

2 ACCESSING JUSTICE AMID THREATS OF CONTAGION

Janet Mosher*

While plans for the containment and control of new and potentially deadly pathogens have long existed, pandemic planning and preparedness efforts proliferated rapidly after the outbreak of SARS (severe acute respiratory syndrome) in 2003, the emergence of the looming threat of H5N1 (avian influenza), and the declaration by the World Health Organization of an H1N1 (swine flu) pandemic in 2009. The projection of 62 million deaths and devastating economic consequences arising from the next influenza pandemic is frequently cited (The Lancet, 2009).¹ Importantly, plans to respond to the worrisome possibility of a global influenza pandemic have been developed in an environment significantly influenced by the events of 9/11 and subsequent anthrax attacks in the United States. “Legal preparedness,” understood as the enactment of the necessary constellation of law and legal authority, has emerged as a critical component of pandemic preparedness. Yet, this description invites the question of precisely what laws are indeed necessary — a question that can only be answered by interrogating more closely how the threat is conceptualized and who is understood to be threatened.

Pervasive in the pandemic planning literature is an analogy between contagious disease and terrorism; between the individual carrier of disease and the terrorist intent on destruction. Both are depicted as threats to national

* Reprinted with permission. Original citation: Mosher, J. E. (2014). Accessing justice amid threats of contagion. *Osgoode Hall Law Journal*, 51(3), 919-956. This chapter derives from two research projects on pandemic planning and homelessness in which I was a co-investigator (principal investigator, Dr. Stephen Gaetz). The two projects, *Responding to H1N1 in the Context of Homelessness in Canada and Understanding Pandemic Preparedness within the Context of the Canadian Homelessness Crisis*, involved several academics, and included interviews and surveys of people experiencing homelessness, as well as service providers and public health officials in four Canadian cities. In this article I draw upon the data derived from the Toronto component of the projects. The funding for these research projects from the Canadian Institute for Health Research (CIHR) is gratefully acknowledged. An earlier version of this article was originally presented at the Symposium in Honour of John McCamus: Scholarship, Teaching and Leadership (7 February 2013), hosted at Osgoode Hall Law School, York University, Toronto.

¹ Citing Christopher Murray and colleagues who used data from the 1918–20 Spanish influenza pandemic as the basis for this prediction. Others predict that the number of deaths globally will be as high as 369 million (Gostin & Berkman, 2007).

security, and best managed through surveillance, borders, containment, and control (Mariner, Annas, & Parmet, 2009).² Given the stark threat posed by contagious disease in the context of an environment depicted as increasingly risky, the role of law is first and foremost to confer sufficient legal authority upon public health officials (aided by police where necessary) to engage in surveillance, apprehend and detain carriers or suspected carriers of disease (that is, to quarantine or isolate), and compel treatment. While not criminal law *per se* (although certainly some commentators have argued for the expansion of criminal law powers to respond to pandemics), this approach shares many features of the law-and-order framework that has dominated neo-liberal governance (Attaran & Wilson, 2007). The approach positions public health in opposition to individual rights to privacy, liberty, and security of the person, and accepts that infringement of the latter is justified to secure the former. In keeping with other laws enacted in the name of national security, the curtailment of the rights of some promises safety and security for others (Toope, 2002).

As one might anticipate, this approach to pandemic planning has evoked critical responses from civil libertarians, who rightly worry that in a climate of fear and where national security is understood to be threatened, the curtailment of individual liberties will almost invariably be seen as justified (Annas, Mariner, & Parmet, 2008). Assurances that voluntary compliance and individual responsibility will be widespread, that compulsion will be rare and invoked only when necessary, and that procedural rights of review will guard against abuses of power, for reasons elaborated below in the The Promise of Procedural Justice section, do little to placate these worries.

Yet, a more fundamental critique of the conceptualization of pandemics as national security threats directs attention to the question of who, precisely, is the subject of the promised safety and security. Critical purchase on

²Wendy Mariner, George Annas, and Wendy E Parmet draw upon Priscilla Wald's work in their description of this response as an "outbreak narrative." People with contagious diseases are characterized as a threat to society, and the threat is countered by giving scientists control, which includes the authority to monitor and manage people, and requires people to obey strict regimens of isolation or treatment (Wald, 2008).

this issue is grounded in the lived realities of those persons and groups who experience social marginalization (Young, 2011).³ In what follows I turn to the experiences of persons who are homeless in order to delineate the differential and harmful impact of approaching pandemics as a matter of national security.⁴ To develop this analysis I draw from accounts of past pandemics and disasters as well as from recent empirical research into the experiences of homeless individuals in Toronto during the H1N1 pandemic, including their access to information about the pandemic, to vaccines, and to trusted medical personnel. With limited ability to stockpile resources, self-quarantine, or follow public health advice on preventative measures such as hand washing, those who are homeless are among the least likely to be in a position to comply voluntarily with public health edicts. This reality renders the homeless particularly vulnerable to coercive state action, especially when considered together with the possibility that the stereotyping and social stigmatization of homeless people may mark them as vectors of disease. Moreover, there is good reason to conjecture that procedures for judicial review of coercive state action will be of limited assistance to most people in the context of an actual pandemic, and of virtually no assistance to the homeless. The law-and-order/containment approach arguably promises more harm than good for those who are homeless.

Attention to marginalized populations exposes additional flaws in the pandemics-as-national-security frame, and suggests an alternative approach grounded in principles of social justice. Shifting the focus from abstracted, undifferentiated individuals to marginalized individuals and groups makes it abundantly clear that social, economic, and geographic position matters enormously in the distribution of the burdens of pandemics and of the benefits of medical and non-medical countermeasures. It exposes the reality that those who are most socially vulnerable are likely to bear the greatest burdens

³I use “marginalization” in the sense articulated by Iris Marion Young to capture the social processes that exclude members of particular social groups from, or limit their participation in, economic, political and social spheres. Processes of marginalization result not only in material deprivation but, as Young argues, deprivation of the rights and freedoms others enjoy, the denial of opportunities to develop and exercise capacities, and the erosion of dignity.

⁴There is currently no accepted pan-Canadian definition of homelessness. The Canadian Observatory on Homelessness has developed a useful definition and topology that importantly moves beyond only those who are visibly homeless on the streets or utilizing emergency shelters. A broader definition is particularly important to capture women’s homelessness; given the violence women face on the streets and concerns to retain custody of their children, women’s homelessness is far less visible than men’s. For the COH’s definition, see Appendix A.

of a pandemic. The homeless, given already compromised health and living conditions conducive to the spread of disease (for example, over-crowding, poor ventilation, and limited access to running water), are at greater risk of acquiring a communicable disease (Leung, Ho, Kiss, Gundlapalli, & Hwang, 2008). They have the fewest resources to protect themselves (including access to housing, food, information, and health care), and little capacity to shoulder the social and economic impact of measures such as quarantine. Countless historical (and indeed contemporary) examples demonstrate that pandemics are not equal opportunity events. Social vulnerability increases the likelihood of disease acquisition, reduces access to both medical and non-medical forms of remediation, and tightens the grip of morbidity and mortality. In virtually all forms of disasters and emergencies, marginalized groups, both globally and domestically, bear the largest burden, yet they continue to be routinely overlooked in pandemic plans (Kerridge, & Gilbert, 2014; Gostin, Lucey, & Phelan, 2014).⁵ Unless attention is paid to social vulnerability in pandemic planning, such plans are likely to not only replicate, but exacerbate, existing inequality and deepen social injustices. The national security frame positions the “nation” as under threat, obscuring the reality that the likelihood and severity of the threat materializing depends very much on one’s social location.

Approaching pandemic planning with those who experience social marginalization clearly in view also prompts a shift in temporal focus. The national security approach to pandemic planning is temporally concentrated upon the moment of crisis — that is, upon the containment and treatment of those exposed to disease. Here too, foregrounding the needs and experiences of the homeless exposes the limitations of this gaze. Rather the gaze must be expanded outwards to the pre-crisis period — to the long haul — and to the necessity of building trust, and the capacity to fulfill the social determinants of health.

