity and Prioritisation in Health Services, Provisional UK Guidance* (London: Department of Health, 2007) at 16 [UK Surge].

¹¹⁸ *Ibid* at 18.

¹¹⁹ See e.g. California, *supra* note 57 at 54.

¹²⁰ OHPIP, *supra* note 62 at 17-3.

In most provinces, regional or local health authorities and individual hospital institutions are responsible for developing their own surge capacity protocols with few province-wide plans. Ontario is a notable exception, with both local health authorities and the province-wide pandemic response plan containing surge capacity plans. This can in part be explained by the fact that the local plans are not pandemic-specific, and geared primarily towards non-public health disaster events. Such response plans anticipate a one-time increase in demand as a result of a catastrophic event, whereas pandemics create a sustained over-demand on health services outside of a singular event. This sustained demand from a pandemic may last months and even years.

An example of a local disaster plan, the Toronto Local Health Integration Network (LHIN) Critical Care Surge Capacity Management Plan, provides that while critical care for all that need it is a priority, in certain circumstances exclusion criteria, such as organ failure or short life expectancy as a result of chronic health conditions, may exclude individuals from receiving scarce lifesaving resources.¹²¹ Exclusion criteria are used to ensure those that receive the resource are those most likely to benefit from it, thus minimizing the potential for resource wastage and maximizing lives saved. Furthermore, the Toronto LHIN plan states that such resources will be distributed equally and without regard to preferential treatment of population subgroups. Likewise, the Ontario plan states that, “[t]riage must be based upon established medical criteria, not factors such as socioeconomic status or political affiliation.”¹²² This is an important acknowledgment of equality, but the plan lacks in operational detail as to how that would be accomplished, particularly if certain population sub-groups are more likely than others to have exclusion criteria.

¹²¹ Toronto Central Local Health Integration Network, *Critical Care Surge Capacity Management Plan* (np: no publisher, 2009) at 6.

¹²² OHPIP, *supra* note 62 at 17-9.

In Ontario, once surge capacity planning has been exhausted (reached at over 170% capacity), ‘mass emergency care’ will be declared, resulting in the rationing of critical care services to, “maximize the benefit to the population at large,” and is consistent with the goals of pandemic response.¹²³ It is not clear under what circumstances such an event can be declared, who declares ‘mass emergency care’ (likely the Chief Medical Officer of Health, but it is not clear from the legislation), nor when to conclude that surge capacity has been exhausted.¹²⁴ Any such rationing would in essence be triage – designed to maximize survival of the greatest number – and would only be used in extraordinary circumstances.¹²⁵

A triage system would apply to any patients considered for admission to critical care wards, not just those with pandemic influenza. Ontario has proposed the Sequential-Organ-Failure-Assessment (SOFA) tool as the province’s default triage rationing system.¹²⁶ The province’s draft SOFA protocol includes three components: inclusion criteria; exclusion criteria and minimum qualifications for survival.¹²⁷ Patients meeting inclusion criteria are those that would benefit from critical care admission, and in need of ventilator support. Prospective patients would meet exclusion criteria if their likelihood of survival is extremely low even if provided with aggressive ICU treatment. For example, for patients with a SOFA score greater than 11, mortality results in 90% of cases even with the highest level of treatment. Thus, it functions as a ceiling over which no additional resources are to be spent. Exclusion criteria also covers those who would require an inefficiently large quantity of resources and those with advanced underlying medical conditions resulting in a poor prognosis and low short-term survival even without critical care interventions (e.g. advanced

¹²³ *Ibid* at 17-4.

¹²⁴ *Ibid* at 17-4 - 17-7.

¹²⁵ *Ibid* at 17-10.

¹²⁶ *Ibid* at 17-9.

¹²⁷ *Ibid* at 17-10 - 17-12.

cancer or end-stage organ failure). Any patients excluded from critical care would still receive alternative or palliative care and would not be simply abandoned.

The use of strict criteria under such a triage system is a marked departure from typical legal standards of care. While the presence of a different legal standard – an ‘emergency standard of care’ – is hotly debated in the literature, it is acknowledged that, “in extreme scarcity, exclusion criteria will be much more restrictive than standards of medical futility and will also exclude patients for whom treatment is still considered necessary and useful.”¹²⁸ This concept will be further explored in Chapter 4.

The third component of SOFA – minimum qualification for survival – mandates that patients be re-assessed frequently, and those not improving be removed from care so the resource in question can be re-allocated, thereby placing a ceiling on the level of care patients can receive without showing substantial improvement. Early identification of those not improving is vital in order to maximize scarce resources, and represents a further departure from non-triage standards of care where, “it could be days or even weeks before the inevitability of a poor outcome was accepted, by which time several patients who might have benefits from treatment would have been denied treatment.”¹²⁹

Any triage protocol will be supervised by senior specially-trained physicians and the criteria reviewed and revised by a central committee as necessary, and not revised in the field.¹³⁰ However, it must be recognized that applying SOFA criteria will inevitably require the exercise of physician judgment and discretion. Any appeals from in-field triage decisions would be made to the central oversight committee, who may order a temporary trial of care if

¹²⁸ Marcel Verweij, “Equitable Access to Therapeutic and Prophylactic Measures” in World Health Organization, *Addressing Ethical Issues in Pandemic Influenza Planning: Discussion Papers* (Geneva: World Health Organization, 2008) at 16.

¹²⁹ UK Surge, *supra* note 117 at 27.

¹³⁰ OHPIP, *supra* note 62 at 17-10 - 17-12.

deemed prudent. However, it remains uncertain when any triage protocol is activated, or who makes the decision to do so. This could pose liability problems if the adoption of a triage protocol results in the provision of substandard care.

2.4.3. Antivirals

The use of anti-influenza antivirals may be an important first response to a pandemic while vaccines are still under development and unavailable for mass use. Governments have recognized antivirals as, “the only specific medical intervention that targets influenza and that potentially will be available during the initial pandemic response.”¹³¹ Antivirals have been shown to reduce comorbidities associated with influenza infection; however, their ability to reduce influenza-related mortality has not been shown.¹³² Antiviral drugs of choice for pandemic treatment response include neuraminidase inhibitors oseltamivir (trading under the brand name Tamiflu) and zanamivir (Relenza).¹³³ Antivirals are most effective in reducing the length and severity of any infection if administered within 48 hours of symptom onset.¹³⁴

Antivirals may be used for prophylaxis or treatment. The CPIP calls for antivirals to be used primarily for treatment during any pandemic period, based on a nationally agreed upon strategy.¹³⁵ The main concern with potential widespread use of antivirals for prophylaxis is the possible development of drug-resistant strains.¹³⁶ By restricting their use to treatment, a much smaller proportion of the population will qualify for receipt of the antiviral, thereby limiting the ability of drug-resistant influenza developing. Containment is

¹³¹ CPIP, *supra* note 35 at Annex E-3.

¹³² *Ibid* at Annex E-13.

¹³³ APPI, *supra* note 16 at 45.

¹³⁴ See e.g. OHPIP, *supra* note 62 at 9-2.

¹³⁵ CPIP, *supra* note 35 at Background-8, Annex E-8 - 9.

¹³⁶ See e.g. HQC, *supra* note 47 at 47.

also a third potential use of antivirals to delay or limit the spread of pandemic influenza in certain populations; however, it is acknowledged that such a strategy would be ineffective once a virus is widespread in the community.¹³⁷

There is some tension between the two primary goals of the Canadian pandemic planning program, as societal continuity and mortality and morbidity are very different things, and satisfying one objective could harm the other. These two objectives are not equal; minimizing morbidity and mortality is clearly emphasized as the primary goal. In terms of prophylactic use of antivirals, receipt of such drugs by health care and public health workers could indeed directly contribute to that primary goal. The government recognizes that, “prophylaxis of health care workers, key decision makers and public health and societal responders ... could contribute to the Canadian pandemic goals of minimizing serious illness and death, and societal disruption.”¹³⁸ This is understandable for frontline health care workers who are needed to treat ill patients, but providing limited quantities of drugs to ‘key decision makers’ is less certain. While it is perhaps consistent with the second goal of maintaining societal continuity, doing so could jeopardize achieving a minimization of morbidity and mortality. That is, working to save those who would contribute the most to societal continuity could conceivably result in greater mortality. This is particularly true given that prophylaxis use requires a greater quantity of drug, so much so that one six-week course of prophylaxis for a single person could be used to treat 4-5 infected patients.¹³⁹ Furthermore, prophylactic antiviral use, while potentially useful in protecting critical

¹³⁷ APPI, *supra* note 16 at 46.

¹³⁸ CPIP, *supra* note 35 at Annex E-8.

¹³⁹ *Ibid.*

functions and key persons, would have only a negligible impact in reducing the spread of any pandemic.¹⁴⁰

Clinical recommendations issued by the Public Health Agency of Canada provided that patients admitted with influenza-like symptoms, in addition to a risk factor for mortality or morbidity from pandemic influenza, were to be administered antivirals.¹⁴¹ Any patients not meeting the foregoing criteria were to be discharged with instructions for self-isolation and self-care. As laboratory-confirmed testing of pandemic H1N1 is a lengthy process and infeasible in the face of case surge during pandemics, plans and treatment guidelines call for the assumption of pandemic H1N1 when an individual presents with influenza-like-illness symptoms during a pandemic outbreak.¹⁴²

This is clearly a form of rationing – restricting the use of a potentially lifesaving resource to those most vulnerable of mortality or morbidity for treatment purposes only. In contrast, not rationing would involve dispensing antivirals to anyone for any use. Unlike ventilators and vaccines that are supply-constrained, there are sufficient stockpiles of antivirals to provide to more people. The rationing of antivirals for treatment only courses of persons presenting with specific conditions appears to occur because of concerns of efficacy and drug resistance, not supply.

Unlike vaccines delivered through public health clinics and other channels, antiviral drugs are distributed based on physician prescription.¹⁴³ The administration of antivirals represents a unique challenge as compared to public-health delivered vaccines, as during annual influenza seasons, antivirals are prescribed, and therefore rationed, by physicians on a

¹⁴⁰ OHPIP, *supra* note 62 at 9-3.

¹⁴¹ Public Health Agency of Canada, *Clinical Recommendations for Patients Presenting with Respiratory Symptoms During the 2009-2010 Influenza Season*, online at: <<http://www.flightflu.ca>>.

¹⁴² CPIP, *supra* note 35 at Annex D-5.

¹⁴³ Quebec, *supra* note 86 at 69.

first-come-first-served basis.¹⁴⁴ This is expected to continue during a pandemic.¹⁴⁵ Thus, even in light of government recommendations, front-line personnel still retain sufficient flexibility and discretion to deviate from any restricted uses or priority groups for the rationing of antivirals. For example, the use of antivirals during the H1N1 pandemic was, based on government (Public Health Agency of Canada) guidelines, to be restricted to treatment of persons with severe symptoms or in high risk groups. However, those guidelines built in allowance for clinical judgment. Therefore, it was still up to the physician to determine priority group status, if any, for antivirals, prior to writing a prescription. The Quebec pandemic response plan states that prescribing physicians must follow guidelines identified by the Ministry of Health, but it is unclear if this is legally binding, and likely not, so long as prescribing professionals were not deviating from the accepted standard of care. While government guidance and recommendations are important and valuable, they are not hard and fast reflections of the standard of care (as Chapter 4 will show).

In summary, antivirals are effective and potentially lifesaving, to be rationed for the treatment of vulnerable persons suspected of being infected with pandemic influenza. The implementation of such government recommendations is clouded by the requirements of the legal standard of care, which mandates how physicians should act. If antivirals are only to be distributed in accordance with a physician's prescription, the government cannot impose priority group restrictions on physicians unless it forms part of the standard of care, which is a legal determination independent of government-issued documents (as the discussion in Chapter 4 will demonstrate).

¹⁴⁴ CPIP, *supra* note 35 at Preparedness-11.

¹⁴⁵ See e.g. New Brunswick, *supra* note 91 at 19.

2.5. Conclusion

This chapter has shown the tragic reality that rationing of lifesaving resources (vaccines, ventilators and antivirals) has been, and will most likely continue to be an integral element of government pandemic response. The experience with H1N1 showed that vaccines in particular are likely to be rationed. Existing government pandemic response plans prioritize the minimization of mortality and morbidity as their primary objectives. The translation of these broad goals into operational rationing methods (or priority/sequencing groups) is a daunting task with much uncertainty. The resulting discretion and lack of hard legal rules creates an opportunity for legal challenge by the citizenry on questions of authority, jurisdiction and private law duties.

Chapter 3

Administrative Law Challenges

3.1. Introduction

This chapter will examine a key mechanism for challenging rationing decisions made in the course of a pandemic: judicial review of executive action. The practice of medicine and administration of public health agencies and hospitals is highly regulated, and so the first step of a potential legal challenge is to argue that the government decision-maker simply lacks authority to make rationing decisions (they have acted *ultra vires*). As rationing is not a Crown prerogative, there must be clear statutory authority authorizing government ministers and other decision-makers to impose rationing or priority guidelines. This chapter will examine all relevant legislation to determine what authority there is for governments to promulgate priority sequencing guidelines and protocols. Second, we will examine how those rationing decisions can be enforced and what, if any, avenues or penalties exist for those who violate them? Finally, what allowance does the legislation make for the appeal of any rationing decisions, guidelines, or regulations?

To answer these questions, this chapter will examine all relevant medical, hospital, public health, and emergencies legislation in order to demonstrate that past and proposed government-mandated rationing is strongly supported by statutorily-conferred powers. While this suggests ample opportunity for judicial review of such decisions, it is likely that the exercise of powers will be found to be reasonable and *infra vires*.

3.2. Principles of Administrative Law

To appreciate how delegated authority may be challenged and reviewed by courts, a brief overview of administrative law principles is in order.

Administrative law is that, “body of law that establishes or describes the legal parameters of powers that exist by virtue of statute.”¹⁴⁶ It is a basic component of a parliamentary system of government that powers are delegated from the legislative to the executive branch through statutory enactments. Likewise, actors exercising delegated power must be able to specifically refer to statutes authorizing their actions. Any actions taken without statutory authorization are *ultra vires* – beyond their granted powers – and thus unlawful. Of relevance to rationing, delegated authorities may include hospitals, cabinet, ministers, other government servants and public health officers.

If persons wish to challenge the exercise of statutory authority, they turn to the legal mechanism of judicial review. Courts, however, have a limited role in reviewing actions in that they can only examine the legality of a decision. Administrative law principles dictate they examine only that the actor was acting within the scope of their delegated authority, and that they acted properly (reasonably and based on a fair process).¹⁴⁷ As Cherniawsky notes, judicial review, “cannot be used to import a substantive obligation or a right which the government has not otherwise enacted.”¹⁴⁸ That is, judicial review is constrained – like the actions of the delegated actor – by the constituent legislation.

3.2.1. Jurisdiction & Grounds for Review

The first principle of administrative review relevant to our discussion is one of jurisdiction: what authority do courts have to review the decisions of government actors?

As will be seen in the subsequent sections, several pieces of legislation explicitly create appeal mechanisms, and none relevant to rationing foreclose the ability to appeal. This

¹⁴⁶ David J Mullan, *Administrative Law* (Toronto: Irwin Law, 2001) at 3.

¹⁴⁷ See e.g. Cherniawsky, *supra* note 18.

¹⁴⁸ *Ibid* at para 5.

is important because there is no common law right to appeal – generally, it must be authorized by statute. With that said, superior courts may exercise their supervisory powers authorized under the Constitution. These superior courts – or section 96 courts (so named after the section of the *Constitution Act, 1867* authorizing the federal appointment of judges) – have the inherent authority to review delegated actions. In addition, the Attorney General has a common law right to seek judicial review of any decision made by a public body or pursuant to a statutory power.¹⁴⁹

For an example of the foregoing, in examining the judicial review options for health care decisions made in Alberta, Cherniawsky notes that, at least in Alberta, the health care statutes create few statutory rights of appeal to the courts. Thus, recourse must be had to Superior Courts’ inherent jurisdictional powers for judicial review. If statutory appeal rights do exist (such as to the Health Services Appeal and Review Board in Ontario), then judicial review may not be the appropriate first avenue for review of delegated powers.

Cherniawsky also notes that the presence of fractionalized health authorities complicates the judicial review process: “when a conflict arises, judicial review will be made with reference to the bylaws and policies unique to the specific regional authority where the problem occurred.”¹⁵⁰ Furthermore, the presence of delegated and sub-delegated authority common in health systems suggest that administrative challenges will focus on the identity of the decision-maker and whether they held proper delegated authority.¹⁵¹

The Supreme Court of Canada has outlined a series of jurisdictional errors (exceeding one’s authority) that constitute sufficient grounds for judicial review of a delegate’s

¹⁴⁹ See e.g. *Ontario (Attorney General) v Ontario (Health Services Appeal and Review Board)*, [2006] OJ No 52 (Div Ct) at para 3 [*Ontario*].

¹⁵⁰ Cherniawsky, *supra* note 18 at para 31.

¹⁵¹ *Ibid* at para 33.

decision.¹⁵² First, the actor failed to obtain jurisdiction: exercising a power not delegated by the legislature; where conditions precedent to authority have not been met; or the source of authority is not valid (an expired or repealed provision or regulation). The former two are most relevant to a discussion of pandemic rationing, particularly conditions precedent.

In cases of cabinet orders or other orders authorized under statute, if a statutory condition precedent has not been met prior to the issuance of the order, a court may declare it invalid.¹⁵³ As will be seen, certain emergencies and public health powers can only be exercised when a declared public health or non-health emergency exists. Thus, if no such emergency has been declared and the delegated powers are being exercised, the government actor has exceeded their jurisdiction.

Second, the delegate may exceed their granted jurisdiction, if they:

- fail to consider relevant matters in exercising its delegated authority;
- takes account of irrelevant matters in exercising its delegated authority;
- makes a decision without any reasons or based upon inadequate reasons;
- exercises its authority for an improper purpose;
- exercises its authority in bad faith (dishonesty, malice and fraud);
- exercises its authority in a discriminatory manner, absent clear statutory authority;
- improperly limits, fetters or sub-delegates its authority (for example, by adopting an inflexible internal or external policy to deal with all cases);
- exercises its authority retroactively in the absence of clear statutory authority;
- [or]
- acts in an unreasonable manner.¹⁵⁴

An example of this type of jurisdictional problem is if a statute exists for the purpose of regulating certain institutions (such as public hospitals), the only factors that can be considered are those relevant to the regulation of hospitals. Thus, if other extraneous factors are considered, such as financial limitations, that are found to be irrelevant to the granted delegated authority, then the delegate has exceeded his/her jurisdiction. As Craik and

¹⁵² *S.E.I.U., Local 333 v Nipawin District Staff Nurses Association* (1973), 41 DLR (3d) 6 at 11 - 12 (SCC).

¹⁵³ *Re Doctors Hospital*, *supra* note 19.

¹⁵⁴ Cherniawsky, *supra* note 18 at para 10.

colleagues note, substantive *ultra vires* review, “tends to turn on questions of the interpretation of the authorizing legislation,” and are thus highly fact-specific.¹⁵⁵

The objects of the statute in question are necessary to inform the decision-making process.¹⁵⁶ The goals of the statute must be followed with good faith. As the Supreme Court noted in the seminal case of *Roncarelli v. Duplessis*: “[d]iscretion necessarily implies good faith in discharging public duty; there is always a perspective within which a statute is intended to operate; and any clear departure from its lines or objects is just as objectionable as fraud or corruption.”¹⁵⁷ Applying this to the case of pandemic rationing, if the goal of the constituent legislation is protecting the public health, then only factors relevant to that goal may be considered by the delegated actor.

Finally, judicial review may be based on an alleged breach of a principle of natural justice such as a duty to be fair. Such duties typically encompass procedural aspects: providing notice, receiving representations, holding hearings and providing reasons.¹⁵⁸ Of most relevance to pandemic rationing, decisions must be free from a reasonable apprehension of bias (i.e. an impartial decision-maker).¹⁵⁹ A reasonable apprehension of bias may exist if a government-mandated rationing scheme in some form or another favoured government ministers or agents over members of the general population. In such a case, it is possible that a well-informed member of the community might perceive it more likely than not that the administration of such a rationing regime is biased.

¹⁵⁵ Neil Craik et al, *Public Law: Cases, Materials, and Commentary* (Toronto: Emond Montgomery, 2006) at 285.