⁵ While not a pandemic, the current outbreak of the Ebola virus in West Africa makes clear the critical role inequality plays not only in the acquisition and spread of disease, but in explaining the little attention Ebola has garnered since its first outbreak in 1976. Ebola is spread through close contact with the blood or body fluids of an infected person. Inadequate infection control in rural hospitals, and more broadly an under-resourced health care infrastructure, have been blamed, in part, for the spread of the disease.

Finally, an approach to pandemic planning that takes the needs and experiences of socially marginalized populations seriously prompts us to think anew about the nature of the rights at stake, the ethical values that ought to guide decision-making, and our choices about the role of law. Without a doubt, rights to privacy, liberty, and security of the person (usually defined in negative terms, as limits on the state) are implicated by current approaches. But consideration of the needs and experiences of marginalized populations suggests that a positive conception of rights — for example, of the right to health — might serve us all much better in preparing for and responding to a pandemic. It also stresses engagement with law’s role in furthering a substantive vision of social justice. It moves us beyond procedural justice — that is, beyond rights of review to test the balancing of individual rights and public health — and indeed beyond the coercive power of law. It moves our attention from national security to the role of law in securing social justice.

Pandemics as a National Security Threat

Many commentators have documented the emergence of a new paradigm in which public health emergencies and public health policy more broadly are filtered through “the prism of national security and law enforcement” (Annas, Mariner, & Parmet, 2008, p. 5).⁶ A prism of precisely this sort is found in Canada’s 2004 National Security Policy, the Executive Summary of which cautions:

But as all Canadians know, we live in an increasingly interconnected, complex and often dangerous world. The increase in terrorist acts and the threat of rapid, globalized spread of infectious disease all challenge our society and the sense of security that is so critical to our quality of life. Canadians understand this new reality (Government of Canada, 2004, p. vii).

⁶They also note that “President Bush’s first suggestion to contain a bird flu pandemic was to call in the military to quarantine large sections of the United States”. Gostin and Berkman describe how, in the United States, H5N1 was regarded by policy makers as a threat to national security (2007). Benjamin and Mouton suggest that “public health emergencies are now seen under the intense spotlight of national security concerns” (2008, p. 13). Selgelid references the World Health Organization’s description of pandemic influenza as “the most feared security threat” (2009, p. 255).

The policy continues:

Terrorism is a global challenge that has been recognized by the United Nations as a crime against humanity. Canada is not immune to this threat.

But the threats we face are not limited to terrorism. The SARS (severe acute respiratory syndrome) outbreak demonstrated the power of individuals to unintentionally transmit threats around the globe at the speed of air travel.

The Government is determined to pursue our national security interests and to be relentless in the protection of our sovereignty and our society in the face of these new threats (Government of Canada, 2004, p. 1).⁷

...

The world is a dangerous place, even if the relative safety of life in Canada sometimes obscures just how dangerous it is. As recent events have highlighted, there is a wide range of threats facing Canada from pandemics to terrorism. These threats can have a serious impact on the safety of Canadians and on the effective functioning of our society (Government of Canada, 2004, p. 6).

The Policy renders the risky and threatening environment as taken for granted, a matter of common sense, and cautions the reader not to be lulled into complacency by the relative safety we may, in fact, temporarily experience. The Policy depicts the environment as equally risky for all. In their portrayal of that risky environment the authors of the Policy collapse acts of terrorism,

⁷The various threats identified are terrorism, the proliferation of weapons of mass destruction, failing states, foreign espionage, natural disasters, critical infrastructure vulnerability, organized crime, and pandemics. In Chapter 5, which addresses public health, the context is described as follows:

A robust public health system is a critical line of defence in protecting Canadians against many current and emerging threats, including contamination of our food and water, major disease outbreaks such as SARS, natural disasters, major accidents like chemical spills, and even the terrorist threat of a chemical, biological, radiological or nuclear attack. The complex, multijurisdictional nature of such threats also speaks to the necessity for Canada's approach to public health emergencies to be more than strictly local or national in its orientation, and to proactively contribute to the building of a more resilient international public health architecture (Government of Canada, 2004, p. 29).

failing states, foreign espionage, natural disasters, organized crime, critical infrastructure vulnerability, the proliferation of weapons, and pandemics into a singular “all-hazards approach,” and then locate these threats within a framework of national security.⁸ More broadly still, the Policy calls for the continuous inclusion of “the public health dimension in the ongoing national security debate” (Government of Canada, 2004, p. 29).

While the physical borders of the nation state are certainly important in this account (one need think only of the airport surveillance of passengers’ body temperatures during the SARS crisis), the relevant borders are also internal. Quarantine and isolation — the power to construct internal borders to seal off and contain those infected or exposed to disease — have emerged as critical tools in the legal preparedness toolkit.⁹ Individuals carrying disease, or indeed even exposed to disease, can be apprehended, detained, and treated without consent. They are explicitly recast within Canada’s national security policy as threats to Canada’s sovereignty, and as persons against whom the state must act in order to secure the life, liberty, and security of Canadians.

This approach has been operationalized in a variety of ways, but significantly through the framework of legal preparedness. As the post-SARS Commission of Inquiry chaired by Justice Archie Campbell (the “Campbell Commission”) observed, legal preparedness has increasingly come to be viewed as a critical component of public health preparedness.¹⁰ The definition of legal preparedness first developed in 2003 by Moulton et al as “the attainment by a public health system ... of specified legal benchmarks or standards essential to the preparedness of that system” (Benjamin & Moulton, 2008, p. 14)¹¹ has been widely adopted, as has their elaboration of its four core elements.

⁸ This all-hazards approach has been described and critiqued by a number of American and Canadian authors. For examples in the Canadian context, see Van Wagner, 2008. For examples in the American context, see Mariner, Annas, & Parmet, 2009; Kamoie, et al., 2008. In this all-hazards approach “no matter what happens ... a law enforcement/national security approach is required” (Annas, Mariner, & Parmet, 2008, p. 16).

⁹ The terms quarantine and isolation are not used consistently in the cited literature. I use the terms in a manner consistent with the definitions offered by the World Health Organization: isolation is defined as “the separation, for the period of communicability, of infected persons”; quarantine as “the restriction of the movement of healthy persons who have been exposed to a suspected or confirmed case of infection with a highly communicable disease during the likely infectious period”; and social distancing to include “a range of community-based measures to reduce contact between people (e.g., closing schools or prohibiting large gatherings)” (2007, p. vi).

¹⁰ An independent Commission was established by the Government of Ontario to investigate the introduction and spread of SARS. Justice Archie Campbell of the Ontario Superior Court of Justice was appointed Commissioner. The Commission released three reports, totaling some 1,500 pages and published in five volumes. Throughout this chapter, I focus on the *Second Interim Report: SARS and Public Health Legislation* (Government of Ontario, 2005).

¹¹ See also Moulton, Gottfried, Goodman, & Murphy, 2003; Kouzoukas, 2008.

1. The creation of laws and legal authorities conferring necessary powers on various levels of government and in particular, on public health officials;
2. Competency in using these laws effectively (competencies of public health professionals, among others, to know when and how to apply their legal powers);
3. The coordination of legally based interventions across jurisdictions (horizontally and vertically) and sectors; and
4. The sharing of information about public health laws and best practices (Benjamin & Moulton, 2008; Moulton, Gottfried, Goodman, & Murphy, 2003; Kouzoukas, 2008).

While in theory the concept of legal preparedness leaves open a multiplicity of possibilities for the sorts of laws one might argue are warranted to prepare for a pandemic, legal preparedness has generally been taken up in a manner in keeping with the national security account (Kouzoukas, 2008).¹² In practice, what one sees is the call for — and in many jurisdictions the adoption of — legal frameworks that expand the ground for disease surveillance, the control of movement through quarantine, isolation, and other social distancing measures, and forced assessment and treatment.¹³ A brief overview of *Ontario's Health Protection and Promotion Act (HPPA)* elucidates the nature of the powers granted to public health officials to control the movement and behaviours of persons infected, or assumed to be infected, with a communicable disease (Government of Ontario, 2015).

¹²Kouzoukas, Deputy General Counsel in the United States Department of Health and Human Services, identifies the first element as the “central, substantive aspect of public health legal preparedness” and notes that the need for additional federal laws in the United States to respond to the threats of bioterrorism and pandemics led to the passage of the Pandemic and All-Hazards Preparedness Act of 2006; the Public Readiness and Emergency Preparedness Act of 2006 and the Public Health Security and Bioterrorism Preparedness Response Act of 2002. Similarly, in the Canadian context, Attaran and Wilson make an argument for the need for a greater role of the federal government in the management of pandemics (2007). In both Canada and the United States, issues of the scope of federal jurisdiction are debated. Attaran and Wilson suggest that the federal head of power under the Constitution in relation to quarantine has been read far too narrowly, limiting the role of the federal government solely to the regulation of national borders. They advance a further argument grounding increased federal jurisdiction in regulating pandemics within the federal criminal law power.

¹³Authority to detain and treat does not exhaust the role envisioned for law; jurisdictional clarity (within and between nations), surveillance, and patenting have also received attention within the national security framework.

Ontario's legislative regime

Pursuant to subsection 22(1) of the HPPA, a Medical Officer of Health (MOH) may, by written order, “require a person to take or to refrain from taking any action that is specified in the order in respect of a communicable disease” (communicable diseases are identified by regulation) (Government of Ontario, 2015a, s. 22[1]).¹⁴ Section 22 orders, as they are known, may be issued if an MOH believes, upon reasonable and probable grounds,

- A) that a communicable disease exists or *may exist* or that there is an immediate risk of an outbreak of a communicable disease in the health unit served by the medical officer of health;
- B) that the communicable disease presents a risk to the health of persons in the health unit served by the medical officer of health; and
- C) that the requirements specified in the order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease (Government of Ontario, 2015a, s. 22[2]).

Such orders may require, among other things, that a person who “has or may have a communicable disease or is or may be infected with an agent of a communicable disease” isolate himself or herself; submit to an examination by a physician; conduct himself or herself in such a manner as to not expose another person to infection; and where the disease is identified by regulation as virulent, place himself or herself under the care and treatment of a physician (Government of Ontario, 2015a, s. 22[4]).

A significant reform introduced in Ontario between the first and second wave of SARS cases in 2003 was the expansion of the power of a MOH to direct an order against a class of persons (Government of Ontario, 2015a, s. 22[5.0.1]). The HPPA provides no definition of “class” and, consequently, a MOH retains broad powers to determine the contours of the class that constitutes the subject of the order. If notice to members of the class is likely to cause delay that “may significantly increase the risk to the health of any person,” notice may be given through “any communications media” deemed appropriate by a MOH, although the MOH must post the order at an address

¹⁴ Boards of health in Ontario are municipally based and each has a medical officer of health.

or addresses where it is most likely to be brought to the attention of the members of the class (Government of Ontario, 2015a, s. 22[5.0.2 - 5.0.3]).

A person who is the subject of a section 22 order is entitled to a hearing before the Health Services and Appeal Board established under the *Ministry of Health and Long-Term Care Appeal and Review Boards Act, 1998* (Government of Ontario, 2010). A request for a hearing must be made in writing within fifteen days of notice of the order, and the Board must hold a hearing within a further fifteen days. An appeal is available to the Divisional Court, from where yet another appeal is available by leave to the Court of Appeal. Although the Appeal Board may stay an order pending its decision, this is a matter of discretion (Government of Ontario, 2015a, s. 44).

An entirely different procedural route exists should a MOH wish to take steps to enforce an order he or she has issued. The MOH must apply to the Ontario Court of Justice, seeking an order pursuant to section 35 requiring a person to isolate himself or herself, submit to an examination by a physician, place himself or herself under the care and treatment of a physician, and/or conduct himself or herself in a manner that avoids exposing other persons to infection (Government of Ontario, 2015a, s. 35[2]). The coercive powers of the court include the potential to order that a person be taken into custody, admitted and detained in a hospital or “other appropriate facility,” (a provision added during SARS) and be examined and treated for a period of up to six months (which may be extended, on motion, for further periods, each of not greater than six months) (Government of Ontario, 2015a, s. 35[3;4;5;7;11]).¹⁵ A section 35 order may be directed to any police force in Ontario for enforcement (Government of Ontario, 2015a, s. 35[6]).¹⁶ An appeal of a section 35 order to the Court of Appeal is restricted to questions of law alone and subject to a “special leave” requirement that the circumstances of the case are such that it is “essential in the public interest or for the due administration of justice that leave be granted” (Government of Ontario, 2015a, s. 35[18;19]).

¹⁵ Prior to SARS the HPPA referred only to hospitals.

¹⁶ Prior to an amendment in 2007, the order was only enforceable by the police force in the health unit of the Ministry of Health.

Justifying Limits on Individual Rights

Significantly, section 22 and 35 orders override provisions of the *Health Care Consent Act*, which would otherwise require consent to an examination by a physician and to treatment (Government of Ontario, 2015b, s. 102[3]). Needless to say, orders requiring isolation, submission to a medical examination without consent, or detention for treatment (again absent consent) reflect the exercise of extraordinary state powers. The circumstances in which infringements of rights may be justifiable in order to protect public health is a much debated issue. In the Canadian context, limitations on *Charter* protected rights, such as liberty and security of the person, are scrutinized under section 1 to determine whether they are reasonable and demonstrably justifiable in a free and democratic society (Government of Canada, 1982).¹⁷ Without embarking on that analysis here, it is nevertheless important to note two sources that might usefully guide such an analysis in the context of a pandemic, the International Covenant on Civil and Political Rights (ICCPR) and the Siracusa Principles, a set of non-binding guides to the interpretation of the limitation clauses contained in the ICCPR (United Nations, 1966; 1984).¹⁸ While no derogation is permitted of particular rights (for example, to life or to freedom from torture and slavery) the ICCPR contains both a general derogation clause related to public emergencies (Article 4) and specific provisions regarding limitations on specified rights in order to protect, among other interests, public health.¹⁹ Article 4 requires that the public emergency be of a nature that “threatens the life of the nation,” the emergency must be officially proclaimed, and the measures taken must be “strictly necessary” and must “not involve discrimination solely on the ground of race, colour, sex, language, religion or social origin.” In addition, a state taking such measures is obligated to inform other states parties to the Convention.

¹⁷ See Ries, 2005.

¹⁸ The Siracusa Principles were developed during a meeting of international experts in Siracusa, Italy in 1984 and subsequently adopted by the United Nations Economic and Social Council. Although a non-binding set of interpretive principles, they are widely referenced in the academic literature and in international jurisprudence. Note that Canada is a signatory to the *Covenant*.

¹⁹ Limitations of the rights to freedom of movement and to leave one’s country, to peaceful assembly, to association, and to manifest one’s freedom of religion and of conscience in order to protect public health are all recognized. While the provisions vary somewhat, common features are the requirement that such limitations be provided by law, are necessary in order to protect public health, and are consistent with other rights recognized by the *Covenant* (United Nations, 1966: Articles 12; 18; 19; 21; 22).

Informed by the interpretive guidelines provided by the Siracusa Principles, the derogation of rights guaranteed by the ICCPR in order to protect public health is commonly understood to require that restrictions be provided for and carried out in accordance with law, directed towards a legitimate objective of general interest, strictly necessary to achieve the objective, based on scientific evidence, the least intrusive or restrictive means available, neither arbitrary nor discriminatory, of limited duration, respectful of human dignity, and subject to review (World Health Organization, 2007, p. 9).²⁰

More particularly, in the context of a pandemic, these principles require clear and convincing evidence that the person whose rights are to be curtailed is infected with a contagious disease (or at a minimum, is reasonably suspected of being infected) and poses a demonstrable threat to others; that the intervention is an effective means of combating the public health threat; that the burden is proportionate to the expected benefit; that the measure is the least restrictive of the options available; and that the measure is applied in a non-discriminatory manner (Gostin & Berkman, 2007).²¹

Difficult questions will no doubt arise in the application of these principles to an actual pandemic, particularly in the context of an emerging disease about which little is known. How effectiveness is understood and operationalized will be important. In relation to isolation and quarantine in particular, one might insist upon scientific evidence demonstrating that the disease is contagious and that isolation and/or quarantine stand a “reasonable scientific chance of substantially diminishing the spread of disease” (Bensimon & Upshur, 2007, s. 6). But as Bensimon and Upshur caution, the effectiveness of quarantine “depends as much on evidence from epidemiological studies as it does on explicitly identifying and addressing the preferences and cultural commitments of affected and involved communities” (Bensimon & Upshur, 2007, s. 47-48).