¹⁵⁶ See e.g. *Re Doctors Hospital*, *supra* note 19 at para 49.

¹⁵⁷ *Roncarelli v Duplessis*, [1959] SCR 121 at 140, 16 DLR (2d) 689 at 705.

¹⁵⁸ Cherniawsky, *supra* note 18 at para 13.

¹⁵⁹ *Baker v Canada (Minister of Citizenship & Immigration)*, [1992] 2 SCR 817 at para 45.

In an apropos example of judicial review – *Ontario v. Ontario* – a medical officer of health issued a blanket order prohibiting smoking in ‘test’ hotels, bars and restaurants, purportedly under their statutory authority to order persons to do or refrain from doing anything in relation to a ‘health hazard’ (in this case, second-hand smoke). On judicial review, the Divisional Court held that the medical officer of health exceeded their statutory authority, which did not extend to making inflexible blanket orders.¹⁶⁰ Instead, their powers only related to case-specific orders. In sum, the court found that the order had the same effect of legislation, a power that clearly a medical officer of health does not possess. Thus, it was quashed as being excessive and an abuse of power.

3.2.2. Standard of Review

Generally, if a decision is made outside the delegate’s jurisdictional authority, courts will always interfere with such decisions. If a decision is made within jurisdictional authority, courts then apply one of two standards depending on the circumstances of the delegated authority and the identity of the decision-maker. *Dunsmuir*, a relatively recent Supreme Court of Canada decision, clarified the standards of such review into only two categories: reasonableness and correctness.¹⁶¹ If wide discretion is authorized under the constituent statute, then the court will be inclined to apply a test of reasonableness: did the delegate choose from a range of reasonable options (even if the court may believe such a decision was incorrect). On the other hand, if limited discretion is authorized, then the stricter correctness standard may be applied.

¹⁶⁰ *Ontario*, *supra* note 149.

¹⁶¹ *Dunsmuir v New Brunswick*, 2008 SCC 9, [2008] 1 SCR 190.

In determining which standard of review to apply, the Supreme Court's ruling in *Dunsmuir* is instructive.¹⁶² First, a privative clause is a clear indication that deference is warranted and that a reasonableness standard may be most appropriate, though not determinative of the issue. Second, if the decision-maker has expertise in the area of their decision, that will generally suggest a reasonableness standard. Third, if the decision is primarily one of fact, or mixed law and fact, then a reasonableness standard is also called for. Finally, if a decision is highly discretionary, or a policy decision, it will attract a reasonableness standard.

Assuming the standard is one of reasonableness, the court must determine both the appropriate degree of deference and whether, the decision falls within a, "range of acceptable actions that are defensible in respect of the facts and the law."¹⁶³ This is obviously a fact-driven exercise, and to speculate on how it would be applied, or on possible outcomes in prospective challenges to rationing decision in pandemics, would be imprudent.

3.2.3. Relief

One of the greatest problems with judicial review of administrative decisions is that of remedy. As Wruck notes, "more often than not an applicant is unable to obtain a meaningful remedy."¹⁶⁴ This is because the purpose of administrative law is not compensatory, but to ensure the proper exercise of public powers. As such, remedies courts can order are generally restricted to granting an applicant the chance to receive a lawful and proper administrative decision – issuing an injunction or declaring the exercise of power illegal. Wruck notes that the function of courts on judicial review is not to substitute their

¹⁶² *Ibid* at paras 52 - 55.

¹⁶³ *Ibid* at paras 74, 149.

¹⁶⁴ Harry Wruck, "The Continuing Evolution of the Tort of Misfeasance in Public Office" (2008) 41 UBC L Rev 69-100 at para 1.

own judgment for that of the decision-maker, but instead determine whether the actor or tribunal acted in accordance with the law.¹⁶⁵ Therefore, remedies are restricted to those of injunctory or declaratory relief, and not compensation. Such remedies have been held as being available to any person with standing – direct or discretionary (public interest).¹⁶⁶

Furthermore, administrative cases are often moot by the time a re-hearing or reconsideration of the decision is ordered because the government may act in the interim by passing additional legislation or regulations. For example, in the case above of *Ontario v. Ontario*, the orders of the medical officer of health were to be effectively replaced with passed legislation of the *Smoke-Free Ontario Act*.¹⁶⁷ Therefore, the court considered whether the application for review was moot. It was held not to be because, even though a referral back to the Health Services Appeal and Review Board would not be timely, delineating the scope of delegated authority was an important issue.

3.3. Statutory Authority: Physicians & Hospitals

Given the foregoing, it is clear that in order for administrative review to be a promising avenue of challenging rationing decisions in pandemics, there must be statutorily delegated and discretionary powers that could be subjected to jurisdictional challenges and standards of review. As the subsequent sections will show, the government has a vast array of statutory authority for rationing in pandemics, thereby making them vulnerable to administrative law challenges.

Provincially – and using Ontario as an example – significant authority rests with the Minister of Health and Long-Term Care to promulgate guidelines for the use of resources

¹⁶⁵ *Ibid.*

¹⁶⁶ See e.g. *Finlay*, *supra* note 19.

¹⁶⁷ *Ontario*, *supra* note 149 at paras 21 - 22.

and direct the activities of health care professionals and hospitals, all of which could be possible rationing tools during a pandemic. Likewise, in declared emergencies (public health and otherwise), additional powers are available to governments to control resource supply and allocation.

3.3.1. Regulated Health Professions

Provincial governments hold enormous authority over the regulation of the medical profession and the operation of hospitals. It is through these powers that the government may impose rationing criteria and control the use of scarce lifesaving resources during a pandemic.

First, governments may control the allocation of resources through the use of professional standards guidelines for physicians, pharmacists, nurses, etc. In Ontario, these and other regulated health professions are governed by their respective health profession acts and broadly as a class under the *Regulated Health Professions Act, 1991 (RHPA)*.¹⁶⁸ As an example of the former, the *Medicine Act, 1991*, governs the medical profession in Ontario, and incorporates by reference Schedule 2 of the *RHPA* – the Health Professions Procedural Code.¹⁶⁹ Similar statutes exist for nurses (*Nurses Act*), midwives (*Midwifery Act*), and others. Given that the regulation of physicians is most germane to rationing (as they control the dispensing of antivirals, use of ventilators, and immunization orders) they will be the primary focus of this section.

It is important to note that any regulated health profession college has a statutory duty to serve and protect the public interest.¹⁷⁰ Thus, one potential for abuse of the delegated

¹⁶⁸ *Regulated Health Professions Act, 1991*, SO 1991, c 18 [*RHPA*].

¹⁶⁹ *Medicine Act, 1991*, SO 1991, c 30, s. 2(1).

¹⁷⁰ *RHPA*, supra note 168, Schedule II, s. 3(2).

authority may be in considering irrelevant factors, or failing to consider relevant factors if decisions are not made in the public interest. This may result in a declaration that government actors exceeded their jurisdiction.

The *RHPA*, and, to a lesser extent, the *Medicine Act, 1991*, confers on the executive council of the College of Physicians and Surgeons of Ontario the power to make regulations regarding the professional practice under its purview. For example, with prior review by the Minister of Health and Long-Term Care and with the approval of cabinet, a governing council of a regulated health professions college may make regulations, “prescribing the standards of practice of the profession and prohibiting members from acting beyond the scope of practice of the profession in the course of practicing the profession.”¹⁷¹

Furthermore, any such regulation, “may adopt by reference ... any code, standard or guideline relating to standards of practice of the profession and require compliance with the code, standard or guideline as adopted.”¹⁷²

It seems therefore, that governing professional colleges can issue practice guidelines regarding the rationing of resources by physicians or other health care practitioners. For example, this may be done by adopting a guideline on the use of triage criteria for ventilator use, restricting antivirals to treatment of certain patient groups and not for prophylaxis treatment, or mandating priority groups for vaccination. On a practical level, in the event college-issued regulations on vaccine use conflict with those issued by government ministries, and the vaccines are provided by the government, it seems evident that in order to gain access to, and distribute the resource, government-imposed requirements must be observed.

¹⁷¹ *Ibid*, Schedule II, s. 95(1)(n).

¹⁷² *Ibid*, Schedule II, s. 95(1.1).

While most rule and standards-making authority for health professionals rests with the colleges, the enabling legislation has reserved similar powers for the government (via the Minister of Health and Long-Term Care). For example, under the *RHPA*, the Minister may:

[R]equire a Council [of a regulated health professions College] to make, amend or revoke a regulation under a health profession Act; [or] require a Council to do anything that, in the opinion of the Minister, is necessary and advisable to carry out the intent of this Act, [or] the health professions Act [specific to the relevant profession].¹⁷³

Furthermore, if the governing council of a health profession college fails to make, amend or revoke a regulation as directed by the Minister, the Lieutenant Governor in Council may do so after sixty days.¹⁷⁴

It seems clear then that the government or regulatory colleges may impose rationing guidelines through the regulation of the standards of practice; it appears to be *prima facie* within their statutory jurisdiction to do so. While difficult to speculate on future developments, judicial review challenges may succeed if it could be argued that the imposition of rationing guidelines are due to factors not regulatory in nature, or driven by factors inconsistent with the objectives of regulating medical professions in the public interest.¹⁷⁵

From the perspective of a private law suit against the Minister, or others (including the governing bodies of the health profession colleges), broad liability immunity is provided by the *RHPA* to those persons. As per the *RHPA*, the Crown, its employees, and members of College councils and committees and similar actors have statutory immunity for acts:

[D]one in good faith in the performance or intended performance of a duty or in the exercise or the intended exercise of a power under this Act, a health profession Act ... or a regulation or a by-law under those Acts or for any neglect or default in the performance or exercise in good faith of the duty or power.¹⁷⁶

¹⁷³ *Ibid.*, s. 5(1)(c) - (d).

¹⁷⁴ *Ibid.*, s. 5(3).

¹⁷⁵ See e.g. *Re Doctor's Hospital*, *supra* note 19

¹⁷⁶ *RHPA*, *supra* note 168, s. 38.

If rationing decisions are promulgated under these powers, and are done so in bad faith, then individual actors are open to private liability in negligence.

The extent to which physicians follow any college or Ministry-imposed guidelines is also vitally important: if they ignore them, the policies are essentially useless. Therefore, there must be a mechanism available to enforce those guidelines. Schedule 2 of the *RHPA* contains the Health Professions Procedural Code (Code), and this provides such a mechanism. Pursuant to section 87 of the Code, “any regulated health professions college may apply to the Superior Court of Justice for an order directing a person to comply with a provision of the health profession Act, this Code, the *Regulated Health Professions Act, 1991*, the regulations under those Acts or the by-laws.”¹⁷⁷ While it is doubtful any college would get to the level to necessitate a court order, the statutory power is present, which may serve an important deterrence (or compliance) function.

Antivirals, as shown in chapter one, are a special problem. With antivirals there are, unlike with specially-manufactured vaccines, private stocks available for dispensing from pharmacies upon a physician’s prescription. The argument could be made that any physician prescribing antiviral medications to patients not in priority groups is, or would be, committing professional misconduct. This is due to a provision in O. Reg. 856/93 that makes it professional misconduct to prescribe, dispense or sell drugs for an ‘improper purpose’.¹⁷⁸ This provision could be an important tool in imposing restrictions on the use of privately-held antiviral medications, if it can be established that prescribing them contrary to government guidelines constituted an ‘improper purpose’. This would be a challenging hurdle to clear on judicial review, as it not so much that prophylactic use of antivirals is an

¹⁷⁷ *Ibid*, Schedule II, s. 87.

¹⁷⁸ O Reg 856/93, s. 1(1)(6).

‘improper purpose itself’, it is just that such use may only be considered improper under conditions of extreme scarcity where public health concerns dictate a restricted use for treatment purposes only.

3.3.2. Public Hospitals

In the case of potentially scarce ventilators, if public hospitals (a term which covers nearly all of Ontario’s 200+ hospitals) adopt rules mandating the use of triage criteria, such as a SOFA score system for ventilators, physicians must comply with such rules.¹⁷⁹ The statutory authority for mandated physician compliance with hospital policies can most aptly be seen under clause 28 of section 1(1) of Ontario Regulation 856/93, whereby it is professional misconduct for a physician to contravene a, “federal, provincial or territorial law, a municipal by-law or a by-law or rule of a public hospital if, the purpose of the law, by-law or rule is to protect the public health.” An argument would still have to be proffered that the rule restricting ventilator use was in the public’s health. As the primary goal of pandemic response plans is to minimize morbidity and mortality, such an argument would likely pass any level of judicial muster. But, if the goals are changed such that social continuity, the protection of key decision-makers, or even lottery-based systems dominate rationing regimes, then it could be argued that such actions are not consistent with the public’s health, thus being *ultra vires* considerations. Public hospitals may also control the standards of physicians working within its confines through the privilege-granting process.¹⁸⁰

The Minister of Health and Long-Term Care, or their authorized delegate, may also mandate specifics of the treatment and control of any class of patients being treated in the

¹⁷⁹ Similar rules for the other two classes of healthcare institutions: private hospitals (*Private Hospitals Act*, RSO 1990, c P-24) and independent health facilities (*Independent Health Facilities Act*, RSO 1990, c I-30).

¹⁸⁰ See e.g. Colleen M Flood, Bryan Thomas & Leigh Harrison-Wilson, “Cosmetic Surgery Regulation and Regulation Enforcement in Ontario” (2010) 36 Queen’s LJ 31-70 at para 17.

province's public hospitals. In Ontario, under the *Public Hospitals Act*, subject to the approval of cabinet, the Minister of Health and Long-Term Care may make regulations with respect to hospitals as are considered necessary for, "the admission, treatment, care, conduct, control and discharge of patients or any class of patients."¹⁸¹ Therefore, it seems likely that issuing directives to public hospitals to adopt triage protocols would fall under the Minister's statutory regulation-making aegis and ruled *infra vires*, unless extraneous factors are considered.

Public hospitals are under no obligation to admit patients to their service of care if a staff physician determines it not clinically necessary.¹⁸² While morbid, this could be the case if patients present, for example, with very high SOFA scores that makes them ineligible for ventilator treatment. Of course, as is the case with most triage protocols, palliative care should be provided, but the clinical necessity of that is at the discretion of the admitting physician, as per the regulations.

Public hospitals are also required to maintain surge capacity plans for, "emergency situations that could place a greater than normal demand on the services provided by the hospital or disrupt the normal hospital routine."¹⁸³ The regulations do not specify the requisite content of any such plans. Therefore, ventilator triage prioritization plans do not necessarily have to be part of every hospital's surge operating plan.

3.4. Statutory Authority: Public Health

Outside of regulating the practice of health professionals and the internal operation of hospitals, all levels of government have dedicated and separate public health powers on

¹⁸¹ *Public Hospitals Act*, RSO 1990, c P-40, s. 32(1)(j).

¹⁸² RRO 1990, Reg 965, s. 11(2).

¹⁸³ *Ibid*, s. 2(3)(e)(i).

which they can draw before and during pandemics. The provinces in particular have oftentimes extraordinary powers available to cabinet, the Premier or public health officials (namely, the Chief Medical Officer of Health), that are amplified during public health emergencies such as pandemics. As Ries notes the, “exercise of restrictive [public health] powers raises concerns about excessive interference with personal liberties.”¹⁸⁴ Therefore, judicial review serves an important function by checking the exercise of those powers.

3.4.1. Provincial / Municipal

In Ontario, the *Health Promotion and Protection Act (HPPA)* is the primary public health statute.¹⁸⁵ The *HPPA*’s stated purpose is to, “provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario.”¹⁸⁶ Any government actions ostensibly under the authority of the *HPPA* must accord with its objectives, and if not, could be declared *ultra vires* on judicial review.

3.4.1.1. Boards of Health

Public health authority under the *HPPA* lies primarily with local boards of health. These boards are formed generally around county or municipal boundaries. Boards of health exist in Durham, Halton, Niagara, Peel, York, Waterloo and the County of Oxford as well as within single-tier municipalities.¹⁸⁷ For example, under the *City of Toronto Act, 2006*, the Toronto board of health is deemed to be a board of health established under the *HPPA*.¹⁸⁸ Each board of health in turn has a Medical Officer of Health (MOOH). The province’s

¹⁸⁴ Ries, *supra* note 1 at 11.

¹⁸⁵ *Health Promotion and Protection Act*, RSO 1990, c H-7 [*HPPA*].

¹⁸⁶ *Ibid.*, s. 2.

¹⁸⁷ At the time of writing, there were 36 public health units across Ontario, each governed by a board of health.

¹⁸⁸ *City of Toronto Act, 2006*, SO 2006, c 11, Schedule A, s. 405.

functions under the *HPPA* are typically vested in the province's Chief Medical Officer of Health (CMOH).

Regarding local control over pandemic responses, the Campbell report on SARS noted regarding the discretion of local MOOH's:

The present distribution of legal powers under the *Health Protection and Promotion Act* gives the local Medical Officer of Health an enormous ambit of uncontrolled personal discretion, which is not ordinarily subject to the review or influence of the Chief Medical Officer of Health. The Chief Medical Officer of Health does have some override powers, and cumbersome machinery does exist under which the province might ultimately bring to heel a rogue board of health. But public health authority in Ontario over infectious disease control, including outbreak management, is primarily that of local officials with no direct accountability to any central authority.¹⁸⁹

What that said, as the legislative analysis will show, the province retains substantial legal authority to impose its will on public health units. As the Campbell report also noted: "it is the machinery of last resort, akin to managing a local conflict through the threat of thermonuclear force."¹⁹⁰

Every board of health must provide and manage health services and programs regarding, *inter alia*, "[the] control of infectious diseases and reportable diseases, including provision of immunization services to children and adults."¹⁹¹ All of the preceding programs are considered 'mandatory health programs and services'. By regulation, the government may also place additional health programs and services under the purview of boards of health.¹⁹²

The Minister of Health and Long-Term Care may publish guidelines on the provision of mandatory health programs and services and boards of health must comply with any such

¹⁸⁹ Ontario, Commission to Investigate the Introduction and Spread of SARS in Ontario, *Spring of Fear* (Commissioner: Archie Campbell, J.) (Toronto: Ministry of Health and Long-Term Care, 2006) at 1538 [Campbell].

¹⁹⁰ *Ibid* at 1503.

¹⁹¹ *HPPA*, *supra* note 185, s. 5, para 2.

¹⁹² *Ibid*, s. 5, para 4.2.

guidelines.¹⁹³ This would seem to permit the Minister to issue guidelines on pandemic influenza response to the extent such programs and services relate to controlling the spread of influenza and/or providing immunization services. Given the latter element of the definition, there is little doubt the management of mass immunization programs would fall under the subject matter that such guidelines can cover. Therefore, boards of health appear not to be at liberty to deviate from guidelines issued by the province in such regards, including priority groups such as were published during the H1N1 pandemic. As previously mentioned, if boards of health are not complying with the guidelines, then public interest standing may be sought to compel governments to enforce their own laws.

The Minister may also make regulations stipulating what diseases classify as a ‘communicable disease’, ‘reportable disease’, or ‘virulent disease’.¹⁹⁴ Influenza is listed in the reportable diseases regulation,¹⁹⁵ and the communicable diseases regulation,¹⁹⁶ but not as a virulent disease. Additionally, ‘infectious disease’, ‘pandemic’, ‘provincial, national, or international health event’ and ‘public health emergency preparedness’ may also be further defined by the Minister. Such definitional flexibility may allow the government to bring otherwise *ultra vires* executive action within the public health legislation.

It is unclear whether antiviral priority groups or ventilator triage protocols would also fall under the Minister’s guideline-making umbrella. This seems unlikely, as they are not directly related to the ‘control’ of influenza *per se*, which suggests a preventative element. Instead, such pandemic responses may fall under the statutory role of ‘health protection and disease and injury prevention’. After all, the goal is to minimize overall mortality and

¹⁹³ *Ibid.*, s. 7(1).

¹⁹⁴ *Ibid.*, s. 97.

¹⁹⁵ O Reg 559/91, s. 1.

¹⁹⁶ O Reg 558/91, s. 1.

morbidity as a result of a pandemic – clearly disease and injury prevention. Thus, an argument could be made that to the extent the board of health is involved in the provision of antiviral medications or triage protocol-setting, the Minister may also make guidelines in those regards.