²⁰ In the context of the current outbreak of the Ebola virus and the mass quarantine of the West Point slum in Liberia arguably none of these conditions have been satisfied. The quarantine, originally to last for 21 days, ended after 10 days of escalating protest, violence and food scarcity and likely did more to spread the virus than to contain it; see Rothstein, 2015.

²¹ The World Health Organization’s ethical guidelines on pandemic planning provide that “public health measures that involve significant costs and/or burdens should be reserved for situations where they can be reasonably expected to make a difference to the consequences of a pandemic” (2007, p. 3).

The importance of considering the role of social, economic, and cultural factors in assessing the efficacy of quarantine and social distancing measures is underscored by the experience of SARS in Ontario. There is considerable post-SARS evidence of the tremendous challenges even relatively well-resourced people faced in maintaining quarantine. Reynolds et al surveyed some 1,057 people who had experienced quarantine in Toronto during SARS. Compliance with quarantine behaviours varied from 50.4% (use of mask when other household members were present) to 99.4% (did not go out of the house to socialize) (Reynolds et al., 2008).²² The proportion reporting compliance with all household protective measures was 38.4%, and with all community protective measures 54.1%. Quarantine also came with costs, both financial (although the Ontario and federal governments later introduced financial compensation that partially addressed this issue) and health (symptoms of depression and posttraumatic stress disorder were commonly reported). The data on compliance led Reynolds et al to contemplate the need for the expansion of coercive measures to shore up the effectiveness of quarantine, including quarantine facilities, compliance hotlines, and the immediate issuance of legal orders (Reynolds et al., 2008).²³ This suggestion for an escalation in measures of compliance enforcement is particularly troubling in light of the widely shared medical view that quarantine and isolation will be of limited utility in controlling the transmission of the flu virus (Gostin & Berkman, 2007).²⁴ Escalating compliance measures are rendered all the more concerning by the possibility that, because quarantine creates the impression that the state is actively pursuing the public's health, its use may be driven by its political, rather than scientific, value (Garoon & Duggan, 2008).

²² See also Hawryluck et al., 2004. The latter study involved a survey of 129 persons quarantined in Toronto during SARS. As many as 50% felt they had not received adequate information about infection control, and, as in the Reynolds study, compliance rates varied. As a further consideration, Ries notes the challenge of locating the contacts of those infected; of the twenty-three thousand people who were contacts of SARS patients, approximately nine thousand could not be reached or were only reached after the ten day quarantine period had passed (Ries, 2005).

²³ In Singapore and Hong Kong, measures to enforce compliance were much stronger and more coercive than in Toronto and included cordoning off buildings, electronic monitoring and the use of surveillance cameras.

²⁴ In a recent editorial, Richard Schabas (Ontario's chief medical officer of health from 1987-1997) and Neil Rua had this to say about quarantine: "Quarantine didn't help control SARS and it won't help control Ebola. Because of fear of Ebola, whole areas of West Africa are being cordoned off and airlines are cancelling services. These are forms of quarantine. They will hinder the flow of aid without stopping the disease's spread" (Schabas & Rau, 2014).

But beyond this concern, assessments of what actions are necessary — and of what restrictions on various rights are justified — are substantially impacted by perceptions of risk, and these perceptions are often anything but evidence-based. As Parmet has argued, disease is not only biological, but social and political; as such, the level of fear may have little to do with actual lethality or incidence. She maintains that especially as contagious disease has become less common in developed countries, the fear of such diseases those of us living in such countries experience has increased. Pandemics, by definition, are global outbreaks caused by a strain of virus not already known to be circulating in the human population. The unknown quality of the virus (how it is transmitted, and its impact on morbidity and mortality), the absence of immunity in the population, and the unavailability of vaccines combine with anxieties related to global travel and trade to render pandemics particularly threatening in the Western public imagination. The intensity of this fear creates pressure for state action, which frequently takes the form of strong social controls and, occasionally, extreme measures. By contrast, Parmet points out, “common and deadly diseases, such as childhood diarrhea or cardiovascular disease, elicit little concern and frequently are met with neglect by state officials” (Parmet, 2009).²⁵

Sunstein offers important insights into our perception of risk, delineating two potential sources of error at play when public fear leads to support for the erosion of civil liberties. He calls one error the “availability heuristic” to capture the potential of salient incidents (i.e., incidents that stand out due to vivid imagery or recent occurrence) to generate an exaggerated sense of risk (Sunstein, 2004, p. 969). If the harm is easily imagined, public demand for state action increases, leading to potentially excessive precautions. If not easily imagined, the risk may be neglected (Sunstein, 2004). He also points to the role of “availability entrepreneurs” who actively “drive public fear in their preferred directions” (Sunstein, 2004, p. 970). The second error is “probability neglect,” where focus is directed to the worst-case scenario, regardless of how likely it is to happen (Sunstein, 2004, p. 971).

²⁵ A similar point has been made about the Ebola virus: In the same time period that the Ebola virus is estimated to have caused 1,000 deaths, malaria is estimated to have killed 300,000, and tuberculosis is estimated to have killed 600,000. See Kerridge & Gilbert, 2014.

Sunstein and Parmet both identify the important role of the media in the construction of risk and fear. As Sunstein argues, “[m]any perceived ‘epidemics’ are in reality no such thing, but instead a product of media coverage of gripping, unrepresentative incidents” (Sunstein, 200, p. 976). Indeed the whipping up of fear and of concerns about safety is a common technique of governance (Morley, Hermer, & Mosher, 2002; Parnaby, 2003). The expanding reach of criminal law, the recent proliferation of mandatory minimum sentences, and the creation of quasi-criminal ‘safe streets’ legislation and by-laws, for example, have all been justified by ‘claims-makers’ or availability entrepreneurs as necessary for the safety and protection of the public (or more aptly, some members of the public) (Roach, 2002). Claims of threats to safety, rather than empirical data, have propelled these reforms. With the production of fear comes increased demand for government action and the very real possibility of disproportionate responses and unnecessary curtailment of civil liberties (Sunstein, 2004). Fear, as Gagnon, Jacob, and Holmes maintain, is inherently political, invoked by the state as a tool of governance. They suggest that fear is invoked in public health campaigns (they examine campaigns regarding sexually transmitted diseases in particular) as a “strategy to create a state of permanent (in)security and manipulate people into becoming calculating, rational and self-interested subjects who avoid the perils of human desires and contagion” (Gagnon, Jacob, & Holmes, 2010). In summary, there is good reason to think that assessments of the measures considered strictly necessary to protect public health may be driven more by fear and political expediency than by science.