Local medical officers of health (MOOHs) also have extensive powers under the *HPPA* regarding communicable diseases, including influenza. By written order, a medical officer of health may compel any person to do or refrain from doing anything specified in the order.¹⁹⁷ Such an order may only be made when the MOOH is of the opinion, on reasonable and probable grounds, that the following conditions have been met: (a) “... a communicable disease exists or may exist or that there is an immediate risk of an outbreak [in the MOOH’s health unit]”; (b) the communicable disease presents a risk to the health of persons [in the MOOH’s health unit]”; and (c) the order is necessary, “to decrease or eliminate the risk to health presented by the communicable disease.”¹⁹⁸ If the preceding conditions are met, any order may be made requiring a person (or class thereof) to, *inter alia*, shut down premises, submit to a physician’s inspection to determine if they are infected, and/or quarantine themselves.¹⁹⁹ Returning to the principles of administrative law, if the above conditions precedent are not met and actions are taken by a MOOH ostensibly under the foregoing authority; on judicial review, such actions will likely be declared *ultra vires*.

The enumerated list of orders that could be made by a MOOH is not exhaustive. Therefore, in addition to quarantine orders, it seems possible that MOOH may also order health care professionals to treat certain patients over others, as is the case with priority groups. Pharmacists may also be ordered to turn over any private stockpiles of antiviral

¹⁹⁷ *HPPA*, *supra* note 185, s. 22(1).

¹⁹⁸ *Ibid.*, s. 22(2).

¹⁹⁹ *Ibid.*, s. 22(4).

medications or cease their distribution. Likewise, in the management of priority groups, it is possible a MOOH may deliver orders to classes of persons informing them to remain home during immunization periods, or to attend at immunization clinics. Of course, as with any government actors' actions, they must comply with the *Charter*. In addition, any order must contain the reasons for the order,²⁰⁰ and be made within in the confines of the objectives of the *HPPA*, which is protecting the public's health – not social continuity.

3.4.1.2. Enforcement

If an individual fails to complete or undertake a recommended course of treatment (for example, refusing to take antivirals or complete the course or within the specified time frame), they must be reported by the treating health care professional to the medical officer of health.²⁰¹ However, such actions (e.g. failing to take antivirals) do not constitute direct offences under the *HPPA* and are therefore of little practical consequence.

Contravening section 42 of the *HPPA* is an offence, which provides that no person shall obstruct a medical officer of health who is, “lawfully carrying out a power, duty or direction.”²⁰² Likewise, failure to comply with any order under the *HPPA* or regulation, or failure to comply with select sections of the *HPPA*, constitutes an offence.²⁰³ On conviction for an offence, any person is liable for a maximum fine of \$5,000 for each day of the offence.²⁰⁴ Corporations, municipalities and boards of health are liable to a maximum \$25,000 fine, per day.²⁰⁵

²⁰⁰ *Ibid*, s. 22(7).

²⁰¹ *Ibid*, s. 34(1).

²⁰² *Ibid*, s. 42(1).

²⁰³ *Ibid*, s. 100.

²⁰⁴ *Ibid*, s. 101(1).

²⁰⁵ *Ibid*, s. 101(2).

It is also a contravention of the *HPPA* to knowingly provide false information to the CMOH, MOOH or, “a person who is carrying out any power, duty or direction under [the *HPPA*] or is otherwise acting in the lawful performance of his or her duties under [the Act].”²⁰⁶ This is a highly relevant provision, as it would seem that lying to public health nurses about one’s status in a priority group (be it age, disability status, medical history, etc.) would thus constitute an offence. However, this provision is only truly relevant to the extent it can deter such behaviour. It is unlikely that most persons are aware lying to public health officials during a pandemic is illegal. Therefore, the realistic impact of this section is questionable.

Any contravention of an order made pursuant to the *HPPA* may be restrained by application to the Superior Court of Justice by the order-maker, the Minister of Health and Long-Term Care, or the CMOH.²⁰⁷ A judicial order may also be sought to prohibit a continuing or repeating contravention, and any such order may be enforced as any other judicial order.²⁰⁸ Procedurally, actions in the Superior Court must comply with the slow and cumbersome Rules of Civil Procedure, casting doubt on their utility.

These enforcement mechanisms only serve to restrain contraventions – that is, stopping someone from doing something. They cannot be used to require compliance, unless framed in the double negative. Recourse to the courts for such enforcement measures is not available to the general public, as an application may only be made by select government authorities, such as the Minister or CMOH. Overall, the procedures for judicial enforcement have been criticized as, “confusing and weak ... no way to enforce a statute.”²⁰⁹ Therefore,

²⁰⁶ *Ibid.*, s. 105.

²⁰⁷ *Ibid.*, s. 102(1).

²⁰⁸ *Ibid.*, s. 102(2).

²⁰⁹ Campbell, *supra* note 189 at 1907.

the non-statutory mechanisms for review explored in this thesis – judicial review and private law suits – may be more appropriate at delivering a meaningful remedy.

3.4.1.3. Appeal

Any member of a class of persons subject to a MOOH order may apply to the Health Services Appeal and Review Board (HSARB) for a hearing of their case.²¹⁰ Likewise, any order by a MOOH under the *HPPA* must contain information regarding entitlement to a hearing in front of HSARB, if the person delivers notice of such a request within fifteen days of being served with a MOOH order.²¹¹ Any appeal of a MOOH order does not result in an automatic stay, unless a stay is ordered by HSARB pending the completion of the hearing process.²¹²

The hearing process is slow, and in the case of a pandemic, likely too slow to be effective. For example, total possible time from the date of an order to a hearing is approximately thirty days. In terms of a pandemic, this is substantial and by the time a hearing occurs the order may no longer be necessary (particularly if it is not stayed in the interim). For example, an order may be made regarding rationing of resources, and by the time the hearing comes up, the priority groups may already have changed or expanded, thus nullifying the very point of the hearing.

On appeal hearings, HSARB may rescind, confirm or alter the MOOH's order and in so doing substitute their own findings for those of the MOOH.²¹³ Any decision by HSARB may be further appealed to the Divisional Court on questions of law or fact, and thus subject

²¹⁰ *HPPA*, *supra* note 185, s. 22(5.05).

²¹¹ *Ibid.*, s. 44(1).

²¹² *Ibid.*, s. 44(3).

²¹³ *Ibid.*, s. 44(4).

to traditional standards of judicial review (reasonableness or correctness).²¹⁴ If a MOOH order was stayed by HSARB, a judge of the Superior Court of Justice may grant a further stay pending appeal to the Divisional Court.²¹⁵ On appeal to the Divisional Court, the court may refer the matter back to HSARB for re-hearing or may rescind, confirm or alter the decision of HSARB.²¹⁶

Overall, the procedures for enforcement of orders are not as detailed or ‘convenient’ as ideally would be the case. As has been noted:

The difficulty is that the assessment and compliance machinery is infinitely complicated, replete with notices, directions, orders, procedures before the Health Services Appeal and Review Board and the Superior Court of Justice and appeals therefrom. It more resembles an international peacekeeping operation than it resembles effective machinery to enforce basic health protection standards across the province.²¹⁷

This is problematic, because as the Campbell SARS report notes, “[i]t is not enough to provide legal authority to make orders. If the orders cannot be enforced through a clear set of reasonable and efficient procedures, there is no point in making the order in the first place. The procedures to exercise those powers must be in place and must be clear and fair.”²¹⁸

3.4.1.4. Provincial Public Health Powers

The province’s chief public health officer – the Chief Medical Officer of Health (CMOH) – is empowered under the *HPPA* as follows: “[if the CMOH is] of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, he or she may investigate the situation and take such action as he or she considers appropriate to prevent, eliminate or decrease the risk.”²¹⁹ The sweeping powers of

²¹⁴ *Ibid.*, ss. 46(1), 46(5).

²¹⁵ *Ibid.*, s. 46(2).

²¹⁶ *Ibid.*, s. 46(5).

²¹⁷ Campbell, *supra* note 189 at 1542.

²¹⁸ *Ibid.* at 1915.

²¹⁹ *HPPA*, *supra* note 185, s. 77.1(1).

the CMOH fortunately can be restrained using administrative law. In particular, their actions may be challenged on judicial review as lacking jurisdiction if a condition precedent (e.g. a health risk) is not truly present, or is in fact not a health risk.

The primary distinguishing feature of the CMOH as compared to local medical officers of health is that they are empowered to act anywhere in Ontario, and not simply restricted to the jurisdictions of particular boards of health. Second, the CMOH may exercise all statutory powers of a board of health. However, despite the foregoing broadly-worded section, they cannot act outside the powers or duties listed in the *HPPA* and cannot direct public health officials to do anything they are not empowered to do under the *HPPA*.

The CMOH also has the statutory authority to apply to the Superior Court of Justice for an order to combat public health threats. In order to apply to the court, the CMOH must be of the opinion that a, “situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons.”²²⁰ In return, the court may order a board of health to take such actions as the court considers, “appropriate to prevent, eliminate or decrease the [public health] risk.”²²¹ The scope of orders a judge may make under this section is not restricted to those stipulated elsewhere in the *HPPA*. Thus, as a pandemic is surely ‘a risk to the health of any persons’, if a judge believes that ordering a local board of health to comply with mandated priority lists or guidelines for dispensing vaccines, antivirals or ventilators would ‘prevent, eliminate or decrease the risk’, it would seem this section sanctions such an order. This may be another weapon in the government toolbox to combat a pandemic through the use of health resource rationing, so long as a judge would agree to grant the order.

²²⁰ *Ibid*, s. 77.2(1).

²²¹ *Ibid*, s. 77.2(2).

3.4.1.5. Procurement

The *HPPA* also empowers the Minister of Health and Long-Term Care to order the, “procurement, acquisition and seizure of any medications and supplies provided for in the order.”²²² The Minister may also compel private individuals to provide information necessary to determine who holds medications and supplies.²²³ ‘Medications and supplies’ are defined to include: “antitoxins, antivirals, serums, vaccines, immunizing agents, antibiotics and other pharmaceutical agents, medical supplies and medical equipment.”²²⁴ Thus, in the case of pandemics, the three likely scarce resources identified in chapter one – vaccines, ventilators and antivirals – all fall within the scope of this provision.²²⁵

The foregoing appears to be clear legislative authorization for the identification and seizure of scarce lifesaving healthcare resources in a pandemic. This provision will prove most useful in controlling the dispensing of antiviral medications, as many private stockpiles exist in pharmacies, hospitals and elsewhere. In order for any mandated priority or distribution guidelines to be followed, seizure of those holdings may be necessary, and doing so is clearly authorized by the *HPPA*.

Of course, any exercise of the Minister’s discretionary power must be consistent with administrative law principles, and thus in accordance with the objectives of the *HPPA*. In

²²² *Ibid*, s. 77.5(1).

²²³ *Ibid*, s. 77.5(6).

²²⁴ *Ibid*, s. 77.5(11).

²²⁵ An interesting situation would arise if a province such as Ontario tried to use this provision to order the procurement of pandemic vaccines manufactured or held in Ontario by the federal government. For example, the federal government’s contract with the manufacturer provides for first priority for any supplies manufactured on Canadian soil. However, a contract must comply with statutory law (provided the manufacturer carries on business in the relevant province), which takes precedence. In this case, if the provincial government opted to utilize the foregoing provision, it would seem to trump any contractual agreement, permitting the seizure and use (perhaps contrary to the federal government’s recommended priority groups (if there were a jurisdictional difference). This is not an option for the Ontario government, as section 77.5(2) of the *HPPA* exempts persons from complying with seizure or procurement orders for medications and supplies if, “there exists or may exist an immediate risk that the health of patients in another province or territory of Canada would be jeopardized.”

particular, certain conditions precedent must be met prior to the Minister's exercise of the emergency procurement power, in order for it to be *prima facie infra vires*. There must be a public health emergency; the supplies must be necessary, and unable to be procured otherwise. Specifically, the CMOH must also certify in writing the following conditions precedent:

- (a) there exists or there may exist an immediate risk to the health of persons anywhere in Ontario;
- (b) the medications and supplies are necessary to address the risk; and
- (c) the Chief Medical Officer of Health is of the opinion that regular procurement processes for medication and supplies are unable to meet the needs of persons in Ontario.²²⁶

In the event persons fail to comply with a Minister's orders (re: seizure) or directions (to provide information), a judge of the Superior Court of Justice may on application issue an order requiring compliance, including ordering police officers to physically seize the medications or supplies.²²⁷

3.4.1.6. Emergency Response & Planning: Declaration of Pandemic

The provincial CMOH may also direct boards of health or medical officers of health to adopt or implement policies or measures concerning infectious diseases, health hazards, or public health emergency preparedness.²²⁸ In order to make such orders, the CMOH must be of the opinion that:

- (a) that there exists, or there is an immediate risk of, a provincial, national or international public health event, a pandemic or an emergency with health impacts anywhere in Ontario; and (b) that the policies or measures are necessary to support a co-ordinated response ... or to otherwise protect the health of persons.²²⁹

²²⁶ *HPPA*, *supra* note 185, s. 77.5(3).

²²⁷ *Ibid.*, s. 77.5(7).

²²⁸ *Ibid.*, s. 77.9.

²²⁹ *Ibid.*, s. 77.9(1).

Any such order may not exceed six months of effective duration, subject to unlimited renewal of same periods or earlier termination by the CMOH.²³⁰

Condition (a) above is also likely the derivation of the ‘declaring a pandemic’ step found in most pandemic plans. While there are few explicit criteria for the activation of pandemic preparedness and response plans, some have made it clear that the provincial Chief Medical Officer of Health will declare a pandemic, at which point that province’s plan is in effect.²³¹ The presence of conditions precedent, and time limits on the orders all suggest a strong potential for judicial review. This is an important role, because as the Campbell report notes, “[e]mergency powers are inherently dangerous. They carry the twin dangers of overreaction and underreaction.”²³²

The declaration of a public health emergency (or pandemic) is not a certain event during a pandemic. For example, during the H1N1 pandemic, most provinces did not declare a public health emergency. As part of a review of Alberta’s response, it was noted that a formal emergency was not declared because it, “is an extraordinary measure and used as a last resort when other measures do not adequately protect the public.”²³³ In other words, “the pandemic was not an emergency ... the challenge was managing the immunization clinics.”²³⁴

Notwithstanding the foregoing, when the CMOH declares a pandemic, the first condition in the *HPPA* provision above is met, enabling the emergency response plan to be activated. But, there is no statutory requirement that emergency response plans require a pandemic declaration, as local boards of health may still act without the CMOH’s directions

²³⁰ *Ibid*, ss. 77.9(4), (5).

²³¹ See e.g. British Columbia, *supra* note 60 at 20.

²³² Campbell, *supra* note 189 at 1585.

²³³ *HQC*, *supra* note 47 at 17.

²³⁴ *Ibid* at 37.

or orders by drawing on their own powers. In the event a board of health refused to comply with CMOH directions or any other provincial direction, regulation, guideline or part of the *HPPA*, the Minister of Health and Long-Term Care may direct compliance, and take whatever measures are necessary to ensure compliance.²³⁵

As with the other statutes examined in this chapter, personal liability immunity (civil) is conferred by the *HPPA* on MOOHs and the CMOH and other select classes of public health workers for the good faith execution (or lack thereof) of their duties and powers.²³⁶ This immunity does not apply to the Crown, who remains liable under the *HPPA*.²³⁷ Importantly, the barring of a proceeding for liability does not preclude judicial review.²³⁸

3.4.2. Federal

As health administration is a predominantly provincial matter, there are far fewer federal statutes and regulations on public health matters, including pandemics. Most of the federal government's role appears to be in the 'soft law' area (non-binding public health guidelines) and in acting in a coordinating role between the provinces and territories. An example of the latter is its role as the lead purchaser (and capacity-builder) for domestic pandemic vaccine supply. As previously mentioned, agreements between the provinces and the federal government are not legally binding. As the party entitled to receipt of the vaccine under the manufacturing contract, the federal government has a large and extremely important non-statutory role in distributing those vaccines across the country. As well, the federal government fulfills its roles by maintaining a national stockpile of antiviral medication and other health resources to respond to a public health emergency.

²³⁵ *HPPA*, *supra* note 185, ss. 82 - 84.

²³⁶ *Ibid.*, s. 95(1).

²³⁷ *Ibid.*, s. 95(1.1).

²³⁸ *Ibid.*, s. 95(2).

The Public Health Agency of Canada is the lead federal department on health promotion and other public health matters (including public health emergency preparedness). The agency is under the direct leadership of the federal Minister of Health.²³⁹ The Minister has overall public health powers for the Government of Canada as a result of the *Department of Health Act (DHA)*.²⁴⁰ Unfortunately, other than establishing the agency and reaffirming the Minister's jurisdiction over public health matters, the *Public Health Agency of Canada Act* contains little else of relevance.²⁴¹ The Minister may, and does delegate their powers to the agency and its officers and employees, most notably the Chief Public Health Officer (CPHO), who is also the deputy head of the agency.

The Minister of Health may also act in response to a pandemic through their powers under the *DHA*. Pursuant to the *DHA*, the Minister of Health has authority to make regulations necessary to carry out the objectives thereof (which includes the preservation of the health of Canadians).²⁴² Any contravention of a Minister's regulation is an offence punishable by summary conviction.²⁴³ If a health risk is significant and requires immediate action, the Minister may issue an interim order (similar to a regulation). Unlike regulations, interim orders have expiry dates of approximately fourteen days unless either a replacement regulation is made or the federal cabinet approves the order.²⁴⁴ The interim order power is necessary to enable the Minister to respond to urgent threats where a formal regulation would not be time efficient. It is very conceivable that such an order may be used in the early stages of a pandemic, but given the short time-frame of effectiveness and the length of most

²³⁹ *Public Health Agency of Canada Act*, SC 2006, c 5, s. 4 [PHAC].

²⁴⁰ *Department of Health Act*, SC 1996, c 8, ss. 4(1), (2) [DHA].

²⁴¹ PHAC, *supra* note 239.

²⁴² DHA, *supra* note 240, s. 11(1).

²⁴³ *Ibid.*, s. 11(2).

²⁴⁴ *Ibid.*, s. 11.1(2).

pandemics, a regulation would likely be a more advisable and appropriate course. If a regulation is utilized to impose rationing, the rationing must again be defensible with reference to the objective of the *DHA* – preserving the health of Canadians – so as to pass judicial review on the issue.

Finally, the *Department of Public Safety and Emergency Preparedness Act* establishes the named department and the Minister thereof has all powers of the Government of Canada over emergency preparedness and public safety that have not been assigned by law to another department.²⁴⁵ This is important, as it has already been shown that the Minister of Health has powers over public health matters, including diseases and public health emergencies. Therefore, while the Public Safety Minister may have some role in public health emergencies in areas not related to or ancillary to ‘health’, any role would be diminished during a pandemic, and relate mostly to logistics coordination, etc.

3.5. Statutory Authority: Emergencies

Other than regulated health professions and public health legislation, governments have recourse to extraordinary powers under emergencies statutes, including the explicit authorization for rationing resources. Neither public health nor emergencies legislation specifically precludes the operation of the other during public health emergencies such as pandemics. Therefore, governments may choose to rely on one type of enabling statute or both, depending on what they wish to accomplish and what conditions are requisite to the exercise of specific powers.

Broadly speaking, emergency planning (including pandemics and other non-health-related emergencies) in Canada is bottom-up, starting at the individual level: “the

²⁴⁵ *Department of Public Safety and Emergency Preparedness Act*, SC 2005, c 10, s. 4(1).

responsibility to deal with emergencies is placed first on the individual and then on successive levels of government, as the resources and expertise of each are needed.”²⁴⁶ As emergencies typically threaten great numbers of citizens, and possibly the very existence of the state and civil society, many emergency powers are extreme. It is for this reason that the declaration of an emergency (activating the associated statutory powers) is not to be taken lightly or assumed to occur during a pandemic (which, as the H1N1 experience shows, can be mild). In fact, the CPIP notes that it is unlikely that a federal or provincial emergency will be declared during a pandemic.²⁴⁷ Oddly, this runs contrary to Ontario’s plan which states that an early declaration of provincial emergency is likely.²⁴⁸

Of relevance to administrative law, given the extraordinary powers under emergencies statutes, a more searching judicial review may be warranted. With that said, it could also be argued that the uncertain and fast-moving nature of emergencies demands more judicial deference to executive decision-makers. Regardless of the standard of review adopted, it is clear that the greatest opportunity for judicial override is for a declaration of *ultra vires* – that there was in fact no emergency – which, as this section will show, is obviously a condition precedent to all statutory-conferred emergency powers.

3.5.1. Provincial

3.5.1.1. Emergency Planning & Administration

The Ontario *Emergency Management and Civil Protection Act (EMCPA)*, which replaced the *Emergencies Act (Ontario)*, governs the province’s emergency response

²⁴⁶ CPIP, *supra* note 35 at Annex L-3.

²⁴⁷ *Ibid* at Annex H-3.

²⁴⁸ OHPIP, *supra* note 62 at 3-6.

apparatus.²⁴⁹ Under the *EMCPA*, an ‘emergency’ is defined as, “a situation or an impending situation constituting a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by ... a disease or other health risk.”²⁵⁰ As is clear from a plain interpretation of the statutory language, pandemics (as diseases or health risks) are likely included in the class of emergencies under the *EMCPA*. This is an important inclusion: it ensures the ability of governments to respond in the event a ‘public health emergency’ is not declared under public health legislation. With that said, it is not clear if a pandemic need be declared (by the WHO or the CMOH) or what qualifies as a health risk sufficient to trigger the emergency provisions. Therefore, this condition precedent could be fertile ground for administrative challenge.

The *EMCPA* requires municipalities and each government ministry and agency to develop emergency management programs consisting of, *inter alia*, an emergency plan, training programs and public education efforts regarding public preparedness for emergencies.²⁵¹ All emergency plans must, “provide for obtaining and distributing materials, equipment and supplies during an emergency.”²⁵² The procurement of vaccines and holding of mass immunization clinics seems to clearly fall under this provision. Therefore, it is no surprise that each provincial plan called for the rationing of resources as necessary. True fidelity to the preceding provision would suggest all emergency plans should contain detailed information on how resources are going to be obtained, and most importantly, how they will be distributed in the event of shortfall. However, as was seen with the H1N1 pandemic, how resources are rationed is highly dependant on the science and virulence of the strain (or

²⁴⁹ *Emergency Management and Civil Protection Act*, RSO 1990, c E-9 [*EMCPA*].

²⁵⁰ *Ibid.*, s. 1.

²⁵¹ *Ibid.*, ss. 2.1, 5.1(1).

²⁵² *Ibid.*, s. 9(e).

circumstances of the emergency) and therefore plans cannot be overly detailed, and most rightly maintain sufficient flexibility. Whether a court would agree with such an interpretation on judicial review is less clear.

Provincial and/or municipal emergency response plans must also authorize municipal employees or provincial civil servants to, “take action under the emergency plan where an emergency exists but has not yet been declared to exist.”²⁵³ This section appears intended to ensure that preparatory actions need not wait until an official emergency declaration is issued. This makes logical sense: it would be unwise to wait until a declaration is issued to take any action, and doing so may hinder an effective emergency response. With that said, the wording of the enabling provision appears overly broad and not simply reserved to preparatory actions. For example, it is possible that if, as per the definition of emergency, a public health threat such as a pandemic exists, and an emergency response plan calls for rationing of resources, that such rationing can legally occur even without a formal emergency declaration. Such actions could be subject to challenge on administrative law principles on grounds of abuse, as government actors can take extreme measures without meeting the conditions precedent. It is likely that courts would apply a stricter standard of review in such circumstances in order to mitigate any potential for abuse.

3.5.1.2. Emergency Declarations & Jurisdictional Issues

A head of a municipality (such as a mayor) may declare an emergency and make orders necessary to implement an emergency response plan and to protect property and the health, safety and welfare of residents of the emergency area.²⁵⁴ Fortunately, the *EMCPA* creates a proviso that any such actions or orders must not otherwise be contrary to law. This

²⁵³ *Ibid.*, s. 9(a).

²⁵⁴ *Ibid.*, s. 4(1).

is an important carve-out, as it prevents mayors from exercising legal powers that normally do not reside with them, such as expropriating property, forcing quarantines, etc.

An identical power is reserved for the Premier of Ontario, allowing the higher-tier of government to override the mayor unilaterally.²⁵⁵ Province-wide, the cabinet or Premier (if the situation is extremely urgent) may declare a state of emergency throughout the province or in parts thereof.²⁵⁶ Unless ratified by a cabinet order, any Premier-declared emergency terminates after 72 hours.²⁵⁷ Therefore, if actions that would otherwise not be permitted continue past the expiry time, the authorizing executive would be *ultra vires* their jurisdiction.

Any provincial declaration of emergency must meet two conditions precedent listed in the legislation: (1) the emergency must require “immediate action to prevent, reduce or mitigate a danger of major proportions that could result in serious harm to persons;” and (2) the resources of the government must be insufficient to effectively address the emergency, cannot be relied upon without significant delay, or if it is impossible without delay to determine if the resources are adequate.²⁵⁸

The Premier has unique powers under the *EMCPA* in the event an emergency is declared, either by the Premier him/herself or cabinet under section 7.01. The Premier may step in and exercise the powers of any officers, minister or employees of the Crown under any statute.²⁵⁹ This power could prove vital in a public health emergency, where under public health legislation, the directing mind of the government response is the Chief Medical Officer of Health. The Premier’s powers under the *EMCPA* appear to provide the Premier

²⁵⁵ *Ibid.*, s. 4(4).

²⁵⁶ *Ibid.*, s. 7.0.1(1).

²⁵⁷ *Ibid.*, s. 7.0.1(2).

²⁵⁸ *Ibid.*, s. 7.0.1(3).

²⁵⁹ *Ibid.*, s. 7.0.3(1).

with the ability to step in and exercise the public health authority's powers should it be deemed necessary. However, a further provision in the *EMCPA* provides that nothing therein, "shall be construed as abrogating or derogating from any of the powers of the Chief Medical Officer of Health."²⁶⁰ What is unclear is whether the Premier stepping in to exercise some of those powers constitutes derogating or abrogating – as opposed to complementing – the CMOH's powers.

Furthermore, the Premier's exercise of these powers could be reviewed for bias or abuse. The Campbell report in particular is concerned with political interference in what should be a health decision. For example, the report states:

The most important thing in a public health emergency is public confidence that medical decisions are made by a trusted independent medical leader such as the Chief Medical Officer of Health free from any bureaucratic or political pressures. This is particularly true of public communication of health risk. People trust their health to doctors, not to politicians or government managers.²⁶¹

If any part of the emergency falls in the area of a municipality, the Premier may also exercise all the powers and duties of the municipality, effectively stepping into the shoes of municipal council, and issue any such orders necessary to that end.²⁶² The Premier may also delegate their powers to any minister or to the Commissioner of Emergency Management.²⁶³ Likewise, cabinet may also delegate its powers to any minister of the Crown or to the Commissioner of Emergency Management.²⁶⁴

As the powers of the Premier, cabinet and other government ministers and commissioners during a declared emergency are extreme, such decision-makers cannot act opaquely. As per section 7.0.6 of the *EMCPA*, the Premier, or a delegated minister, must

²⁶⁰ *Ibid*, s. 7.2(5).

²⁶¹ Campbell, *supra* note 189 at 1586.

²⁶² *EMCPA*, *supra* note 249, s. 7.0.3(2).

²⁶³ *Ibid*, s. 7.0.4(1).

²⁶⁴ *Ibid*.

make regular public reports on the emergency.²⁶⁵ Likewise, within 120 days of the end of a declared emergency, the Premier must table a report on the matter in the legislature, including a detailed account of any orders issued and how they fit within the criteria specified in the *EMCPA*.²⁶⁶

In a further effort to limit the extensive powers of government actors during a declared emergency, any emergency declaration automatically terminates after fourteen days (if not earlier terminated).²⁶⁷ The period of a declared emergency may be extended by cabinet approval for one additional fourteen day period.²⁶⁸ The legislature may, by resolution, also extend a declared emergency for periods of up to twenty-eight days.²⁶⁹ An important phrasing of the section providing the legislature the power to extend is that they may do so for periods. Therefore, each extending resolution has a sunset clause of twenty-eight days, but there is no limit on how many resolutions may be passed. Thus, with the continuous approval of the legislature, it is possible a declared emergency may persist indefinitely, as would emergency powers under the *EMCPA*. The legislature may also, by resolution, disallow any declaration of emergency or extension thereof.²⁷⁰ Failure to abide by these provisions would be grounds for judicial review, though the remedy may illusory.

3.5.1.3. Emergency Orders

The purpose of declaring an emergency under the *EMCPA* is to gain access to provisions authorizing special orders. The *EMCPA* explicitly states that the goal of such emergency orders is to, “promote the public good by protecting the health, safety and welfare

²⁶⁵ *Ibid*, s. 7.0.6.

²⁶⁶ *Ibid*, s. 7.0.10.

²⁶⁷ *Ibid*, s. 7.0.7(1).

²⁶⁸ *Ibid*, s. 7.0.7(2).

²⁶⁹ *Ibid*, s. 7.0.7(3).

²⁷⁰ *Ibid*, s. 7.0.9(1).

of the people of Ontario in times of declared emergencies in a manner that is subject to the *Canadian Charter of Rights and Freedoms*.²⁷¹

There are several conditions precedent to cabinet orders that may be made during a declared emergency. The only orders that may be made are those that cabinet believes:

Are necessary and essential in the circumstances to prevent, reduce, or mitigate serious harm to persons ... if in the opinion of [cabinet] it is reasonable to believe that: (a) the harm ... will be alleviated by the order; and (b) making an order is a reasonable alternative to other measures that might be taken to address the emergency.²⁷²

Furthermore, any such orders must only apply to the affected areas of the province, be effective for only as long as necessary, and the authorized actions exercised so as to limit their intrusiveness.²⁷³ Finally, any orders made under section 7.0.2(4) are automatically revoked after fourteen days, unless renewed for identical periods by cabinet or a delegated minister.²⁷⁴

As can be seen from the immediately foregoing provisions, it is possible that rationing measures in response to pandemics meet the conditions precedent in the event an emergency is declared. Any such measures are clearly designed to mitigate or reduce serious harm to persons and will likely be effective at doing so. One question that may arise is whether mandating priority groups or triage protocols are reasonable alternatives to other measures. If a rationing situation is necessitated due to the severity of the pandemic or resource supply challenges, there may be no alternative other than to ration according to some regime. It is doubtful that a challenge on the type of rationing protocol adopted would fit under this provision, as it is the rationing orders themselves that are the only reasonable alternative to doing nothing. In essence, the question of the provision is not: ‘is a lottery

²⁷¹ *Ibid*, s. 7.0.2(1).

²⁷² *Ibid*, s. 7.0.2(2).

²⁷³ *Ibid*, s. 7.0.2(3).

²⁷⁴ *Ibid*, s. 7.0.8.

better than a utilitarian approach?’ Instead the question is: ‘is any government mandated resource rationing reasonable as compared to allowing physicians to decide at the bedside?’ It would be a steep climb indeed to claim that such actions are *per se* unreasonable, but nonetheless a potential area for judicial review.

The class of orders that the provincial cabinet may make during a declared emergency is an enumerated, but not exhaustive list.²⁷⁵ Several classes of orders in particular are relevant to rationing. First, orders may be made implementing emergency plans. If these plans involve rationing of resources or prioritization of recipients, this provides further legal legitimacy to those ‘soft law’ plans seen in Chapter 1. Second, cabinet may make orders to, “prevent, respond to or alleviate the effects of the emergency ... appropriating, using ... of property.”²⁷⁶ Thus, if antiviral medication or other resources are privately held they may be appropriated by the government in order to combat the pandemic. Such takings are not to be considered legal expropriations so as to require compensation by the government.²⁷⁷ Reasonable compensation may be made for losses as a result of the taking, but there is no obligation on the government to do so.²⁷⁸ Likewise, government-held resources (such as vaccines, ventilators or antivirals) may be used in any manner the government deems necessary in order to respond to or alleviate the effects of the pandemic.

A second rationing-relevant order cabinet may make during a declared emergency is the ability to authorize, “facilities ... to operate as is necessary to respond to or alleviate the effects of the emergency.”²⁷⁹ It is not apparent on its face whether such a provision would permit orders to be made requiring hospitals to comply with, for example, triage protocols. It

²⁷⁵ *Ibid.*, s. 7.0.2(4).

²⁷⁶ *Ibid.*, s. 7.0.2(4), para 6.

²⁷⁷ *Ibid.*, s. 13.1(1).

²⁷⁸ *Ibid.*, s. 13.1(3).

²⁷⁹ *Ibid.*, s. 7.0.2(4), para 8.

appears that the provision exists to require power generators and other essential utilities and institutions to operate outside normal hours or staffing requirements. However, the argument could be made that in order to alleviate the effects of a pandemic, it is necessary for a hospital at above-surge capacity levels to implement a triage protocol plan.

Third, and perhaps most relevant, cabinet may make orders regarding, “[u]sing any necessary goods, services and resources within any part of Ontario, distributing, and making available necessary goods, services and resources and establishing centres for their distribution.”²⁸⁰ This provision goes hand-in-hand with the next power: “[p]rocurring necessary goods, services and resources.”²⁸¹ Combined, such orders would seem to encompass purchasing emergency pandemic supplies as well as setting criteria for their use and distribution. This includes not only those goods procured by the government, but seems to cover ‘all goods’, whether or not in government custody.

The language on ‘using’, ‘distributing’ and ‘making available’ is important, as it covers all relevant manner of ensuring resources can be utilized. ‘Distributing’ and ‘making available’ would include providing immunizations and perhaps antiviral medications. Likewise, ‘using’ would certainly encompass setting criteria for the use of ventilators. The provisions restrict any such orders to ‘necessary’, but it is not clear what this term implies. It would seem discretion rests with cabinet to determine what resources are necessary. However, given the vagueness, this may be an avenue for legal challenge.

In addition to the listed classes of orders, the final enumerated paragraph provides cabinet with the power to issue orders, “[c]onsistent with the powers authorized in this subsection, taking such other actions or implementing such other measures as the Lieutenant

²⁸⁰ *Ibid.*, s. 7.0.2(4), para 9.

²⁸¹ *Ibid.*, s. 7.0.2(4), para 10.

Governor in Council considers necessary in order to prevent, respond to or alleviate the effects of the emergency.”²⁸² This is a catch-all provision, demonstrating that the enumerated order classes are not an exhaustive list. Therefore, if particular rationing mechanisms or resources do not easily fit within an enumerated power, there can be little doubt (given the foregoing provision) that cabinet has authority to issue such orders as long as they are necessary to respond to the pandemic (a condition that may be debatable upon review).

The *EMCPA* explicitly provides that it does not affect the rights of a person to seek judicial review for any acts or omissions under the *EMCPA*.²⁸³ The *EMCPA* does provide private law statutory actor immunity to, public servants, ministers, municipal councils, and others for actions made in the good faith exercising (or neglect thereof) of their duties and powers under the *EMCPA* and associated orders.²⁸⁴ Such immunity is only personal immunity, as the Crown is not relieved of liability.²⁸⁵

It is an offence to fail to comply with an *EMCPA* order (issued under section 7.0.2(4)) or obstruct the exercise of a power or duty related to those orders.²⁸⁶ Each day that an offence continues constitutes a separate offence for the purpose of the following penalties.²⁸⁷ Liability on conviction for individuals includes a maximum fine of \$100,000 or imprisonment for not more than one year.²⁸⁸ A corporation is liable for a maximum fine of \$10,000,000.²⁸⁹ And a director or officer of a corporation is liable to a maximum fine of \$500,000 and imprisonment for not more than one year.²⁹⁰ The legislation also empowers

²⁸² *Ibid*, s. 7.0.2(4), para 14.

²⁸³ *Ibid*, s. 7.2(7).

²⁸⁴ *Ibid*, s. 11(1).

²⁸⁵ *Ibid*, s. 11(2).

²⁸⁶ *Ibid*, s. 7.0.11(1).

²⁸⁷ *Ibid*, s. 7.0.11(2).

²⁸⁸ *Ibid*, s. 7.0.11(1)(a).

²⁸⁹ *Ibid*, s. 7.0.11(1)(c).

²⁹⁰ *Ibid*, s. 7.0.11(1)(b).

judges on conviction to increase the maximum fine beyond that stipulated, to an amount not exceeding any financial benefit a person would have received for their contravention.²⁹¹ Any contravention of any orders under the *EMCPA* may also be restrained by to the Superior Court of Justice.²⁹²

As the above breadth of orders demonstrates, there are numerous administrative law principles that would be applicable to the exercise of emergency powers. Of most relevance are conditions precedent and the consideration of factors outside the objectives of the statutes (or in most cases, the specific provision which qualifies how the powers may be used). Therefore, governments would be advised to tread carefully in utilizing these powers and issuing orders so as not to exceed the scope of their lawful jurisdiction.

3.5.2. Federal

The federal government's main public health role arises only in cases of emergencies. The Government of Canada has primary responsibility for emergency response in areas of its constitutional jurisdiction or where assistance has been requested from a province(s). There are two main legislative planks to the federal response to emergencies: the *Emergencies Act (EA)* and the *Emergency Management Act (EMA)*.

3.5.2.1. Emergency Management Act

Under the *EMA*, the Minister of Public Safety and Emergency Preparedness is responsible for coordinating the federal government's 'emergency management' activities across departments and with the provinces.²⁹³ 'Emergency management' is defined as: "the prevention and mitigation of, preparedness for, response to and recovery from

²⁹¹ *Ibid*, s. 7.0.11(3).

²⁹² *Ibid*, s. 7.0.5.

²⁹³ *Emergency Management Act*, SC 2007, c 15, s. 3.

emergencies.”²⁹⁴ The Minister is responsible for, *inter alia*: supervising the preparation, maintenance and testing of government emergency management plans; coordinating the federal government’s response to an emergency; providing non-monetary assistance to provinces; continuity of constitutional government; and any other responsibilities empowered by cabinet.²⁹⁵ The *EMA* also provides that the federal government may not respond to provincially declared emergencies unless requested to do so, or required by an inter-jurisdictional agreement.²⁹⁶

As can be seen, the Minister’s role is broadly preparatory and coordinating in nature, without specific powers to implement any departmental emergency management plans or programs. Instead, the power to implement, and in fact develop, topical emergency plans rests with the respective departmental ministers (as was seen with the Minister of Health and the Public Health Agency of Canada).²⁹⁷ The Minister of Public Safety also does not have direct power to influence content of emergency management plans; therefore, they would be unable to insist on rationing or the adoption of specific sequencing criteria. As well, the *EMA* does not confer legal status on emergency management plans, nor make it an offence to contravene any such plans.

The only potential opportunity for the Minister of Public Safety to control any rationing would be regarding their responsibility for ensuring continuity of constitutional government.²⁹⁸ It seems likely that if they deem it necessary for the continuity of government to vaccinate or provide scarce lifesaving resources during a pandemic to select persons with constitutional authority, they would be within their legal powers and obligations to do so.

²⁹⁴ *Ibid.*, s. 2.

²⁹⁵ *Ibid.*, ss. 4(1), 4(2).

²⁹⁶ *Ibid.*, s. 6(3).

²⁹⁷ *Ibid.*, s. 6(1).

²⁹⁸ *Ibid.*, s. 4(1)(1).

This would be consistent with ‘social worth’ regimes, language which is not found in the stated objectives of any of the public health acts and would certainly be subject to strict judicial review (possibly on correctness).

3.5.2.2. *Emergencies Act*

The *Emergencies Act* replaced the *War Measures Act* and is the federal government’s main vehicle for responding to major emergencies.²⁹⁹ Unlike the *EMA*, the powers under the *EA* are far greater and authorize measures that would normally be considered inappropriate. This is seen in the preamble to the *EA*, which states: “in order to ensure safety and security during such an emergency, the Governor in Council should be authorized, subject to the supervision of Parliament, to take special temporary measures that may not be appropriate in normal times.”³⁰⁰

Of note, the *EA* is explicitly binding on both federal and provincial governments.³⁰¹ This ability of the federal government to intervene in areas that may normally be considered provincial jurisdiction has sound constitutional footing under the Peace, Order and Good Government phrasing found in the preamble to section 91 of the *Constitution Act, 1867*.³⁰² The notwithstanding clause (section 33) of the *Charter* was not invoked as part of the *EA* legislation package, and therefore the statute remains subject to the provisions of the *Charter of Rights and Freedoms*, as the preamble explicitly states.