Another set of questions concerns who will most likely be affected and how readily their rights, in particular, might be ignored. In the ‘preparedness’ environment, responsibility is seen to rest with individuals, as well as governments, to adequately prepare for hazards of all sorts. Individuals are expected to stockpile food and other necessities, wash their hands, disinfect surfaces, and obtain seasonal vaccinations. Voluntary compliance with public health orders — be they for quarantine, isolation, school closures or

a prohibition on social or religious gatherings — is assumed to be a widely accepted norm and practice (Government of Canada, 2015).²⁶ As such, resort to coercion is understood to be exceptional and thus, infringements on rights rare. Moreover, given the emphasis on individual responsibility to prepare, avoid, and comply, those who fail to take these precautionary measures are faulted and blamed for their own neglect.²⁷ Both the SARS and the H1N1 outbreaks made clear that those without resources, such as a home in which to isolate themselves, stockpiles of food, running water and soap for regular hand washing, or access to trusted medical personnel, are less able to protect themselves. Their ability to comply is structurally limited; they are unable, and presumptively not unwilling, to comply. But their lack of compliance renders them more vulnerable to the coercive arm of law.²⁸

Volumes of historical evidence of pandemics tell us that those who are socially marginalized bear the greatest burden in terms of disease acquisition, death, rights deprivations, and depletion of resources and assets.²⁹ History also tells us, repeatedly, that marginalized social groups —

²⁶ See Public Health Agency of Canada, Canadian Pandemic Influenza Plan for the Health Sector, online: www.phac-aspc.gc.ca/cpip-pclcpi. The plan emphasizes personal preparedness but does, in Annex O, detail a coordinating role for the Council of Emergency Social Services Directors in organizing volunteers, distributing food, and creating temporary shelters. The May 2009 editorial of *The Lancet*, issued in the midst of the H1N1, urges readiness to self-isolate at home if flu-like symptoms appear (*Lancet*, 2009). Ontario has produced a series of one page fact sheets about pandemic flu, these include: “Taking Care of Yourself and Your Family: What to Do If You Get Pandemic Flu” (stay home, rest, take a warm bath); “Preparing for a Pandemic Flu: Making Individual and Family Plans” (including a series of questions to consider, such as what to do if your child’s daycare closes, but provides no solutions); and “Staying Healthy During a Flu Pandemic” (the advice is to eat well, drink lots of water, exercise regularly, stay home, wash your hands often, stay away from people, and avoid public gatherings and crowds). Clearly, this advice presupposes access to considerable resources; the overwhelming majority of these recommendations are simply impossible for the homeless to implement.

²⁷ A 2007 New York Academy of Medicine study concluded that “planners are developing emergency instructions for people to follow without finding out whether it is actually possible for them to do so or whether the instructions are even the most protective action for certain groups of people to take” (Annas, Mariner, & Parmet, 2008). The study further notes that the administration’s preference for market-based health care leaves individuals to fend for themselves.

²⁸ This is evident in the case of *City of Newark v JS*, 279 NJ Super 178, 652 A.2d 265 (1993) (holding that illness alone does not permit confinement, but that a homeless person suffering from active tuberculosis could be confined because other accommodations were insufficient).

²⁹ See for example Batlan, 2007. Annas, Mariner, & Parmet conclude that “[m]easures like quarantine, surveillance, and behavior control have historically been targeted at people who are already disadvantaged, those on the margins of society, especially immigrants, the poor, and people of color” (2008, p. 358-59). Gostin & Berkman express concern that “governments would use social distancing in a discriminatory fashion, scapegoating ethnic or religious minorities, or using social distancing to pretextually crack down on dissidents who assemble to protest” (2007, p. 165). And Annas, Mariner, & Parmet remind us that:

Highly discriminatory and forcible vaccination and quarantine measures adopted in response to outbreaks of the plague and smallpox over the past century have consistently accelerated rather than slowed the spread of disease, while fomenting public distrust and, in some cases, riots. The lessons from history should be kept in mind whenever we are told by government officials that “tough,” liberty-limiting actions are needed to protect us from dangerous diseases. (Annas, Mariner, & Parmet, 2008, p. 5-6).

the poor, immigrants, particular racialized groups — have been identified as vectors of disease, scapegoated, blamed, cordoned off, and banished. The inculcation of fear of the homeless and of squeegee workers used to justify Ontario’s *Safe Streets Act* (Government of Ontario, 2005b), combined with the fear of contagion and the absence of resources to protect themselves, may render homeless people scapegoats during the next pandemic. These are the ‘foreigners’ — the internal and external enemies³⁰ — who, as outlined in Canada’s National Security policy, pose a threat to national security and who must therefore be contained and neutralized. The willingness to curtail rights arises not only from flawed perceptions of risk, but as Toope reminds us, from an implicit assumption “that ‘we’ are giving up somebody else’s rights for a perceived improvement in our security” (Toope, 2002).

The promise of procedural justice

As noted at the outset, in response to concern over the violation of individual rights in the name of public health (reinscribed as national security), the availability of judicial review of public health orders is proffered as a means to guard against abuses of power and to ensure the proper balance is struck between individual rights and “the right of the public to be protected against infectious disease” (Government of Ontario, 2005a, p. 335). The Campbell Commission, in its Final Report, *Spring of Fear*, identified a host of “glaring deficiencies in Ontario’s health protection and emergency response laws” (Government of Ontario, 2005a, p. 3). Many of these glaring deficiencies relate to failings in procedural justice, where “confusion and uncertainty are the only common threads throughout the legal procedures now provided by the *Health Protection and Promotion Act* for public health enforcement and remedies” (Government of Ontario, 2005a, p. 9).³¹

For the person seeking to challenge a section 22 order, a fifteen day period to file a written notice, and a further fifteen day period during which the Board must hold a hearing, creates the absurd result that the time period of the original order may well have expired. For example, during the SARS period,

³⁰ See also Dhamoon & Abu-Laban, 2009.

³¹ In addition to the powers reviewed above there are separate powers to make orders and to enforce them for occupational and environmental hazards (Government of Ontario, 2015a, s. 13) and where the Chief Minister of Health needs to act in the face of a health risk (*ibid*, s. 86).

quarantine was usually for a ten day period, so the period of containment and restricted mobility would in all likelihood have expired before an order was subject to review.³² The Campbell Commission also notes the further delay caused by an appeal to the Divisional Court, a leave application, and a further appeal to the Court of Appeal. As such, most rights violations — if subject to review at all — will occur only after the period of isolation, quarantine, or treatment has been completed. The response of the Coalition of Muslim Organizations to Canada’s anti-terrorism legislation captures well the unsatisfactory nature of an *ex post* review:

The adverse impacts of this Bill [C36] will not be remedied by judicial oversight and post-facto vindication. Stern judicial sanctions of the State’s violation of rights make great case law...[.] However, case law will not put together ruined families, regain lost livelihoods, or rebuild friendships and trust, which were fractured by the suspicion, innuendo, and stigmatization sown by the overly zealous acts of the State (Roach, 2002, p. 193).

Moreover, the restriction of appeals of section 35 orders to the Court of Appeal to questions of law alone, and then only with “special leave” is deeply troubling in light of the real possibility, canvassed above, that the evidentiary threshold for resorting to coercive measures may be driven more by fear and political expediency than by science.³³

Further procedural challenges relate to the opportunity for those who are the subject of orders to participate in the processes for review. Given the short timeframes for action and the nature of the rights in issue — security of the person, autonomy, and liberty — and the complexity of the legal regime, it is

³² During the SARS period, between fifteen thousand to twenty thousand people with epidemiologic exposure to SARS were instructed to remain in “voluntary” quarantine, meaning they were to remain in their homes, avoid having visitors, wash their hands frequently, wear masks in the same room with other household members, avoid sharing personal items, sleep in separate rooms, and measure their temperature twice daily. Some health care workers were on “work quarantine” and permitted to travel only between their homes and the health care facilities where they were employed. In total, only twenty-seven section 22 orders were issued during the SARS period. While many characterize the quarantines during SARS as voluntary (apart from these few instances where orders were issued), others question this characterization given that non-compliance would lead quickly to the issuance of an order.

³³ The Campbell Commission describes this as a restriction of access to justice of a person whose rights have been significantly infringed. Campbell Commission (Government of Ontario, 2005a, p. 332).

hard to imagine effective participation without access to counsel. For those without resources to hire counsel, rapid access to state-funded legal counsel will be critical, but nowhere is this assured.