The *EA* governs the federal response in four emergencies: public welfare emergencies; public order emergencies; international emergencies; and war emergencies. For

²⁹⁹ *Emergencies Act*, RSC 1985, c 22 (4th Supp) [*EA*].

³⁰⁰ *Ibid*, Preamble.

³⁰¹ *Ibid*, s. 2(1).

³⁰² For more detailed analysis of the p.o.g.g. powers see *Reference re Anti-Inflation Act*, [1976] 2 SCR 373; 68 DLR (3d) 452.

the purposes of a pandemic, the only one of relevance is the first – public welfare emergency. A ‘public welfare emergency’ is defined by the *EA* as meaning, “an emergency that is caused by a real or imminent ... disease in human beings ... and that results or may result in a danger to life or property, social disruption ... so serious as to be a national emergency.”³⁰³ Clearly, a pandemic fits the first part of that definition but where it may fail is in the definition of a ‘national emergency’.

A ‘national emergency’ is defined by the *EA* as, “an urgent and critical situation of a temporary nature that ... seriously endangers the lives, health or safety of Canadians and is of such proportions or nature as to exceed the capacity or authority of a province to deal with it ... and that cannot be effectively dealt with under any other law of Canada.”³⁰⁴ Pandemics would seem to apply – they are temporary (albeit less temporary than other emergencies) and seriously endanger the lives of Canadians. The problem that may arise should the federal government seek to rely on the *EA* for jurisdiction during a pandemic, is that it is clear from the preceding study of provincial legislation that provinces do have the capacity to deal with pandemics, as does existing federal law. Therefore, the second part of the test may not be met – existing capacity may be sufficient. Of course, any such conclusion is highly dependant on the nature of the pandemic, but from the retrospective of H1N1, it is possible a similar pandemic would not pass the *EA* test.

Given the potential for ‘inappropriate’ actions resulting from the exercise of *EA*-authorized powers, judicial review will be extremely important in constraining those actions unless the statutory tests have been met. The above definitions implicitly build in opportunities for judicial review, as they function as conditions precedent. If either of the

³⁰³ *EA*, *supra* note 299, s. 5.

³⁰⁴ *Ibid*, s. 3.

definitional tests fail on review, any actions pursuant to the *EA* are *ultra vires* and could be declared invalid.

For the sake of analysis, let us assume that a pandemic fully passes the definitional tests, so as to constitute a public welfare emergency under the *EA*. If the Governor in Council (federal cabinet) believes on reasonable grounds that such an emergency exists, a declaration of a public welfare emergency may be made.³⁰⁵ Any declaration must meet additional formal requirements, including consultations with affected provincial governments.³⁰⁶ The declaration must also state what temporary measures are believed necessary to address the emergency and the parts of Canada over which the declaration is to apply.³⁰⁷ Any such declaration is immediately effective, but must be confirmed by Parliament within seven sitting days.³⁰⁸ The initial effective period of a declaration is a maximum of ninety days.³⁰⁹ A declaration may be revoked by cabinet at any time.³¹⁰ Parliament may also revoke a declaration either by a direct revocation or by voting down a confirmation of a declaration of emergency.³¹¹ Unlimited continuances of public welfare emergency declarations may be issued for periods of up to ninety days.³¹²

Pursuant to a ‘declaration of a public welfare emergency’, cabinet may make orders and regulations reasonably believed to be necessary to deal with the emergency. The subject of such orders may include, *inter alia*: travel and movement restrictions; ordered evacuations; requisition and use of property; direction to qualified individuals to render

³⁰⁵ *Ibid*, s. 6.

³⁰⁶ See e.g. *ibid*, s. 14(1).

³⁰⁷ *Ibid*, s. 6(2).

³⁰⁸ *Ibid*, ss. 7(1), 58(1).

³⁰⁹ *Ibid*, s. 7(2).

³¹⁰ *Ibid*, s. 11.

³¹¹ *Ibid*, ss. 58(7), 59.

³¹² *Ibid*, s. 12.

essential services; and establishment of emergency shelters and hospitals.³¹³ Most relevant to pandemic rationing is the ability to make regulations and orders regarding, “the regulation of the distribution and availability of essential goods, services and resources.”³¹⁴ If vaccines and other scarce lifesaving resources can be considered essential goods, then the federal government may control their distribution via prioritization guidelines. This can occur only under a formally declared *EA* emergency, and only if believed to be reasonably necessary to alleviate the emergency – a plethora of conditions precedent.

The *EA* specifies that any orders or regulations made in the event of a public welfare emergency are to function concertedly with provincial efforts and are not be exercised, “in a manner that will not unduly impair the ability of any province to take measures.”³¹⁵ In fact, a declaration of a public welfare emergency may not be made if the emergency is confined to only one province, unless the relevant provincial government states that the, “emergency exceeds the capacity or authority of the province to deal with it.”³¹⁶ All these statutory restrictions on discretion and procedural requirements again suggest that judicial review of executive action is likely to be a promising avenue of challenge however indeterminate the results may be.

In order to enforce any regulations or orders made under the foregoing provisions, cabinet may provide, for contravention of any order or regulation, the imposition of summary conviction penalties (maximum \$500 fine or six months imprisonment, or both) or indictment penalties (maximum \$5000 fine or five years imprisonment, or both).³¹⁷ Control over police forces for enforcement of any contraventions remains with the provinces or

³¹³ *Ibid.*, s. 8(1).

³¹⁴ *Ibid.*, s. 8(1)(e).

³¹⁵ *Ibid.*, s. 8(3).

³¹⁶ *Ibid.*, s. 14(2).

³¹⁷ *Ibid.*, s. 8(1)(j).

municipalities as the case may be, and the *EA* does not authorize derogating such control.³¹⁸ Therefore, any federal enforcement attempts may be limited.

Section 47(1) of the *EA* provides personal immunity to ministers and Crown actors for any act or omission in the good faith exercise of their duties and powers pursuant to orders or regulations.³¹⁹ The Crown itself remains liable for any actions for which personal immunity is granted.³²⁰ Also, the federal Crown must – not may – grant, “reasonable compensation to any person who suffers loss, injury or damage as a result of any thing done, or purported to be done, under ... any proclamation, order or regulation.”³²¹

As this section has shown, the powers and responsibilities of the federal government are much less comprehensive and specific to rationing than their provincial counterparts. The federal government’s primary legal ability to ration, let alone respond generally during pandemics, exists only if a national public welfare emergency is declared pursuant to the *Emergencies Act*. Such a declaration is highly unlikely to be made given that the conditions for declaration would not be met during a mild pandemic, as provinces would be most capable to respond and federal government assistance would not likely be superior to their own. The multitude of conditions precedent and formal requirements suggests that, if the *EA* were relied on, administrative review could be a propitious area for legal challenge.

3.6. Conclusion

It is clear that all levels of government have a breadth of statutory powers to rely on in promulgating and enforcing rationing decisions in the course of a pandemic. Those powers can often be considered extreme (as compared to normal functions of government and

³¹⁸ *Ibid.*, s. 9(1).

³¹⁹ *Ibid.*, s. 47(1).

³²⁰ *Ibid.*, s. 47(2).

³²¹ *Ibid.*, s. 48(1).

relations between the government and the citizenry); and so it is no surprise that enabling statutes contain many conditions precedent and other qualifications to action. As such, judicial review of rationing by delegated actors is a strong possibility, likely demanding searching levels of inquiry by the courts to match the powers and the potential for abuse. While administrative law may be most promising in terms of the sheer number of potential areas of challenge, its predictive success is uncertain due to the lack of analogous cases considered to date. Instead, private law may offer a more determinate level of success (or lack thereof).

Chapter 4

Private Law Challenges

4.1. Introduction

In addition to administrative law challenges of executive action, governments may also be sued in private law for negligently making or implementing rationing decisions. It is possible suits may be brought if death or harm befalls individuals and they believe it was because they did not receive necessary resources on time, due to negligently created or operated government-mandated rationing programs.³²² Similar actions may also be brought against physicians and hospitals if supply-constraints result in delivery of substandard care.

Such suits are not new to the public health realm, occurring both during the West Nile Virus outbreak and SARS in Toronto, though not in relation to rationing. Both public health crises spawned law suits, and those instances coupled with existing case law, suggest governments will likely not be held liable in tort for rationing decisions, due to duty of care issues and a distinction between ‘policy’ and ‘operational’ decisions.

In the first part of this chapter, the primary focus will be on the potential negligence liability of provincial and federal governments for promulgating rationing/priority guidelines. In this regard, past jurisprudence arising from SARS and West Nile Virus suggest the turning point of any liability analysis will be on whether the government in its public health capacity, is sufficiently proximate to individual plaintiffs such that a private law duty of care arises. Current case law suggests that no private law of duty would be owed to private citizens.

³²² While beyond the scope of this thesis, it is possible that if delegated actors acted with the intent of wrongdoing or bad faith, the tort of misfeasance of public office may be triggered. For a more detailed analysis of this tort, see Wruck, *supra* note 164.

Second, even if a duty of care were found, rationing decisions may be exempt from liability due to the legal distinction between ‘operational’ and ‘policy’ decisions. While the law in this area is unclear, it seems likely that the act of making rationing guidelines would be ‘policy’, thereby exempting upper-tier governments from liability. On the other hand, implementation of those guidelines would trigger a full-fledged liability analysis, involving the additional elements of negligence claims – standard of care, causation and damages.

The remainder of the chapter will examine possible tort liability of hospitals and physicians. Hospitals do not owe a duty to patients to provide a reasonable level of care and therefore there would be no cause of action. On the other hand, it is widely recognized that physicians do owe a duty of care to patients, and thus the analysis will turn on whether the standard of care was breached. That is, did abiding by rationing protocols result in the provision of substandard of care? As courts appear to apply a contextualized standard of care, it seems unlikely that private law liability will be found, at either the institution or health care provider level.

4.2. Key Elements of the Tort of Negligence

Tort law can be considered a predominantly compensatory/corrective regime: justice is achieved when the wronged party is returned to the original position they would have been in but for the defendant’s negligence. However, compensation is not the only goal of tort law (though many academics quibble with the normative implications of such a statement).

Deterrence must also be considered an element of tort law, and it will exist regardless of whether it is an explicit goal as it flows naturally from compensating injured parties.

Economically rational actors, and in the case of governments politically rational, seek to reduce liability exposure and will do so when it is economically (or politically) efficient.

Thus, tort law sets a legal standard that governments and others must meet. Falling below the standard will result in liability, and therefore, it is assumed, they will seek to avoid doing so.

The private law tort of negligence is founded in common law principles. There are four essential elements for a court to find negligence, each of which must be proven on a balance of probabilities:

- (a) the defendant owed the plaintiff a legal duty of care;
- (b) the defendant breached that duty of care;
- (c) the plaintiff suffered legally recognized damage/harm; and
- (d) the damage was caused by the defendant's breach of the duty of care.³²³

As subsequent sections will show, any potential tort action for rationing in pandemics will likely fail on the first (if proceedings are brought against governments as policy-setters, or hospitals) or second elements (if brought against physicians). Failure on either of the first two elements would halt any further judicial consideration of the remaining factors, but it is obvious that the plaintiff must have suffered some harm (capable of being compensated) as a result of rationing decisions such as morbidity or mortality. Finally, any alleged substandard actions must have directly caused those harms suffered by the plaintiff. If all four elements are found, governments, physicians and others may be held liable.

4.3. Sovereign Immunity & Proceedings against the Crown

At common law, governments (as embodiments of the Crown) enjoy sovereign immunity from tort claims. This traditional common law approach has largely been abandoned through statutory modification. Such statutes waive the Crown's traditional

³²³ Bernard Dickens, "Medical Negligence" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 3d ed (Markham: LexisNexis, 2007) at 103.

immunity. For example, the *Proceedings Against the Crown Act (PACA)* in Ontario subjects the Crown to liability as a capable and full-aged person.³²⁴

The *PACA* stipulates what actions in tort lie against the Crown, as if it were a person of full age and capacity.³²⁵ Specifically, the Crown would be subject in tort to the following actions:

- (a) in respect of a tort committed by any of its servants or agents;
- (b) in respect of a breach of the duties that one owes to one's servants or agents by reason of being their employer;
- (c) in respect of any breach of the duties attaching to the ownership, occupation, possession or control of property; and
- (d) under any statute, or under any regulation or by-law made or passed under the authority of any statute.³²⁶

Furthermore, no proceeding lies against the Crown in tort for the acts or omissions of a servant/ agent unless a proceeding would also lie personally against same servant/agent.³²⁷

In other words, unless the person who committed the tort would be liable, the Crown is not liable.

The scope of statutes such as the *PACA* is limited in waiving statutory immunity in several key areas.³²⁸ First, the *PACA* does not open the Crown to liability exceeding that which would apply to a natural person. Second, causes of action may not be brought against the Crown if they instead lie against a Crown agency or corporation. Third, actions brought against the Crown as a result of acts or omissions of employees (including ministers of the Crown) may only be brought if the employee (or 'servant', as the statute states) was actually appointed to that position. Finally, the Crown, through the *PACA* and similar legislation,

³²⁴ *Proceedings Against the Crown Act*, RSO 1990, c P-27 [*PACA*].

³²⁵ *Ibid.*, s. 5(1).

³²⁶ *Ibid.*

³²⁷ *Ibid.*, s. 5(2).

³²⁸ *Ibid.*, s. 2(2).

does not waive its sovereign immunity respecting, “the due enforcement of the criminal law or of the penal provisions of any [a]ct of the [l]egislature.”³²⁹

The liability of Crown servants may also be directly curtailed or protected by legislation. As was seen in virtually every emergencies or public health statute examined thus far, statutes confer personal immunity on government actors exercising their powers, duties or obligations (or failing to act) in good faith. Thus, civil suits cannot be successfully launched against those individuals (as individuals *per se*) for their actions. The *PACA* also provides that if personal tort liability of a servant or agent is limited by legislation, then the Crown is similarly protected.³³⁰ Therefore, given the language of the *PACA* and personal immunity provisions of various statutes, the conferring of personal immunity to Crown actors would appear to confer complete immunity on the Crown itself.

However, sections subsequent to the personal immunity protections in the legislation examined claw away Crown (not personal) immunity from the immediately preceding *PACA* provision. Thus, public health and emergencies statutes, while providing personal immunity to Crown actors, re-provides for direct Crown liability. Such provisions explicitly state they apply notwithstanding the sections of the *PACA* that relieve the Crown of liability. For example, the *Emergency Management and Civil Protection Act* provides that despite sections 5(2) and 5(4) of the *Proceedings Against the Crown Act*, the Crown is not relieved of liability, “for the acts omissions of a minister of the Crown or a public servant ... and the Crown is liable under that Act as if ... [the foregoing section] had not been enacted.”³³¹ This

³²⁹ *Ibid.*, s. 2(2)(d).

³³⁰ *Ibid.*, s. 5(4).

³³¹ *EMCPA*, *supra* note 249, s. 11(2).

is not the case under the *RHPA*, where the Crown is also granted immunity for good faith actions.³³²

A unique situation arises when government actors are also physicians, such as local medical officers of health and provincial chief medical officers of health. In terms of personal liability for negligence, are they held to different standards because they are physicians (and required to be so for their appointment)? As physicians, the common law standard of care is generally that of reasonable professional competence. However, as some commentators have noted, the statutory provisions providing personal immunity effectively (and as they argue, inappropriately) alter the traditional common law standard of care of those physicians to one of simple ‘good faith’.³³³ The overall liability of physicians will be explored in more detail later in this chapter.

Any claims against government pursuant to the *PACA* would by definition have to be made after the pandemic. In the event persons wished to claim the government was negligent in rationing of lifesaving resources such as vaccines, the negligent decision would have already been made and any finding of a court on negligence would not alter any such decision. The time delay is also amplified by the requirement in the *PACA* that any notice of claim must be served on the Crown at least sixty days before the commencement of an action.³³⁴ Given the delay in commencing an action against the Crown, and by its very nature, any action would only be compensatory and would not rectify the situation during a public health crisis. The compensation-only reality is further solidified by the *PACA* which prohibits the granting of injunctory relief or specific performance and, “in lieu thereof may

³³² *RHPA*, *supra* note 168, s. 38.

³³³ Andrew Flavelle Martin, “Statutory Good-Faith Immunity for Government Physicians: Cogent Policy or a Denial of Justice?” (2011) 4:2 McGill JL & Health 75-97.

³³⁴ *PACA*, *supra* note 324, s. 7(1).

make an order declaratory of the rights of the parties.”³³⁵ Therefore, unless a settlement is agreed upon that alters a rationing priority group so as to include the claimant, no action against the Crown will provide an affected person with the recourse of receiving the resource in question, only compensatory money or declaratory relief.³³⁶ And, that is only if negligence is proven and liability found against the Crown which, as the next section will show, is unlikely to be the case.

4.4. Liability of Governments in Negligence for Pandemic Rationing

Government decisions regarding rationing in pandemics (and the implementation of those decisions) may open the government to private law liability in tort.³³⁷ A potential plaintiff may be someone who believes rationing or sequencing guidelines were negligently crafted or implemented. For example, it may be argued that if the goal is to protect the public’s health and reduce morbidity and mortality, school-aged children should have been vaccinated first or other claims along similar lines. Of course, the plaintiff must have personally suffered some legally cognizable harm as a result of those decisions.

Past cases considering the government’s liability in responding to the public health threats of SARS and West Nile Virus show that the central issue is one of duty of care: does the government owe a private law or public law duty of care to the citizenry? Further complicating this analysis are courts’ hesitations in holding governments liable for ‘policy’ decisions, as opposed to ‘operational’ ones. These issues will be explored below.

³³⁵ *Ibid*, s. 14(1).

³³⁶ As mentioned in the introduction to this section, compensation also acts to deter substandard conduct, and therefore the threat of potential liability may be sufficient to discourage actions by the government that would open them to liability.

³³⁷ Likewise, physicians may also find themselves defendants in malpractice suits for rationing decisions, should they be involved in making them. Any such case would rely on the same duty of care, standard of care, and causation analysis typical of common law malpractice claims.

4.4.1. Duty of Care

4.4.1.1. *The Cooper-Anns Test*

There is a preponderance of existing case law on the key elements of negligence claims. The leading test for the first element of negligence – duty of care – was set down by a series of cases starting with the House of Lords decision in *Anns v. Merton London Borough Council*, and continuing through the Supreme Court of Canada cases of *Kamloops v. Nielsen* and *Cooper v. Hobart*.³³⁸

Before applying the *Cooper-Anns* test as it is known, courts must determine if existing case law recognizes the duty of care alleged by the plaintiff. If so, then a duty of care exists and a full analysis in that regard is not necessary. If not, then a full *Cooper-Anns* two-stage analysis is warranted to investigate the novel claim.

The first stage of the test investigates the relationship between the plaintiff and defendant, and involves an examination of proximity, foreseeability and policy. Policy considerations at this stage are only concerned with the relationship between the parties and not external factors. As the next section will show, most claims to date involving the public health role of governments have been struck on this matter, with courts finding there is insufficient proximity between the public health authority and the individual plaintiff to ground a private law duty of care.

In the unlikely event a *prima facie* duty of care is found under stage one, the second stage of the test is undertaken and involves looking at external residual policy concerns that would militate against recognizing a novel duty of care.³³⁹ Such policy considerations would

³³⁸ *Anns v Merton London Borough Council*, [1977] 2 All ER 492 (HL); *Kamloops (City) v Nielsen*, [1984] 2 SCR 2; *Cooper v Hobart*, [2001] 3 SCR 537.

³³⁹ *Cooper*, *ibid* at para 30.

include the desire to immunize government ‘policy’ decisions from tort liability.³⁴⁰ This has led to a judicially recognized dichotomy between ‘policy’ and ‘operational’ decisions, with only the former attracting immunity. This is the primary focus of the second part of this section, drawing on a critical review of jurisprudence to show that setting rationing guidelines is likely to fall within the realm of decisions constituting ‘policy’, whereas the implementation of those guidelines are ‘operational’.