Moreover, a further quandary identified by the Campbell Commission in its work is that of respecting the participatory rights of those subject to orders, while simultaneously preventing the “court process from becoming a vector of infection” (Government of Ontario, 2005a, p. 352). The need to protect the health and safety of court staff may well require specific procedural modifications, such as the ability to conduct hearings via videoconference. A related, but broader, concern is the potential closing of courts; as a Florida bench guide concludes, “[i]f the courts fail to open or to function for any reason, the revered concept of ‘access to justice’ becomes meaningless. To ensure that access to justice is, in fact, a reality, it is essential to make sure that the courts have in place deliberately-designed strategies for addressing potential court-closing emergencies of all kinds” (Florida Court Education Council’s Publications Committee, 2007, p. 4). But as the Florida bench guide and others have acknowledged, in the context of a serious pandemic, access to meaningful procedures may simply be non-existent.

The need for clarity and speed for all concerned leads the Campbell Commission to recommend the creation of a single, simple, codified, self-contained, and complete set of procedures in the Superior Court. As envisioned it would include special procedures, such as *ex parte* applications for interim and temporary orders, and video and audio hearings.³⁴ Significantly, consistent with recommendations of the Commission, the HPPA has been amended to enhance the powers of Medical Officers of Health, to allow for the mandatory surrender of premises for use during an outbreak, to facilitate the sharing among state officials of personal health information, to obligate doctors and nurses to report a patient with a communicable disease who refuses or neglects to continue with treatment, and to expand the police services vested with powers to enforce section 35 orders, yet virtually none of the recommendations of the Commission for procedural reform has been

³⁴The Campbell Commission also makes a broad range of additional recommendations regarding the HPPA that speak to employment protections and the conditions of detention, which I review in further detail below.

adopted in Ontario (Government of Ontario, 2015a, ss. 26; 29.2; 35[6]; 77.6; 77.9). The legislative reforms implemented during the unfolding of the SARS outbreak — the expansion of places of detention beyond hospitals to include other “appropriate facilities,” and the ability to issue orders against a class — remained unchanged, notwithstanding the Commission’s recommendation that, with regard to class orders, the legislation be changed to require reasonable efforts be made to consult with the class prior to the issuance of an order (Government of Ontario, 2015a, ss. 5.0.1-5.0.5; s. 35[3]).

As such, we are left in Ontario with a regime in which a person — or indeed an entire class of persons — can be ordered detained and medically examined without consent, and required to take steps to avoid exposing other people to infection, including through quarantine. Beyond this, where the communicable disease is categorized as virulent, persons can be detained for treatment, absent consent, for six months at a time. Notwithstanding these significant infringements of rights to security of the person, liberty, and autonomy, the procedures to challenge such orders are woefully inadequate; they remain the “confusing maze of overlapping and uncertain judicial powers and procedures best described as a legal nightmare” (Government of Ontario, 2005a, p. 337).

This brings us to what is perhaps the crux of the matter: where persons who either have or potentially have a communicable disease are cast as a threat to the public (rather than respected members of that public), and where fear is cultivated, the ‘necessary’ transgression of individual rights becomes all too readily accepted. Given the dominant narrative propelling this account, the outcome of the “delicate task of balancing individual rights against the right of the public to be protected against infectious disease” (Government of Ontario, 2005a, p. 335) identified by the Campbell Commission, or the justifiable derogation of rights envisioned by the ICCPR and Siracusa Principles, may be already largely predetermined. Mariner, Annas, and Parmet identify the edict that we must “trade liberty for security”³⁵ as the signature phrase — or we might say, the central moral lesson — of the national security approach to

³⁵ In the Canadian context, Toope asserts that a culture of rights is being replaced by a culture of security (2002, p. 283).

pandemic planning (Annas, Mariner, & Parmet, 2008, p. 354). The approach implores us to take for granted (or assume that “all Canadians know” and accept) the imperative to trade individual rights for national security.³⁶ Fear is promoted and safety is promised in return; the violation of individual rights is a collateral, but necessary, outcome (Annas, 2003).³⁷

While we could craft procedures that are more appropriate and responsive, provide timely notice and quick access to hearings, fund access to counsel, delineate clearer evidentiary standards, and undertake other measures to better safeguard individuals rights — steps the Campbell Commission suggests we should take — these measures are unlikely to make a substantial difference for marginalized groups or to the health of the population.³⁸ Indeed, that the Ontario government has failed to act on the recommendations of the Commission for procedural reform is a disturbing signal that those whose rights will be at stake are not worthy of protection. Just as we ought to be skeptical of claims that national security is attained by limiting the rights of those suspected of terrorism, so too should we be skeptical of the claim that public health is protected by the limitation of the rights of those who have (or may have) acquired a communicable disease (Roach, 2002; Paciocco, 2002; Smith, 2003). Rather, a fundamental reorientation is required, one that moves beyond a narrow focus on individual autonomy, brings social context and marginalized populations fully into the foreground, and prioritizes public health preparedness.

Securing Public Health

Rather than accepting the catastrophic events of 9/11 as the backdrop and impetus for its framework, a consideration of past pandemics and the current social context is the starting point in this alternative conception. As noted

³⁶ Annas, Mariner, and Parmet persuasively argue that “the notion that we must “trade liberty for security” is both false and dangerous”; false because “coercive actions are seldom conducive to public health protection” and dangerous “because it provides a never-ending justification for the suppression of civil liberties while failing to safeguard public health” (2008, p. 8).

³⁷ More pointedly Annas argues that the approach can be described as “scare them to death and then take power” (2003, p. 1175).

³⁸ Parmet expresses a similar concern about the limitations of judicial review and the inability of existing legal and ethical frameworks to secure human rights (Parmet, 2009). And many have expressed the broader worry that the culture of security threatens human rights. See e.g. Toope, 2002, p. 4. Toope, however, is more optimistic about the potential of the courts.

briefly above in the Introduction and Justifying Limits on Individual Rights, history reveals that the burdens of pandemics — indeed of virtually all forms of disasters — have not been borne equally; those who are the most socially and economically disadvantaged have suffered the greatest burdens, their interests largely disregarded.³⁹ Of the 62 million deaths projected for the next major influenza pandemic, it is estimated that 96% will be in low- and middle-income areas (both nationally and globally) (Lancet, 2009). In Canada, the H1N1 pandemic in 2009 had a disproportionate impact on Canada's aboriginal population: 25.6% of those hospitalized were of Aboriginal ancestry, although they comprise only 4% of the Canadian population (University of Toronto Joint Centre for Bioethics, 2000; Patterson, 2009⁴⁰). During the influenza pandemic of 1918–1919 the death rate among Aboriginal peoples was five times that of the non-Aboriginal population (Appleyard, 2009). In the aftermath of Hurricane Katrina in 2005, it was clear that income differentials, which in New Orleans were heavily correlated with race, led to significantly disparate outcomes (Purtle, 2012; Kayman & Ablorh-Odjidja, 2006). It is worth underscoring that these burdens include not only death but also serious illness, depletion of resources, forced separation, restrictions on movement, and stigmatization.

These disparate outcomes can be traced to the social processes that construct disadvantage, marginalization, and exclusion (Canadian Red Cross, 2007; Viens, 2013). They are shaped, as Tierney suggests, by the “same dimensions of stratification and inequality that influence people’s lives during non-disaster times,” such as wealth, poverty, age, race, ethnicity, gender, and disability (Tierney, 2006, p. 110). Inadequate shelter and income, illiteracy, poor health, food insecurity, and political marginalization all contribute to social vulnerability. These factors, in turn, are connected to larger social and economic structures and processes — for example, the lack of affordable housing, the declining value of the minimum wage, the growth in precarious work, growing income inequality, and discrimination.

³⁹ Harvey Kayman and Angela Ablorh-Odjidja note that in the “absence of social, political, and economic equality, racial and ethnic minorities and individuals of low socioeconomic status are left extremely vulnerable to every threat that may become apparent” (2006, p. 376).

⁴⁰ Kevin Patterson documenting the impact of epidemics (including H1N1) on Canada's First Nations communities and concluding that “the main reason native people die of infections, at rates that would be inconceivable and entirely unacceptable to other Canadians, is because they are poor”.