4.4.1.2. Proximity

Assuming a tort claim against the government for pandemic rationing would not fall within a recognized category of duty of care, a full *Cooper-Anns* test would be necessitated. As the case law shows, the key issue in any such analysis will likely be the issue of proximity. Proximity is necessary for finding a duty of care because if the parties are not sufficiently proximate it would be unfair and unjust to impose a legal requirement on the defendant to be mindful of the plaintiff’s interests.³⁴¹ Unfortunately, there is no single test for proximity, nor is there a single factor that must be considered in the analysis.³⁴²

To date, the key proximity consideration in public health-related cases has been whether a private individual or class of individuals is sufficiently proximate to the government authority as defendant. In leading and early cases on the issue, the Supreme Court has found that regulatory bodies are generally too far removed from plaintiffs to create a private law duty of care. For example, in *Cooper*, the Supreme Court held that the statutory duty of the Registrar of Mortgage Brokers was owed to the public at large, not individual investors. Likewise, in *Edwards v. Law Society of Upper Canada*, the Supreme Court found

³⁴⁰ *Ibid* at para 38.

³⁴¹ *Ibid* at paras 32 - 34.

³⁴² *Ibid* at para 35.

the Law Society was not sufficiently proximate to individuals placing trust funds with solicitors so as to create a private law duty of care.³⁴³

As the Supreme Court made clear in *Cooper*, the statutory scheme authorizing the public decision-making in question is the initial point of the proximity analysis. This is because the stated objectives of the statute(s) are highly determinative of the duties and obligations owed by the government entity. As Chapter 3 showed, there are numerous statutes available for the government to rely on for rationing during a pandemic. However, it is likely the *HPPA* will be most relied on, and fortunately, there is existing case law where that statute was analyzed.

In the first case of relevance – *Eliopoulos Estate v. Ontario* – the plaintiff became infected with West Nile Virus (WNV) after being bitten by a mosquito in Mississauga.³⁴⁴ The plaintiff's estate alleged the provincial government should have prevented the 2002 outbreak of WNV, or in the alternative, managed it better. Areas of alleged negligence included, *inter alia*: the failure to effectively and adequately implement the province's WNV plan; failure to take measures to control the mosquito population; failure to provide accurate information to the public about WNV; and a failure to coordinate the province's response to WNV.

Motions were brought by the defendant to dismiss the claim as disclosing no reasonable cause of action, which were rejected. The central issue on appeal then was whether the province owed a private law duty of care to the plaintiff to take reasonable steps to prevent the spread of WNV – a question of proximity. The defendant province submitted that if any duty were owed it was to the general public, not specific individuals, and that any

³⁴³ *Edwards v Law Society of Upper Canada*, [2001] 3 SCR 562.

³⁴⁴ *Eliopoulos Estate v Ontario (Minister of Health and Long-Term Care)*, [2006] OJ No 4400, leave to appeal to SCC refused, [2006] SCCA No 514.

liability on the ‘operational’ level (implementing policy) should rest with local boards of health and not the provincial government (a dichotomy that will be explored in the next section).

The Ontario Court of Appeal found the claim was not sufficiently analogous to a recognized set of cases where a duty of care had been found: “[t]here is plainly no category of cases that supports the respondents’ assertion that Ontario owes a private law duty to protect all persons within its boundaries from contracting a disease.”³⁴⁵ Therefore, the analysis turned on whether there was a novel duty of care that could be found on the facts of the case, using the two-part *Cooper-Anns* test.³⁴⁶

The Ontario Court of Appeal first turned to the provisions of the *HPPA* to determine whether the statutory scheme created a sufficiently proximate duty of care solely on its terms. The Court held that the *HPPA* created only discretionary powers in the Minister of Health and Long-Term Care to act in the public interest, if they so chose to exercise those powers.³⁴⁷ The Court concluded there was a public law duty, “that requires the Minister to endeavour to promote, safeguard, and protect the health of Ontario residents and prevent the spread of infectious diseases.”³⁴⁸ However, as the Minister’s powers and duties were not mandatory, the public law duty of care could not be extended to a private law duty owed to the specific plaintiff. In other words, a mandate to act in the broad public interest does not equate to a duty to a particular private person. The lack of nexus between the plaintiff and defendant was extensive, as the duties of the Minister were owed to the public at large and not even a

³⁴⁵ *Ibid* at para 12.

³⁴⁶ *Ibid* at para 10.

³⁴⁷ *Ibid* at para 17.

³⁴⁸ *Ibid*.

specific class of the public (such as mortgage investors), as was the case in *Cooper* where a duty of care was also not found.³⁴⁹

The Court in *Eliopoulos* wrote:

This case is concerned with a general risk faced by all members of the public and a public authority mandated to promote and protect the health of everyone located in its jurisdiction. The risk of contracting a disease that might have been prevented by public health authorities is a risk that is faced by the public at large. It is a much more generalized risk than the type faced by mortgage investors or clients of lawyers. Moreover, the nexus or relationship between a member of the public who contracts WNV and the Minister is more attenuated than the nexus or relationship between a mortgage investor and the regulator of mortgage brokers or a client and the regulator of the legal profession.³⁵⁰

In a similar case – *Williams v. Ontario* – a 2009 Ontario Court of Appeal decision decided contemporaneously with four similar appeals, it was established that persons infected with SARS during the 2003 outbreak could not hold the province liable in private law.³⁵¹ The case was a proposed class action with the class being all persons who contracted SARS in Toronto or from a person from Toronto, and their families. Andrea Williams, the representative plaintiff, contracted SARS during the second wave of the outbreak as a surgical patient in late May 2003. The defendant Ontario government sought to strike the claim as disclosing no reasonable cause of action because they argued, along the lines of *Eliopoulos*, they owed no private law duty of care to the plaintiffs.

Many of the powers exercised by the government during the SARS crisis are similar to those that may be applicable in the course of a pandemic. For example, SARS was declared a reportable and communicable disease pursuant to the *HPPA*, and the Premier of Ontario, operating under the then-*Emergency Management Act*, declared SARS a provincial emergency. Toronto-area hospitals were ordered by the Minister of Health to implement

³⁴⁹ *Ibid* at paras 19 - 20.

³⁵⁰ *Ibid* at para 20.

³⁵¹ *Williams v Ontario*, 2009 ONCA 378, [2009] OJ No 1819.

emergency plans, effectively shutting down except for essential services. Likewise, directives were issued by the CMOH (pursuant to the *HPPA*) to hospitals regarding protective gear, disease reporting, limiting non-urgent care and controlling the movement of persons on hospital premises. Eventually, such infection control measures were gradually eased. It was this easing the plaintiffs alleged was negligent and causative of the second outbreak. Other allegations of negligence include that the province prematurely lifted the state of emergency, failed to maintain a proper public health system to deal with outbreaks, and failed to issue proper directives to hospitals.³⁵²

In its analysis, the Ontario Court of Appeal found it necessary to undertake a full duty of care analysis under the *Cooper-Anns* rubric. Like in *Eliopoulos*, foreseeability of harm was not at issue, proximity was.³⁵³ The Court started by canvassing existing case law on the protection of the public interest by health-related regulatory authorities and noted that all of the cases emphasized that the duty of government is to the public as a whole and not specific persons. The Court concluded that decisions of government actors during the SARS crisis were analogous to those in cases where a private law duty of care was rejected (such as *Eliopoulos*). Therefore, the Court held, no private law duty of care or cause of action existed and the first stage of the *Cooper-Anns* duty of care test was not met.³⁵⁴ There was simply insufficient proximity to ground a finding of a *prima facie* duty of care.

In an attempt to distinguish their case, the plaintiffs in *Williams* unsuccessfully argued that the representative plaintiff was not simply a member of the public at large, but of a smaller identifiable class giving rise to sufficient proximity. The same argument may be made regarding pandemic rationing if there are classes of persons identified as more

³⁵² *Ibid* at para 7.

³⁵³ *Ibid* at para 21.

³⁵⁴ *Ibid* at para 34.

susceptible to severe illness and rationing plans do not prioritize those persons. Such lines of argument in *Williams* were based on findings of duties of care in relation to mortgage investors and those dealing with lawyers (in the cases of *Cooper* and *Edwards* respectively).

The Court addressed this argument by stating:

The fact that the plaintiff contracted SARS while she was in the hospital does not put her in a narrow class of individuals in a direct relationship with Ontario. Moreover, as in *Eliopoulos*, the proximity between the province and one who happens to visit a hospital is considerably more remote than the proximity between individuals dealing with lawyers and mortgage brokers and the public authorities charged with the duty to regulate and monitor those very dealings, as in *Cooper* and *Edwards*.³⁵⁵

Therefore, applying the same logic to pandemic rationing, it is doubtful proximity would be found in such a case, as the duty would remain owed to the public at large. This is emphasized by the Court's opinion that, "[d]ecisions relating to the imposition, lifting or re-introduction of measures to combat SARS are clear examples of decisions that must be made on the basis of the general public interest rather than on the basis of the interests of a narrow class of individuals."³⁵⁶

Unlike in *Eliopoulos*, the plaintiffs in *Williams* also argued that the directives issued by the Chief Medical Officer of Health injected the provincial government sufficiently into the management of the crisis so as to pass the proximity hurdle.³⁵⁷ The Court agreed that the directives were more detailed than the West Nile Virus response plan and were mandatory in nature. However, the Court disagreed that this fact had any bearing on the issue of proximity. The Court wrote: "[i]t is simply not arguable in law that by promulgating these quasi-legislative standards to hospitals and health care workers, Ontario created a relationship of proximity with the plaintiff sufficient to give rise to a private law duty of care."³⁵⁸

³⁵⁵ *Ibid* at para 30.

³⁵⁶ *Ibid* at para 31.

³⁵⁷ *Ibid* at para 22.

³⁵⁸ *Ibid* at para 28.

That last statement is highly instructive for rationing in pandemics. In order to mandate rationing, governments may be forced to promulgate standards to hospitals, public health boards and health care practitioners. The decision in *Williams* strongly suggests such standards would not ground a finding of proximity and a corresponding private law duty of care. Thus, it seems provincial governments may utilize many of the statutory powers outlined in Chapter 3 without fear they will expose themselves to liability.

The question that remains after considering *Eliopoulos* and *Williams* is whether the proximity analysis changes if the plaintiffs are not members of the general public, but healthcare workers? Such a situation was considered and disposed of in *Abarquez v. Ontario*, heard and decided together with *Williams*, in which a group of nurses and their families claimed the province was liable for damages suffered as a result of contracting SARS.³⁵⁹ The plaintiffs claimed the directives issued to hospitals by the province's Chief Medical Officer of Health were inadequate and risk-exposing; the directives were not adequately enforced; and timely information about SARS was not provided.³⁶⁰ The plaintiffs also argued that the holdings in *Williams* and *Eliopoulos* do not apply to their claims because the proximity analysis is different, as the class of plaintiffs was not simply members of the public but nurses with direct patient contact making them particularly vulnerable to contracting SARS.³⁶¹ Furthermore, they had no choice but to follow the provincial directions that applied to their workplaces. Therefore, the plaintiffs argued, proximity was established by reasonable reliance: Ontario should have been mindful of their interests when they issued directives directly intervening in the daily operations of hospitals.³⁶²

³⁵⁹ *Abarquez v Ontario*, 2009 ONCA 374, [2009] OJ No 1814.

³⁶⁰ *Ibid* at para 7.

³⁶¹ *Ibid* at para 9.

³⁶² *Ibid* at para 18.

Ultimately, the Court rejected the proximity claims on the same basis as in *Williams* and *Eliopoulos* by stating: “[n]urses were, by virtue of their profession, in the eye of the SARS storm, but they had no higher claim to have their health protected by Ontario than any other resident of the province.”³⁶³ The Court went on to hold that the increased risk of infection of nurses was by virtue of their profession, “not a risk Ontario created when it promulgated the Directives or determined how to deal with the SARS problem.”³⁶⁴

Any finding of a private law duty of care would also potentially conflict with the CMOH’s main concern when promulgating directives – the broader public interest. As the Court stated: “[w]here recognizing a private law duty of care on the part of a public authority towards a certain class of individuals could conflict with the public authority’s overarching duty, proximity does not exist and no private law duty should be found.”³⁶⁵

The duty to the public at large, and courts’ willingness to protect difficult decisions made in the good faith defense of the public interest, can also be seen in courts’ appreciation of the weighing of competing interests. As was found in *Abarquez*, the weighing of competing interests in order to arrive at a position that best satisfies the public interest militates against finding a private law duty of care and public decision-makers will be given wide legal latitude to do so. Likewise, the Court in *Williams* stated:

[A] decision to lift restrictions may increase the risk of the disease spreading but may offer other advantages to the public ... public officials charged with the responsibility for imposing and lifting such measures must weigh and balance the advantages and disadvantages and strive to act in a manner that best meets the overall interests of the public at large.³⁶⁶

Therefore, it appears evident that in a potential legal challenge to rationing guidelines or directives promulgated under the *HPPA* (or using similar discretionary powers), it is

³⁶³ *Ibid* at para 20.

³⁶⁴ *Ibid* at para 24.

³⁶⁵ *Ibid* at para 27.

³⁶⁶ *Williams*, *supra* note 351 at para 31.

highly unlikely that a private law duty of care would be found due to insufficient proximity between the public health authority (acting in the broader public interest) and a private plaintiff. Thus, any negligence suit against the government for rationing decisions or the provision of scarce resources may fail at the outset as disclosing no reasonable cause of action.

4.4.1.3. Policy/Operational Dichotomy

In the unlikely event proximity is found, the second step of the *Cooper-Anns* test must be applied. That is, are there external policy reasons to limit the scope of liability? Perhaps the single largest relevant consideration under the second stage of the test is the traditional exemption courts have given government ‘policy’ decisions (the setting of policy, not the implementation of such) from common law tort liability. ‘Operational’ decisions are not as exempt. As Woodall notes, immunity provided to ‘policy’ decisions has traditional underpinnings in conceptions of sovereign immunity.³⁶⁷ In reviewing the historical development of the policy-operational distinction from early US jurisprudence, Woodall notes that the original dichotomy was between ‘operational’ decisions and those considered to be ‘discretionary’.³⁶⁸ In outlining the modern dichotomy, McLachlin, J. wrote in *Swinamer*:

There is no private law duty on the public authority until it makes a policy decision to do something. Then, and only then, does a duty arise at the operational level to use due care in carrying out the policy. On this view, a policy decision is not an exception to a general duty, but a precondition to the finding of a duty at the operational level.³⁶⁹

³⁶⁷ M Kevin Woodall, “Private Law Liability of Public Authorities for Negligent Inspection and Regulation” (1992) 37 McGill J 83-143 at para 11.

³⁶⁸ *Ibid* at para 10.

³⁶⁹ *Swinamer v Nova Scotia (Attorney General)*, [1994] 1 SCR 445 at 450.

In regards to rationing, the question for this section thus becomes: does the setting and promulgating of rationing/priority sequencing guidelines constitute a ‘policy’ or ‘operational’ decision?

While the foundations for the modern policy-operational dichotomy began with the House of Lords’ decision in *Anns*, the Supreme Court first expounded on the distinction’s development in a trio of cases beginning with *Just v. British Columbia*.³⁷⁰ The plaintiff in *Just* was a man who suffered severe injuries and the loss of his daughter’s life when a boulder came loose on the side of a highway, rolling down onto their car. He alleged the province was negligent in its inspections of the highways. In *Brown*, the plaintiff’s car crashed as a result of skidding on black ice.³⁷¹ The plaintiff alleged the province was negligent in maintaining the highway free of black ice, as road sanding crews were still on a reduced summer schedule. Finally, in *Swinamer* the plaintiff was injured when a tree fell on his truck while traveling on a provincially-maintained highway and sued the province for negligence in the creation and adoption of its tree-removal policy.³⁷² In all three cases, it was conceded that there was a duty of care on the province to maintain the roadways in question. This is easily contrasted with the public health case analysis in the preceding section where it was established there is no private law duty of care. The ‘policy’ versus ‘operational’ distinction was also considered to a lesser extent in both *Eliopoulos* and *Williams*.

In *Just*, the Supreme Court of Canada followed a two-step analysis once a *prima facie* duty of care had been found. First, the legislation was examined to determine if the province was under an obligation to maintain the highways or whether there were statutory exemptions from liability for failure to maintain them. The Court found that the maintenance

³⁷⁰ *Just v British Columbia*, [1989] 2 SCR 1228.

³⁷¹ *Brown v British Columbia (Minister of Transportation and Highways)*, [1994] 1 SCR 420.

³⁷² *Swinamer*, *supra* note 369.

of highways was discretionary.³⁷³ The Court then turned its analysis to a determination of whether or not the province is exempt from liability as a result of the negligence in question relating to a ‘policy’ decision. In this regard, the Court held that the method of inspections were not ‘policy’ decisions –and instead ‘operational’ decisions, ordering a full standard of care analysis at a new trial.³⁷⁴

Analysis of the enabling public health legislation shows that government maintains wide discretion in the provision of health care resources and is not under any obligation to provide them to all persons. Consistent with the principles enunciated in *Just*, if they were under a statutory obligation to provide certain services to a certain standard that would end the matter there. Likewise, an explicit statutory exemption from liability would have the same effect, but a different result. Neither are present in the case of the *HPPA* and similar statutes, where statutory obligations are limited, making it challenging to prove governmental authorities failed to discharge their duties.

In beginning its ‘policy’ versus ‘operational’ analysis, the Supreme Court in *Just* acknowledged growing involvement of government in every aspect of daily life, thereby making historical Crown immunity legally intolerable and leading to statutes (such as the *Proceedings Against the Crown Act*) which treat the government as a natural person for matters of tort liability.³⁷⁵ The Court noted: “the Crown is not a person and must be free to govern and make true ‘policy’ decisions without becoming subject to tort liability as a result of those decisions.”³⁷⁶ The Court went on to state that not all government decisions can be classified as ‘policy’. Instead, the challenge facing courts is to distinguish between cases of

³⁷³ *Just*, *supra* note 370.

³⁷⁴ *Ibid.*

³⁷⁵ *Ibid* at para 16.

³⁷⁶ *Ibid.*

true ‘policy’ decisions and those government decisions which are ‘operational’. The distinction is important because the former, “should be exempt from tortious claims so that governments are not restricted in making decisions based upon social, political or economic factors.”³⁷⁷

In summarizing the policy/operational distinction, Cory, J. for the majority wrote:

In determining what constitutes such a policy decision it should be borne in mind that such decisions are generally made by persons of a high level of authority in the agency, but may also properly be made by persons of a lower level of authority. The characterization of such a decision rests on the nature of the decision and not on the identity of the actors. As a general rule, decisions concerning budgetary allotments for departments or government agencies will be classified as policy decisions. Further, it must be recalled that a policy decision is open to challenge if it is not made in the bona fide exercise of discretion. If after due consideration it is found that a duty of care is owed by the government agency and no exemption by way of statute or policy decision-making is found, a traditional tort analysis ensues and the issue of standard of care required of the government must next be considered.³⁷⁸

The judgment of Cory, J. in *Just* stipulates broad indicia that militate in favour of finding that a decision is ‘policy’ such as those involving budgetary allocation decisions and decisions made by high levels of authority. The latter essentially encompass ‘threshold decisions’ – the initial decision whether to do anything at all.³⁷⁹ Then, once the decision is made to inspect or ration, as the case may be, it must be carried out non-negligently. In *Just*, it was ultimately held at the re-trial ordered by the Supreme Court that the inspection system was negligent for not including a climbing inspection.

Outside of providing the example of budgetary allotments and lighthouse inspections, the Court in *Just* provided little concrete guidance on what characteristics of a decision make it ‘policy’ in nature. Nor did the Court turn its mind to what ‘bona fide exercise of discretion’ means. The result, as Woodall notes, is that ‘policy’ is whatever courts happen to say it is in

³⁷⁷ *Ibid* at para 18.

³⁷⁸ *Ibid* at para 29.

³⁷⁹ Lewis Klar, “Case Comment: Falling Boulders, Falling Trees and Icy Highways: The Policy/Operational Test Revisited” (1994) 33 *Alta L Rev* 167.

the given case, with no general applicable rule or philosophy.³⁸⁰ He posits that, “finding that a decision is by nature policy or operational is invariably a simple assertion [by the court].”³⁸¹

David Boghosian notes, in reviewing the legal landscape after *Brown* and *Swinamer*, that those decisions effectively overturned *Just* in finding that true ‘policy’ decisions may be made at any level of governmental decision-making.³⁸² Thus, it seems the level of the decision-maker’s authority is not helpful in the dichotomous analysis. Instead, Bowal and Boland note that judgments *Brown* and *Swinamer* coalesced around characterizing ‘policy’ decisions as those involving, “the expenditure of funds, budgetary constraints, personnel limitations – decisions involving social, political and economic factors.”³⁸³ For example, the Court in *Brown* noted:

True policy decisions involve social, political and economic factors. In such decisions, the authority attempts to strike a balance between efficiency and thrift, in the context of planning and predetermining the boundaries of its undertakings and of their actual performance. True policy decisions will usually be dictated by financial, economic, social and political factors or constraints.

The operational area is concerned with the practical implementation of the formulated policies; it mainly covers the performance or carrying out of a policy. Operational decisions will usually be made on the basis of administrative direction, expert or professional opinion, technical standards or general standards of reasonableness.³⁸⁴

However, as Bowal and Boland aptly note, clothing in immunity those decisions that involve economic or political considerations is a useless and circular distinction since every function of modern government involves such considerations in some way, shape, or form.³⁸⁵

³⁸⁰ Woodall, *supra* note 367 at para 55.

³⁸¹ *Ibid* at para 67.

³⁸² David G Boghosian, “The ‘Policy Decision’ Defence After *Brown* and *Swinamer*” (np: Boghosian +Associates [nd]), online at: <http://www.boglaw.ca/pdf/policy_decision_defence_paper.pdf> at 1.

³⁸³ Peter Bowal & Lynn Boland, “Crowning Glory: Liability in Negligence of Public Authorities Revisited” (1994) 24 *Revue de droit de Sherbrooke* 436-459 at 457.

³⁸⁴ *Brown*, *supra* note 371 at 441.

³⁸⁵ Bowal & Boland, *supra* note 383 at 455.

Klar likewise critiques the reasoning: “[t]he reality is that initial decisions by government to institute programs are inevitably followed by the need to make more decisions. These subsequent decisions, as with the initial decisions, inevitably involve social, political, and economic factors.”³⁸⁶ As Klar notes regarding the different outcomes on the issue in *Just, Brown* and *Swinamer*, they were all resource allocation decisions.³⁸⁷ Thus, it seems that characterizing a decision as a resource allocation judgment is not truly indicative of its status as ‘policy’ or ‘operational’.

The presence of discretion also does not aid in the ‘policy’ versus ‘operational’ determination. Courts seems to rely on the exercise of discretion often as an indicator of a ‘policy’ decision. However, as Woodall notes, the definition of ‘discretion’ is ambiguous and inconsistently applied. Instead, Woodall suggests discretion should be seen as necessary for a decision to be ‘policy’, but not so for ‘operational’ decisions which he posits come in two forms: “those that are merely mechanical, where the functionary has no discretion, and which are therefore fully reviewable and second, those that involve the implementation of a higher level policy decision, but nevertheless permit wide (non-reviewable) discretion.”³⁸⁸ Therefore, looking for discretion also does not seem to be a promising avenue to determine if rationing decisions would be ‘policy’ or ‘operational’ in nature.

The scaling back of clear pronouncements in *Just* by courts in *Brown* and *Swinamer* suggest that the scope of ‘true policy decisions’ is significantly expanding. As DeRae notes, “[t]rue policy decisions are not restricted to “threshold,” high level decisions involving large sums of money or costs; they also include lower level, “balancing” decisions, involving small

³⁸⁶ Klar, *supra* note 379.

³⁸⁷ *Ibid.*

³⁸⁸ Woodall, *supra* note 367 at para 21.

sums of money or costs.”³⁸⁹ But based on the judgment of the majority in *Just*, even ‘true policy decisions’ can be found not immune from private law action. Cory, J. for the majority wrote: “[t]hus, a true policy decision may be made at a lower level provided that the government agency establishes that it was a reasonable decision in light of the surrounding circumstances.” Woodall notes that this statement is extremely odd, because it not only reverses the burden of proof regarding reasonableness from the plaintiff to the government agency in question, but also means that, counter to the Courts’ holding, ‘true policy decisions’ are not absolutely immune and must instead pass some reasonableness test.³⁹⁰ The result he notes is that, “the presumption that public activity can generate private law liability is virtually irrebuttable.”³⁹¹

Likewise, Boghosian notes that governments are open to civil negligence liability when policy decisions are made irrationally, in bad faith or *ultra vires* the delegated powers.³⁹² Klar similarly states that:

These decisions can only be challenged if they are not made in good faith. In this context, good faith refers to decisions made for ulterior motives, as a result of corruption, or with such a lack of conscientiousness that one can only conclude that no real discretion was ever exercised.³⁹³

In a similar vein, in both *Kamloops* and *Just*, the Supreme Court considered the question of whether discretion includes the authority to not consider making a decision at all, so as to escape liability. The courts held the government is under a duty to consider whether to exercise discretion or not. Failure to make such considerations would amount to

³⁸⁹ Vern W DeRae, “The Supreme Court of Canada in *Brown and Swinamer*: Just to Clarify the ‘Built-In Barriers’ Against Government Liability in Tort” (1994) 22 Man LJ 44-450.

³⁹⁰ Woodall, *supra* note 367 at para 57.

³⁹¹ *Ibid* at para 71.

³⁹² Boghosian, *supra* note 382 at 1.

³⁹³ Klar, *supra* note 379.

unreasonableness and would not be a *bona fide* exercise of discretion, thus opening ostensible ‘policy’ decisions to judicial review for negligence.

It is also possible potential liability may attach to purposely ambiguous policy decisions if they are determined be irrational, unreasonable or made in bad faith. While not tested in court, this may have occurred during the West Nile Virus outbreak when a guide produced by the Public Health Branch of the Ministry of Health, “was supposed to be a clear action plan to guide local health units in their approach to West Nile [but] gave no clear direction on the use of insecticides.”³⁹⁴ It seems possible courts may find such actions to not be *bona fide* exercises of discretion, and therefore reviewable for negligence. Thus, the provincial government would not be certain of escaping liability by purposely failing to issue detailed rationing guidelines or by refusing to issue them at all.

Overall then, while the Supreme Court has attempted to paint in broad strokes what constitutes a ‘policy’ decision of government, it has sadly failed. The result, Bowal and Boland argue, is unwieldy and lacking in predictive powers.³⁹⁵ In particular, they argue the judgments in *Brown* and *Swinamer* only muddy the legal waters further,³⁹⁶ making it impossible to determine ahead of time if a government decision would be considered ‘policy’ or ‘operational’.³⁹⁷ Thus, it becomes a virtual game of chance. Most importantly, they note the difficulty in surmising any consistent judicial approach has, and will continue to result in an enlargement of the scope of government liability.³⁹⁸

³⁹⁴ Campbell, *supra* note 189 at 1392.

³⁹⁵ Bowal & Boland, *supra* note 383.

³⁹⁶ *Ibid* at 453.

³⁹⁷ In lieu of this uncertain approach, Klar advocates the legislature explicitly carving out the liabilities that public authorities should be subject to, when passing their empowering statutes. In the least, he suggests subjecting all public authority to private law review, with variable standards of care to account for the role of financial and allocation decisions, among others.

³⁹⁸ Bowal & Boland, *supra* note 383 at 455.

Given the uncertainty surrounding the policy/operational dichotomy, can we determine if pandemic rationing decisions would be immune from liability? It certainly does not seem possible, at least with any high level of confidence. However, using analogous circumstances, such as those seen in the West Nile Virus and SARS cases, it may be possible to shed some additional light on the question.

Relying on judgments in *Just, Brown* and *Swinamer*, there are conflicting principles that would apply to any prospective challenge to pandemic rationing. First, the use of professional or expert opinions and technical specifications are indicators of ‘operational’ decisions.³⁹⁹ As priority groups for resource allocation during a pandemic are set based on scientific evidence of effectiveness and vulnerability, these appear to be ‘operational’ indicia. At the same time, rationing resources are by definition questions of resource allocation, determined by weighing competing economic, social and political factors, suggesting they are ‘policy’ in nature.

In *Eliopoulos*, the West Nile Virus response plan was found to be vague and if anything policy-based, leaving most ‘operational’ decisions to local boards of health. The plaintiff’s allegations also centered on very broad policy issues such as failing to give the health of residents highest priority, failing to control the mosquito population, and failing to warn citizens.⁴⁰⁰ The Ontario Court of Appeal concluded that the plaintiff’s allegations, “relate to issues of public health policy, the establishment of governmental priorities, and the allocation of scarce health care resources, not the implementation of a specific health promotion or prevention policy at the operational level.”⁴⁰¹ In distinguishing *Just* and *Brown* (both road maintenance cases) the Court held: “[d]eveloping an appropriate policy to control

³⁹⁹ See *Just*, *supra* note 370 at para 31.

⁴⁰⁰ *Eliopoulos*, *supra* note 344 at para 29.

⁴⁰¹ *Ibid* at para 30.

... the spread of an infectious disease across all of southern Ontario bears little similarity to implementing a specific policy for the maintenance and repair of public highways.”⁴⁰² The issues are clearly broader and subject to far more uncertainty (such as epidemiology, quarantine, etc.) than simple road maintenance plans.

Thus, governments would be subject to scrutiny for how rationing is carried out: whether and how priority groups are administered, verified and enforced. As was stated in *Just*, “once the policy decision to inspect has been made, the Court may review the scheme of inspection to ensure it is reasonable and has been reasonably carried out in light of all the circumstances, including the availability of funds, to determine whether the government agency has met the requisite standard of care.”⁴⁰³

In pandemic response plans, the majority of public health response powers are to be operationally exercised at the local level. For example, Toronto Public Health would be responsible for administering immunization clinics. Likewise, the rationing of ventilators would depend on individual hospitals’ surge capacity plans. But, the overall direction for rationing and the setting of priority groups is to be done by higher standards in order to ensure uniformity and fairness in the distribution of scarce lifesaving resources. It is expected that priority group settings of the provincial or federal level will be followed. Thus, ‘operational’ liability is left to lower tier jurisdictions; it is up to the local boards of health how to abide by the priority groups or how to verify individuals’ membership in such groups, as ‘operational’ decisions.

Further buttressing the view that operational control of public health responses does not rest with the provinces, the Campbell report on SARS notes that local health boards have

⁴⁰² *Ibid.*

⁴⁰³ *Just, supra* note 370 at para 23.

significant autonomy. The report states: “[i]t is easy for the province to set minimum standards on paper, but difficult to enforce them on the ground when public health services are paid for and controlled by the municipality either completely or on the present 50-50 basis.”⁴⁰⁴ Furthermore, the few, “elements of provincial influence are indirect and give the province no daily operational or administrative control over the local Medical Officer of Health or the local health unit.”⁴⁰⁵ This is reflected in the Court’s judgment in *Eliopoulos*: “under the *HPPA*, local boards of health ... bear primary operational responsibility for the implementation of health promotion and disease prevention policies.”⁴⁰⁶

It seems unlikely then that the issuance of rationing guidelines by upper-tier jurisdictions would be considered ‘operational’. Certainly at the federal level no concrete actions are mandated or required, and most operationalization of federal policy (including implementing sequencing guidelines) is left to lower tier jurisdictions. Likewise, the provinces recommend priority groups (using the federally-agreed upon guidelines) but in most instances leave it to local boards of health (and hospitals as the case may be) to implement those decisions, including administering immunization centers and developing procedures for verification of priority group status.

Even if liability cannot be found against the province for rationing decisions, there remains potential for recovery. As the Court in *Williams* noted: “this result does not leave the plaintiff without a remedy if she can show that she suffered harm as a result of negligence at the operational level on the part of those responsible for the application and enforcement of the Directives; namely, health care facilities and health care professionals.”⁴⁰⁷ Therefore, hope

⁴⁰⁴ Campbell, *supra* note 189 at 1502.

⁴⁰⁵ *Ibid* at 1503.

⁴⁰⁶ *Eliopoulos*, *supra* note 344 at para 27.

⁴⁰⁷ *Williams*, *supra* note 351 at para 36.

may lie for potential claimants against local health boards and others if they fail to properly implement ‘policy’ decisions. Determining whether that is the case may be a steep challenge.

In sum, the legal quagmire that is the policy/operational dichotomy makes it extremely difficult to predict the outcome of such analysis on pandemic rationing guidelines/protocols. Fortunately, existing case law suggests such analysis will be largely avoidable, as courts instead cloak public health responses in immunity through a finding of insufficient proximity to ground a private law duty of care.

4.4.2. Standard of Care

In the unlikely event proximity is found owing from government entities to individual persons, creating a private law duty of care, and that duty is not negated by policy concerns, the question remains as to whether there was negligence insofar as the standard of care was breached.

A standard of care inquiry would seek to determine whether governments’ implementation of policy decisions was reasonable and proper in the circumstances. There is not an absolute duty of care on the government, merely one of reasonable care.⁴⁰⁸ Did the government exercise reasonable care and skill in fulfilling its’ policies?⁴⁰⁹ In other words, “[t]o avoid liability, the government agency must exercise the standard of care in its ... [actions] that would be expected of an ordinary, reasonable and prudent person in the circumstances.”⁴¹⁰ This often involves a consideration and balancing of several factors

⁴⁰⁸ *Fallowka v Pinkerton’s of Canada Ltd*, 2010 SCC 5, [2010] SCJ No 5.

⁴⁰⁹ See e.g. *Swanson Estate v Canada*, [1991] FCJ No 452 (FCA); *Kamloops*, *supra* note 338.

⁴¹⁰ *Ryan v. Victoria (City)*, [1999] 1 SCR 201 at para 20.

including, “the likelihood of a known or foreseeable harm, the gravity of that harm, and the burden or cost which would be incurred to prevent the injury.”⁴¹¹

In determining the standard of care, courts can consider, “external indicators of reasonable conduct, such as custom, industry practice, and statutory or regulatory standards.”⁴¹² The latter may be particularly germane to rationing if care and treatment standards are set by regulation. However, as with professional college guidelines, they are not absolutely determinative of the standard of care. As the Supreme Court has held:

The fact that a statute prescribes or prohibits certain activities may constitute evidence of reasonable conduct in a given situation, but it does not extinguish the underlying obligation of reasonableness ... [t]hus, a statutory breach does not automatically give rise to civil liability; it is merely some evidence of negligence ... [likewise] mere compliance with a statute does not, in and of itself, preclude a finding of civil liability.⁴¹³

Thus, acting in consonance with legislative or regulatory standards does not preclude a court’s jurisdiction to find the conduct unreasonable and therefore a breach of the standard of care. However, regulatory standards may still inform courts’ decision-making such that otherwise negligent actions would be held to be reasonable.

In a case where a policy decision has been made that constrains those implementing it, their actions will only be investigated on how they conducted themselves given those limitations. As the Supreme Court in *Just* wrote:

[O]nce the policy decision to inspect has been made, the Court may review the scheme of inspection to ensure it is reasonable and has been reasonably carried out in light of all the circumstances, including the availability of funds, to determine whether the government agency has met the requisite standard of care.⁴¹⁴

On its face then it seems that the standard of care owed by the government is similar to that of individuals. Such an interpretation would be incorrect. The government has far

⁴¹¹ *Ibid* at para 28.

⁴¹² *Ibid*.

⁴¹³ *Ibid* at para 29.

⁴¹⁴ *Just, supra* note 370 at para 23.

greater responsibilities than an individual, and therefore the skill and care it applies to each small element of its duties may be less than that of an individual, particularly considering the government's budgetary constraints. But, the government must still act reasonably in the circumstances. The judgment in *Just* is instructive in this regard:

[T]he standard of care imposed upon the Crown may not be the same as that owed by an individual. An individual is expected to maintain his or her sidewalk or driveway reasonably, while a government agency such as the respondent may be responsible for the maintenance of hundreds of miles of highway. The frequency and the nature of inspection required of the individual may well be different from that required of the Crown. In each case the frequency and method must be reasonable in light of all the surrounding circumstances. The governmental agency should be entitled to demonstrate that balanced against the nature and quantity of the risk involved, its system of inspection was reasonable in light of all the circumstances including budgetary limits, the personnel and equipment available to it and that it had met the standard duty of care imposed upon it.⁴¹⁵

The effect of budgetary decisions on the standard of care was also considered by the court in *Just*:

[D]ecisions reached as to budgetary allotment for departments or government agencies will in the usual course of events be policy decisions that cannot be the basis for imposing liability in tort even though these political policy decisions will have an effect upon the frequency of inspections and the manner in which they may be carried out. All of these factors should be taken into account in determining whether the system was adopted in bona fide exercise of discretion and whether within that system the frequency, quality and manner of inspection were reasonable.⁴¹⁶

This is an important holding, as it retraces some of the court's delineation of 'policy' and 'operational' decisions. From this statement, it seems courts are willing to separate truly negligent 'operational' decisions – in that they fell below standards of reasonable care and skill – from those 'operational' decisions that were substandard as a result of budgetary decisions. The latter, even though negligent in other situations, are shielded from liability because they are predicated on financial constraints or scarcity.

If one is to extract the above reasoning and apply it to prospective pandemic rationing suits, it seems local boards of health may not be found to have violated the standard of care

⁴¹⁵ *Ibid* at para 27.

⁴¹⁶ *Ibid* at para 33.

in their ‘operational’ decisions (implementing the rationing priority groups) because of the context of those decisions. They would be able, at least theoretically, to point to supply constraints and scarcity that forced them to act (or not) as they did. If budgetary constraints are sufficient to immunize actions from liability, it seems logical that actual physical scarcity as a result of supply problems or spikes in demand would similarly insulate ‘operational’ activities of governments. Therefore, in the event a private law duty of care was found owing from governments to individual plaintiffs, it is unlikely that a negligence suit would survive the standard of care analysis.

4.4.3. Damages

As Dickens notes, “negligence is actionable only when the plaintiff has suffered damages, or injury.”⁴¹⁷ In cases of pandemic rationing, the guidelines or protocols would likely have resulted in the plaintiff being denied care. But the denial of care must lead to some physical damage (perhaps morbidity or mortality). For example, if an elderly woman was denied care because of the negligently created or implemented rationing policies and dies as a result, her estate could bring a claim in negligence against the government body in question. If there is no damage, there can be no claim. A further analysis of damage (including non-physical damage) is unnecessary given the likely outcomes of the foregoing duty of care and standard of care analyses.

4.4.4. Causation

If a plaintiff is somehow successful in establishing they were owed a private law duty of care by the government, the government failed to act in accordance with the standard of

⁴¹⁷ Dickens, *supra* note 323 at 116.

care, and they suffered harm, the final dot must be connected – their harm must be proven to have been caused by the defendant government. The Supreme Court has held that in cases of government liability, the traditional tests for causation are to be applied.⁴¹⁸

The “but for” test is the traditional test – but for the negligent conduct of the defendant the plaintiff would not have suffered injury.⁴¹⁹ The Supreme Court of Canada has held that a “robust and pragmatic” approach to causation should be applied by trial courts, sometimes permitting inference of causation.⁴²⁰ This essentially becomes an inquiry founded on ordinary common sense.⁴²¹ Furthermore, if there are multiple defendants all of whom contributed to the harms suffered by the plaintiff, the test is modified to the substantial or ‘material contribution’ test, with liability to be apportioned justly thereafter.⁴²²

It is likely causation will be extremely difficult for an individual plaintiff to prove, as at the implementation of policy there could be numerous factors that caused the alleged harm. For example, in rationing ventilators, the plaintiff would have to prove on a balance of probabilities that the government-imposed triage protocols resulted in the patient’s injury (likely death). This could be challenging since the protocols and priority sequences are designed with the goal of minimizing mortality and morbidity – those who are most likely to suffer harm from the pandemic (or benefit most from the resource) will be in the priority group. A patient would be excluded from ventilator use because they are unlikely to survive even with the resource. Therefore, the injury caused may have occurred notwithstanding receipt of the resource (which we assume was denied negligently or on a substandard basis). Therefore, causation presents yet another hurdle to a successful private law claim.

⁴¹⁸ *Swanson Estate*, *supra* note 409.

⁴¹⁹ *Ibid* at 121; *Snell v. Farrell*, [1990] SCJ No 73, 72 DLR (4th) 289.

⁴²⁰ *Snell*, *ibid* at 301.

⁴²¹ *Swanson Estate*, *supra* note 409.