Linking the differential impact of pandemics to patterns of systemic and structural inequality repositions pandemics as problems not of national security but of social injustice. Here, scholarship that frames public health generally as a matter of social justice, and that calls for ethical frameworks that would displace the primacy of individual autonomy, help to flesh out an alternative approach to pandemic preparation.⁴¹ The identification of social determinants of health has been central to the framing of public health as a matter of social justice. This approach challenges the narrow framing of the dominant bio-medical view by underscoring the importance of access to adequate housing, income, food security, and social networks, along with the absence of discrimination and social exclusion, in maintaining health (Mikkonen & Raphael, 2010). Cast as a “health equity” approach, it seeks to redress “differences in health outcomes that are avoidable, unfair and systematically related to social inequality and disadvantage” (Appleyard, 2009, p. 3). Significant here is the shift from the physical body and medical expertise as the loci of health, to the impact on health of the social, economic, and political context.

The dominant approach to ethics in health care is principlism. Grounded in the clinical relationship between doctor and patient, and rooted in liberal individualism, this approach emphasizes respect for autonomy, beneficence, non-maleficence, and justice as its guiding ethical values (Baylis, Kenny, & Sherwin, 2008; Cheyette, 2011). Principlism’s focus upon the individual and its prioritization of autonomy lead, not surprisingly, to identification of the potential infringement of privacy, liberty, and security of the person through quarantine, isolation, and forced treatment as one of the pressing ethical issues posed by pandemic planning. In their critique of principlism, Baylis, Kenny, and Sherwin advance a particularly insightful conceptualization of relational autonomy and social justice (2008). Liberal conceptions of autonomy presuppose persons as self-made and self-governing. Relational autonomy, by contrast, understands persons to be constituted by and through social relations, and their ability to self-govern to be shaped by social structures. Social position or location — race, gender, socio-economic status, immigration status, for example — places people differently in their access to and ability to benefit from social structures and resources. This interface reflects and reinforces the distribution of social disadvantage and privilege,

⁴¹ See the literature on social justice approaches to public health, for example Kayman & Ablorh-Odjidja, 2006; Purtle, 2012; Gostin & Powers, 2006.

including access to health and well-being. As such, our framework of public health ethics needs to be expanded beyond the doctor-patient relationship to take into account the manner in which social structures, systems and policies create options and the means to secure health for some, but not others.

As Baylis, Kenny, and Sherwin suggest, this approach to public health moves beyond a conception of distributive justice as the fair distribution of benefits and burdens, to a conception of social justice. Social justice, in contrast to distributive justice, draws attention to how membership in social groups creates disadvantage. It stretches the conceptualization of benefits and burdens to include not only material resources but also participation, power, and self-respect. This offers, in turn, an alternative framework for the conceptualization of pandemic planning.

Voice and participation

The political exclusion of marginalized social groups has meant that their distinct circumstances and needs have been largely invisible within pandemic and other disaster management plans. Of the 37 national pandemic plans (including Canada's) reviewed by Uscher-Pines et al, only ten plans identified groups whose members might be socially disadvantaged or have special needs, and not a single plan systematically identified and addressed the needs of disadvantaged groups. Only one plan identified a need for temporary housing for disadvantaged groups, and discussion of the impact of social distancing measures such as school closures on families dependent upon the food their children receive at school were rarely identified. None mentioned the broader issue of the need to ensure access to food and water or addressed the disproportionate impact of the loss of income on those who are already socially disadvantaged (Uscher-Pines, Duggan, Garoon, Karron, & Faden, 2007).

Based on surveys of voluntary and emergency management organizations, the Canadian Red Cross concluded that significant gaps exist in emergency management plans at the federal, provincial, and territorial levels in addressing the needs of marginalized populations, with the needs of women, transient populations, and new immigrants/cultural minorities the least likely to be considered (Canadian Red Cross, 2007). Importantly, workers in the voluntary sector expressed little confidence that the needs of such populations

would be addressed during a disaster (Canadian Red Cross, 2007). A 2010 Canadian survey of public health staff regarding the responsiveness of plans to “marginalized urban populations” came to a similar conclusion: community groups have not been engaged early enough in planning and as a result, plans are too generic in nature, with inadequate attention to the needs of marginalized groups (International Centre for Infectious Disease, 2010).⁴² Street nurse Cathy Crowe captures the consequences for the homeless of these gaps within pandemic plans:

When SARS hit Toronto it was evident within weeks that shelters and drop-ins and all the people in them would have to fend for themselves. The City’s best plan in the event that homeless people were exposed to SARS included a proposed ‘lockdown’ of Seaton House — the largest men’s shelter in Canada — and ‘home’ quarantine in the same shelter. No plans for proper quarantine facilities. No plans for drop-in centres. No plans to stop the night-by-night movement of people who are homeless and forced to use the volunteer based Out of the Cold emergency shelter sector. This lack of planning would have made it impossible to contain the outbreak should SARS have entered this population (Canadian Red Cross, 2007, p. 15).⁴³

Redressing the invisibility of the distinct needs of marginalized groups and the often misplaced assumptions underlying existing plans requires the active participation and collaboration of marginalized groups in the planning process.⁴⁴ Collaboration is essential to the creation of plans that move beyond an undifferentiated ‘public,’ that are attentive to the distinct needs, expectations and perceptions of marginalized groups, and that ensure “equal protection and quality of services during a pandemic ... regardless of social

⁴²The survey was sent to 288 public health staff and 96 responses were received. Massey et al similarly conclude that the comprehensive plans developed by most countries neglect the needs of marginalized populations. In particular, they note the failure to include the Indigenous people of Australia in a respectful partnership. While the Australian plan recognizes the increased risk for Indigenous people, it does not adequately attend to the specific context of their lives, including profound social inequality, poor access to health care, and institutionalized racism. They urge a respectful and genuine partnership, grounded in respect for human rights, and they warn that “the consequences of inflexibly enforcing a non-Indigenous model of containment will be dire” (Massey et al., 2009).

⁴³As SARS unfolded in Toronto, the city struggled to find a quarantine site for homeless people, eventually settling on one floor of an existing shelter. Leung et al report that efforts were “hampered by the limited availability of suitable facilities and concerns regarding negative reactions from the community near such a facility” (2008, p. 408).

⁴⁴The central importance of community engagement, and in particular of disadvantaged communities is advocated by, for example, the American Civil Liberties Union (Annas, Mariner & Parmet, 2008, p. 5) and the Canadian Red Cross (2007). See also Saunders 3rd & Monet, 2007.

difference” (Kayman & Ablorh-Odjidja, 2006, p. 83). Such engagement also enables those involved in the planning process to understand and consider local knowledge, skills, and networks, all of which will be critical in a pandemic (Canadian Red Cross, 2007).

The Bellagio Principles, derived during a meeting of public health practitioners to discuss social justice and pandemics, echo this imperative (Bellagio Group, 2006). These principles would require explicit identification of disadvantaged groups, their engagement in the planning process, identification of the distinct needs of diverse disadvantaged groups in the context of a pandemic, and concrete plans to meet those needs.

Engaged conversation and collaboration in pandemic planning are also vehicles for building trust. Many of those who experience profound social marginalization have experienced repeated betrayals of trust, including by state actors. They have little reason to trust that the state will act in their interest. This distrust will, of course, not be mended through a few conversations. Rather, it requires ongoing and sustained opportunities for those who experience social vulnerability to participate, not only in conversations about pandemic planning, but in a vast array of areas of legal and social regulation.

Recalibrating the responsibility mix

Pandemic planning invariably entails decision-making regarding the allocation of responsibility for action not only between differing levels of government, but as between the state, community-based organizations, and individuals. As noted in the Justifying Limits on Individual Rights section, current pandemic plans allocate significant responsibility to individuals to be personally prepared and to voluntarily comply with the advice, directives, or orders of state agents; people are expected to stockpile food, shelter or quarantine themselves in their homes, and faithfully practice germ elimination methods.⁴⁵ These expectations are premised upon a number of assumptions regarding the capacity of individuals, which as the Wellesley Institute concludes in relation to Canada’s federal plan and its campaign

⁴⁵ See footnote 26, above, for particulars of the expectations regarding personal preparedness.

for personal preparedness, may be “unrealistic, unfair and inequitable” (Appleyard, 2009, p. 13). Surveys and interviews conducted with homeless individuals in Toronto after the H1N1 pandemic revealed just how unrealistic and unfair these expectations often are.