⁴²² *Ibid*.

4.5. Suing Hospitals & Physicians

While governments have been, and likely will continue to be, the focus of any tort lawsuit in public health emergencies, hospitals and physicians may also find themselves defendants if rationing results in the provision of negligent or substandard care.

Hospitals can be found vicariously liable for negligent actions of staff. However, substandard care provided by independent physicians operating within a hospital will not result in vicarious liability. Hospitals may also be directly liable to patients for providing inadequate facilities or incompetent staff, but not for specific levels of treatment.

Physicians are clearly liable for malpractice, and the standard of care is that of a reasonably prudent practitioner in like circumstances. Courts have been unwilling to accept cost containment concerns as a defense for the provision of substandard care or denial of care – physicians owe their duties to their patients, not the financial health of medicare. Courts have been more lenient in cases where the resource in question was actually scarce, excusing liability if the defendant performed to their best ability with what they had. This is instructive for prospective liability as a result of pandemic rationing, as the resources are actually scarce, with direct and foreseeable consequences if inappropriately depleted. These issues will be further explored below.

4.5.1. Hospitals

Aside from governments, hospitals may also be sued in tort on the basis of direct or vicarious liability. While most relevant cases are concerned with failures of medical staff,

hospitals have control over the conditions that may cause or contribute to those failures and thus there is potential for liability.⁴²³

Hospitals owe several direct duties to patients such as maintaining competent staff, providing proper supervision, maintaining adequate facilities for safe care and establishing safe policies.⁴²⁴ The direct corporate liability of hospitals can be summarized as:

A hospital has an obligation to meet standards reasonably expected by the community it serves in the provision of competent personnel and adequate facilities and equipment and also with respect to the competence of physicians to whom it grants privileged to provide medical treatment. It is not responsible for negligence of physicians who practice in the hospital, but it is responsible to ensure that doctors or staff are reasonably qualified to do the work they might be expected to perform.⁴²⁵

But courts have held that hospitals do not owe patients a duty to provide a reasonable standard of treatment.⁴²⁶ In the leading case of *Yepremian*, decided by a full panel of the Ontario Court of Appeal, it was held that while a hospital owes a duty to provide staff of reasonable competence or skill, it is not liable at common law for a non-employee physician's negligence.⁴²⁷ As Arnup, J.A. writing for the majority stated: "[b]eyond doubt a patient admitted to a hospital expects to receive not only accommodation but also competent medical care."⁴²⁸ He then went on to conclude that despite the public's understanding, the hospital does not actually have a direct obligation to provide care, only to staff the institution with competent to persons, who in turn provide care.

⁴²³ Dickens, *supra* note 323 at 128.

⁴²⁴ *Ibid* at 130 - 131.

⁴²⁵ *Bateman v Doiron*, [1991] NBJ No 714 (QB); aff'd [1993] NBJ No 598 (CA), leave to appeal to SCC refused, [1994] SCCA No 53 [*Bateman*].

⁴²⁶ See e.g. *Yepremian v Scarborough General Hospital*, (1980), 110 DLR (3d) 513 (OCA); Lorian Hardcastle, "Governmental and Institutional Tort Liability for Quality of Care in Canada" (2007) 15 Health LJ 401-439.

⁴²⁷ *Yepremian*, *ibid.*

⁴²⁸ *Ibid.*

Hospitals can also be vicariously liable, arising automatically from the negligent actions or omissions of their employees performed within the scope of their duties.⁴²⁹ As most hospital-employed physicians are considered ‘independent contractors’, this is a far more relevant consideration for nurses and other healthcare professionals.⁴³⁰

What is not clear is if hospitals become liable by virtue of ordering physicians to comply with certain policies or procedures using the powers outlined in Chapter 3. The Supreme Court has held that there is a legal duty on physicians to follow institutional policies.⁴³¹ However, it seems on a plain reading of the jurisprudence that if a physician complies with a policy or guideline, and that compliance then results at trial in a finding of substandard care, the hospital will not be liable as they did not provide the allegedly negligent care. As was enunciated by Arnup, J.A. in *Yepremian*, the unique status of independent physicians means that the hospital *per se* does not supervise a physician’s treatment and care of patients so much as a physician’s peers do – the medical board and chiefs of staff/service.⁴³² Therefore, it seems possible hospitals will avoid liability in such cases as it will fall to the providing physician (so long as they are not employees). If they are staff employees, then the hospital will be open to vicarious liability.

4.5.2. Physicians

In addition to governments and hospitals/institutions, it is possible patients may pursue tort remedies against physicians, claiming rationing led them to provide patients with substandard care. For example, compliance with triage protocols may result in patients being

⁴²⁹ Dickens, *supra* note 323 at 129 (Dickens notes that a finding of vicarious liability may cause hospitals to seek indemnities from, or commence third-party litigation against its own employees).

⁴³⁰ See e.g. *Yepremian*, *supra* note 426.

⁴³¹ See e.g. *MacPhail v Desrosiers*, [1998] NSJ No 353 (CA) (liability imposed on the physician for failing to follow a hospital policy).

⁴³² *Yepremian*, *supra* note 426.

removed from ventilator life-support even though the treatment has not been offered long enough to definitively determine futility. Such abandonment of patients may be considered negligence.⁴³³ Likewise, refusing to provide vaccines or antivirals to patients (in accordance with priority sequencing guidelines) may be negligence if doing so was found at trial to be substandard care.

4.5.2.1. Standard of Care

The duty of care analysis in physician malpractice cases will likely be straightforward, as physicians have been held to owe patients several duties, including a fiduciary duty of trust and confidence.⁴³⁴ Inclusive in these duties is the duty of a physician to act in good faith, loyalty, and confidentiality.⁴³⁵ Instead, the crux of the analysis will be the standard of care and whether it was breached by the physician in question. The traditional standard of care in Canada can be stated as follows:

Every health practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing.⁴³⁶

As can be seen, this standard of care relies substantially on ‘medical custom’. Medical custom is not to be confused with guidelines or professional standards promulgated by the self-regulating health professions’. Instead, medical custom is a judicially determined legal standard set on the facts of each case. As Dickens notes, this is a positive development, preventing the professions from setting self-serving low standards.⁴³⁷ However, as Caulfield and Robertson note, the development and reliance on clinical practice guidelines by self-

⁴³³ Dickens, *supra* note 323 at 104.

⁴³⁴ See e.g. Caulfield, *supra* note 29; Dickens, *supra* note 323 at 103 (Dickens notes it may be contested whether the plaintiffs were in fact the physician’s patient, as the defendant physician may have declined the patient).

⁴³⁵ *McInerney v MacDonald*, [1992] 2 SCR 138, [1992] SCJ No 57.

⁴³⁶ *Crits v Sylvester*, [1956] OR 132 at 143 (CA), *aff’d* [1956] SCR 991 at 997.

⁴³⁷ Dickens, *supra* note 323 at 108.

regulated medical professional organizations is ‘legally significant’ for another reason:

“[t]hese guidelines are likely to play an increasingly important role in malpractice litigation, as evidence of whether or not the doctor acted in accordance with the generally accepted practice.”⁴³⁸ So then, guidelines of professional conduct are very instructive, but not determinative in setting the legal standard of care.

Courts are also not strictly bound by medical custom in the determination of the standard of care. Established jurisprudence provides courts can refuse to recognize accepted medical custom as the legal standard in cases where common sense suggests that it is in fact substandard. On the issue, the Supreme Court has stated:

While conformity with common practice will generally exonerate physicians of any complaint of negligence, there are certain situations where the standard practice itself may be found to be negligent. However, this will only be where the standard practice is “fraught with obvious risks” such that anyone is capable of finding it negligent, without the necessity of judging matters requiring diagnostic or clinical expertise.⁴³⁹

4.5.2.1.1. ‘Emergency’ or ‘Crisis’ Standards of Care

Many scholars and commentators have argued that ‘emergency’ or ‘crisis’ standards of care should apply during an influenza pandemic.⁴⁴⁰ As Hodge and Courtney note, “[p]rinciples of medical triage do not lend to easy determinations of what care is reasonably due and owed when resources are scarce and no patient may receive optimal care.”⁴⁴¹ They argue that instead of best interests and traditional ideals of reasonable and prudent actions of similarly-situated practitioners, a crisis standard of care should be based on actions consistent

⁴³⁸ Timothy Caulfield & Gerald Robertson, “Cost Containment Mechanisms in Health Care: A Review of Private Law Issues” (1999) 27 Man LJ 1-16 at para 17.

⁴³⁹ *ter Neuzen v Korn*, [1995] SCJ No 79, 127 DLR (4th) 577 at para 41

⁴⁴⁰ See e.g. Institute of Medicine of the National Academies, Board on Health Sciences Policy, Committee on Guidance for Establishing Standards of Care for Use in Disaster Situations, *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report* online at: <http://books.nap.edu/openbook.php?record_id=12749> (Washington: National Academic Press, 2009); James G Hodge & Brooke Courtney, “Assessing the Legal Standard of Care in Public Health Emergencies” (2010) 303:4 Journal of the American Medical Association 361-362.

⁴⁴¹ Hodge & Courtney, *ibid* at 362.

with the need to protect broader community health, as well as compliance with national or local guidelines on allocation of care.⁴⁴² The authors go on to suggest that non-compensable harms to patients during a pandemic are sad and unfortunate realities, but communal interests may take precedence, and a shift in the legal standard of care is necessary to accommodate that.⁴⁴³ This is somewhat reflected in the Canadian Medical Association Code of Ethics which provides that physicians owe certain responsibilities to society at-large. For example, physicians are required to, “[r]ecognize the responsibility of physicians to promote equitable access to health care resources,” and, “[u]se health care resources prudently.”⁴⁴⁴ However, such an obligation has yet to be recognized in Canadian law and conflicts with the long-established goals of tort law and legal duties of care being owed by physicians to their patients and only their patients.

4.5.2.2. Cost Containment

While no Canadian courts have to date considered issues of pandemic rationing, judgments on the effect of cost containment on physician negligence are instructive. As Timothy Caulfield notes, “[i]f individuals feel they have received inadequate care as a result of cost containment pressure they are likely to want to blame someone and their physician, as the bearer of the bad ... news, is the obvious target.”⁴⁴⁵

In the context of the standard of care, the main issue that arises from cost containment policies (or rationing/allocation policies generally) is whether a doctor can use these policies as an "excuse" in defending a malpractice claim. It would have to be argued that the necessity

⁴⁴² *Ibid.*

⁴⁴³ *Ibid.*

⁴⁴⁴ Canadian Medical Association, Code of Ethics (Update 2004), ss. 43 - 44.

⁴⁴⁵ Caulfield, *supra* note 29 at 692.

of rationing should result in an adjustment of the medical custom.⁴⁴⁶ Caulfield notes that courts are sympathetic in malpractice claims against physicians when resource constraints are beyond the clinician's control.⁴⁴⁷ In such cases, the standard of care may appropriately be shifted downwards. That is the real issue – whether courts will grant a reduction in the standard of care because of constraints in resources.

In the context of cost-containment rationing, Caulfield explores certain legal principles that may accommodate such a reduction in the standard of care.⁴⁴⁸ First, the 'locality rule' holds that standards to which physicians are held should be those of physicians in comparable communities. Basically, geographic circumstances or constraints should be factored in. How can, for example, a rural practitioner be held to the same standard as a physician at a large urban teaching hospital? This is germane to rationing in pandemics where resources may be unevenly distributed across geographic areas due to varying demand levels and supply/delivery constraints. However, as Caulfield notes, this rule has been applied invariably in Canadian law and has minimal real impact on judicial decision-making.⁴⁴⁹ More recently, Dickens argues that the locality rule has been discredited.⁴⁵⁰

Notwithstanding the foregoing, the standard of care in rationing cases may still be different based on geographic location. As Dickens posits, since physicians cannot be held liable for not using resources (including skilled nursing services) when none are available, there is invariably a difference in the standard of care between a large urban teaching a

⁴⁴⁶ *Ibid* at 698.

⁴⁴⁷ *Ibid* at 702.

⁴⁴⁸ *Ibid*.

⁴⁴⁹ *Ibid* at 703.

⁴⁵⁰ Dickens, *supra* note 323 at 109.

hospital and a small rural clinic as a result of resource disparities.⁴⁵¹ The same may be true in a pandemic where resources are simply not available in some areas.

Second, Caulfield notes the ‘respected minority’ doctrine may be used to defend against negligence suits in situations of cost constraint. The doctrine holds that a physician may not be held to have violated the standard of care if, even though they deviated from medical custom, their actions conformed to respectable academic opinion.⁴⁵² This rule is designed to permit innovation in medical care, but not quackery or maverick physicians (hence the ‘respectable academic opinion’ moniker).⁴⁵³

Applying the doctrine to pandemic rationing, if physicians have legal authority to make rationing decisions (and are not ordered to follow certain guidelines or rules), then if, for example, a different but academically approved triage protocol is used, it may fall under this doctrine. Likewise, and perhaps more relevant given hospitals’ institutional control of triage protocols, the prescription of antivirals for prophylaxis may be defensible given the substantial academic literature on its benefits, as opposed to guidelines that mandate treatment-only uses. However, as Caulfield notes, courts may be hesitant to accept such a defense, given that it necessarily entails a reduction in the legal standard of care.⁴⁵⁴

In contrast to the above defenses which act by lowering the standard of care, Caulfield presents a different option in cases of cost containment: acknowledging sub-standard care has been provided (and thus not reducing the standard of care), but proffering mitigating circumstances (in our case, the scarcity and reality of a pandemic).⁴⁵⁵ This ‘economic excuse’ as Caulfield terms it, could be analogized to a ‘pandemic excuse’ for our

⁴⁵¹ *Ibid* at 109 - 110.

⁴⁵² Caulfield, *supra* note 29 at 706.

⁴⁵³ For a more fulsome discussions see, Dickens, *supra* note 323 at 108.

⁴⁵⁴ Caulfield, *supra* note 29 at 706.

⁴⁵⁵ *Ibid* at 709.

purposes. In claims that may occur as a result of pandemic rationing, courts would not need to lower the general standard of care, but simply dismiss the claim by acknowledging the unique and care-constraining circumstances of a pandemic.

However, Caulfield goes on to acknowledge several limitations to the ‘economic excuse’ or ‘pandemic excuse’ doctrine that make its use virtually impractical. First, such a doctrine requires courts to intervene in matters of social policy, to the detriment of individual claimants whom the entire private law justice system is predicated on.⁴⁵⁶ Second, in order to prove or counter the pandemic excuse argument, significant evidentiary challenges would be faced, requiring disclosure that neither party may have control over.⁴⁵⁷ Finally, the doctrine may place too great a burden on individual plaintiffs, counteracting one of the core tenets of the tort system – compensation for harm.⁴⁵⁸

It seems therefore that courts are not yet willing to accept financial arguments as sufficient to absolve physicians for not acting in their patient’s best interests. This may be related to the fundamental purposes of tort law – compensating an innocent injured party. But, as cost constraints are not true instances of scarcity, these holdings may not apply in pandemics.

4.5.2.2.1. Budget Scarcity vs. Actual Scarcity

Cost containment is far different from the reality physicians and decision-makers will face during pandemics. A key feature of clinical practice in a cost-contained environment is that of choice (oftentimes to be more economically efficient). As Caulfield posits, “[c]ost containment decisions are based on choice and not necessarily on the actual scarcity of a

⁴⁵⁶ *Ibid* at 710.

⁴⁵⁷ *Ibid*.

⁴⁵⁸ *Ibid* at 711.

given resource.”⁴⁵⁹ It is possible then that the law rejecting cost containment as a defence to malpractice, may not be as applicable in pandemics where actual scarcity reigns.

For example, in *Bateman v. Doiron*, the court dismissed an action for liability against a physician and hospital regarding the allocation of emergency room specialists that resulted in substandard care. The Court found that the defendants were doing their best with the provided resources (hiring only part-time general practitioners).⁴⁶⁰ On the other hand, in *Law Estate v. Simice*, the court rejected claims by the defendant physician that the pressure from hospitals to constrain expenditures for the sake of the greater system was a defense for failing to provide a timely and needed CT scan.⁴⁶¹ In essence, the court found it deplorable that the defendant’s judgment was inhibited by considerations of the economy of the health system to the detriment the best interests of his own patient. The Court wrote:

[I]f it comes to a choice between a physician's responsibility to his or her individual patient and his or her responsibility to the medicare system overall, the former must take precedence in a case such as this. The severity of the harm that may occur to the patient who is permitted to go undiagnosed is far greater than the financial harm that will occur to the medicare system if one more CT scan procedure only shows the patient is not suffering from a serious medical condition.⁴⁶²

The key distinguishing feature between these two cases is the difference between real scarcity and financial or ‘illusory’ scarcity (as in cases of cost containment). In *Law Estate*, the decision not to undertake the CT scan was based on financial concerns for the entire healthcare system. However, that was not real scarcity – both money and the resource (CT machine) were available. In contrast, in *Bateman*, the supply of emergency room specialists was fixed – a case of true scarcity.

⁴⁵⁹ *Ibid* at 705.

⁴⁶⁰ *Bateman*, *supra* note 425.

⁴⁶¹ *Law Estate v Simice* (1994), 21 CCLT (2d) 228 (BCSC), aff'd [1996] 4 WWR 672 (BCCA).

⁴⁶² *Ibid* at para 28.

If this difference can distinguish these judicial holdings, then it appears likely that the findings in *Bateman* could apply to instances of pandemic rationing. The supply of antivirals, vaccines and ventilators are fixed and constrained. Thus, it seems that decision-makers may be granted deference so long as they act to the best of their abilities given the resource constraints, even if that results in the provision of substandard care.

4.6. Conclusion

As this chapter has shown, any negligence suits against provincial or federal governments for harm caused by rationing decisions are prone to failure due to a lack of proximity required for a private law duty of care. It is clear from past public health cases that governments owe duties to the public at-large, but not to specific individuals or classes of persons. In the event a legal challenge makes it past the proximity hurdle, difficulty will also arise regarding the policy/operational dichotomy, as allocation decisions appear to be policy and thus immune from liability. However, the implementation of rationing guidelines at a local level may open local boards of health to liability if they are negligent in the implementation, verification and enforcement of such guidelines.

Hospitals and physicians are similarly unlikely to be found liable in implementing rationing guidelines. Hospitals do not owe patients a duty to provide non-negligent care. Physicians, while owing a duty of care, would likely not breach the standard of care due to contextual factors and actual, as opposed to financial, scarcity.

Chapter 5 Conclusion

Pandemics are potentially catastrophic public health events. Supply constraints and fear-induced demand necessitate the rationing of vaccines, ventilators and antivirals (among other resources). The contentious nature of government-managed rationing raises the specter of legal challenge by those excluded from receipt of lifesaving resources (if not already deterred by difficulties in obtaining meaningful relief in reasonable time). However, the certainty of success of those challenges is questionable, particularly in areas of administrative and private law.

In the area of administrative law, challenges are likely to focus on jurisdictional errors committed by executive actors. As a comprehensive review of the relevant public health and emergencies legislation shows, there are ample statutory provisions delegating discretion to order or control rationing. These include the supervision of medical practitioners, hospitals, and the management of public health threats and other emergencies. Delegated actors have wide statutory-granted discretion, but many of the delegated powers require conditions precedent to exist prior to their exercise, as well as suffering from accompanying time, geographic and procedural limitations.

Private law challenges on the other hand face greater hurdles, but offer compensable remedies. Courts have been generally unwilling to find public health statutes as creating private law duties of care for want of proximity. Even if proximity were somehow found to exist, a jurisprudential desire to immunize policy decisions of government from tort liability also presents a stumbling block. Furthermore, the law on the ‘policy’ versus ‘operational’ dichotomy is unclear, providing little predictive value for prospective private law challenges.

Based on existing case law and indicia of ‘policy’, it seems likely that provincial/federal setting of rationing or priority sequencing guidelines would be immune from liability, whereas local health boards’ implementation and administration of those policies would not. Negligence suits against physicians and hospitals, for alleged provision of substandard care as a result of complying with rationing protocols, are equally unlikely to succeed.

Given the host of issues that may arise in legal challenges to rationing in the course of a pandemic, it would be prudent for governments to take preparatory steps to minimize the denial of lifesaving resources, or in the alternative, statutorily immunize governments from challenge for such decisions, if so desired.

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