Between October 2010 and April 2011, 149 homeless individuals in Toronto completed a detailed survey and participated in a structured interview covering matters such as general health, access to shelter, food, and water, and the use of services, including emergency shelters for drop-ins. The interviews also included questions specifically focused upon the two waves of the H1N1 pandemic in the spring and fall of 2009, exploring such issues as access to reliable information, vaccines and health care.⁴⁶ Among the sample, 64.4% identified as male, 30.2% as female, and 2.7% as transgendered; 45% were street-involved youth (age 24 and under), and 24.8% identified as Aboriginal or First Nations. Ninety-six per cent of those in the sample reported being homeless during the H1N1 pandemic. The homeless individuals who participated in the study reported heavy reliance on shelters (59% used shelters between once per month and most of the time, a percentage that rose to 62.4% during the H1N1 pandemic) and drop-in centres to meet basic needs (48.3% reported accessing these every day, 18.1% more than twice per week, and 71.8% during the H1N1 pandemic). Not only do they not have access to a private sphere over which they can exercise control, they are forced to survive within a homelessness infrastructure in which they frequently sleep and eat in over-crowded conditions (for example, 33.7% reported in the survey sleeping in overcrowded conditions once a week or more often) and where constant mobility is necessary to meet basic needs (travelling to drop-ins, engaging in street-level subsistence activities, seeking protection from the elements).⁴⁷ Social distancing measures designed to limit the spread of contagious disease are fundamentally at odds with the structures, institutions, and routines necessary to access food, shelter, and

⁴⁶ The survey and interviews were components of the two CIHR funded projects mentioned in the acknowledgements at the outset, *Responding to H1N1 in the Context of Homelessness in Canada and Understanding Pandemic Preparedness within the Context of the Canadian Homelessness Crisis*. In addition to the surveys and interviews with homeless individuals, service providers and key informants were also interviewed in four Canadian cities: Toronto, Regina, Calgary and Victoria. The specific details are outlined in case study chapters in this book.

⁴⁷ I draw here from the survey and interview data of the Toronto portion of the empirical research described at the outset of this article.

support. The ability to practice recommended germ elimination methods — regular hand washing and disinfecting surfaces — is similarly constrained.

The concept of relational autonomy helps us to see that social structures and processes create limited, and in some circumstances virtually non-existent, options. Rather than blaming individuals for their ‘failure’ to self-protect, or to comply with public health orders, we need to consider what forms of state action are required to enable compliance. The Campbell Commission provides insight into possibilities of this sort. After a lengthy review of quarantine measures, including compliance data, the Commission recommended legislative reforms that would provide a range of employment protections and a “basic blueprint for the most predictable types of compensation” that would be provided (Government of Ontario, 2005a, p. 8). The importance of enabling compliance was borne out during the H1N1 pandemic in the United States, where a major determinant of compliance with social distancing measures was the presence of employer-paid sick-leave (Purtle, 2012).⁴⁸

The Campbell Commission’s analysis also underscores the reciprocity that is essential to an effective pandemic response: governments cannot expect compliance with measures such as quarantine without a reciprocal obligation to ensure the provision of safe shelter and access to adequate food, water, and other necessities, and to provide job security and adequate compensation (Gostin & Berkman, 2007).⁴⁹ The Commission concludes that “[a]ny fight against infectious disease depends above all on public cooperation. ... [which] must be nurtured and promoted,” (Government of Ontario, 2005a, p. 8) adding that “legal powers by themselves are false hopes” (Government of Ontario, 2005a, p. 11). It continues: “Voluntary compliance is the bedrock of any emergency response. It is essential to compensate those who suffer an unfair burden of personal cost for cooperating in public health measures like quarantine” (Government of

⁴⁸ Where Purtle also references one study estimating that “disparities in paid sick leave policies contributed to an additional 1.2 million cases of probably H1N1 among Hispanics.”

⁴⁹ Gostin & Berkman also emphasize the ethical obligation of society to provide those affected with the necessities of life, including safe and humane housing, high quality medical care, and psychological support.

Ontario, 2005a, p. 11). Further, “without public cooperation, laws are little help Legal procedures are useless without overwhelming public cooperation . . .” (Government of Ontario, 2005a, p. 298; 300).⁵⁰

But here again the advice of the Commission has been largely ignored. Ontario’s *Employment Standards Act* provides for a leave of absence, but the leave is unpaid (Government of Ontario, 2016).⁵¹ Moreover, eligibility arises only after an emergency has been declared and the employee has been made the subject of an order under the *Emergency Management and Civil Protection Act* (Government of Ontario, 2009) or the HPPA, or is required to care for a close relative (as listed in the statute) who is the subject of such an order. This is woefully inadequate because it ignores the impact of lost income on low-wage earners and telescopes our obligation of care to a narrow circle of close relatives, omitting the friends, neighbours, and colleagues who may well require assistance in the time of a pandemic. Complete silence surrounds future compensation plans.

Accessing trusted information

Access to timely and relevant communication from a trusted source has been identified as absolutely critical by the Campbell Commission and by many others who think about pandemic planning. Gostin and Berkman have noted that while misinformation has been rampant during past pandemics, the most marginalized members of society have experienced the least access to credible and reliable sources of information (2007). Differences in culture, language, reasoning processes, and literacy all point to the importance of tailored and targeted communications (Vaughan & Tinker, 2009).⁵² But unless those with varied needs participate in the planning and development of the content of communications and communication

⁵⁰ While here the Campbell Commission emphasized that compliance derives from a sense of civic duty rather than a fear of legal consequences, later in its report the Commission expresses a view that “[e]ducation and moral suasion . . . will not bring results unless the people realize that behind them is the long arm of the Law” (p. 298).

⁵¹ In some instances, other forms of unpaid leave, such as the family medical leave (Government of Ontario, 2016, 49.1), the family caregiver leave (49.3) and the personal emergency leave (50[1]), may be available.

⁵² Here again, the experience of the Ebola virus in West Africa is instructive; not only has the absence of trust in state actors presented a major barrier to containing its spread, but so too has the failure to consider cultural practices in burying the dead (in which the deceased’s body is touched). See Banerjee, Mor, Kok, Sorrell, & Hill-Cawthorne, 2014; Gounder, 2014).

strategies, a nuanced appreciation of those differences will not emerge, and communications during a pandemic will be massively uneven, with potentially devastating implications.

Additionally, the importance of a trusted source of information cannot be under-estimated. Indeed the Campbell Commission identified public confidence that medical decisions are being made by a trusted independent medical leader as “*the most important thing in a public health emergency*” (Government of Ontario, 2005a, p. 13). But do we know whom different populations rely upon and trust for information? The Toronto study of homeless individuals specifically asked about who they trusted to provide public health information during the outbreak of H1N1. Health care providers were ranked as the source of the best information about H1N1, followed by the television, shelter and drop-in centre staff, posters and pamphlets, and family members. Community health clinics were the most common point of access to health care for those interviewed (36.9% report using community health centres, while 30.9% reported having a regular doctor, 24.8% used walk-in clinics, and 22.8% used the health services offered through shelters and drop-in centres). Gathering this type of more finely grained information is critical to developing responses that are attentive to the needs of particular groups, and ultimately to our ability to minimize the impact of a pandemic.

Accessing vaccines

There is widespread agreement that in a pandemic there will be not be an adequate supply of vaccines or anti-viral medications, raising important questions about allocative criteria. Much of the literature here — medical and ethical — focuses on medical vulnerability and the importance of preserving the health of first responders and health care workers.⁵³ Again, a shift in focus to a social justice model challenges these widely agreed-upon priorities (O’Sullivan & Bourgoin, 2010; Ahle, 2007). Viewed through the lens of social vulnerability, the issues of crowded living quarters, inadequate food, and poor ventilation become relevant to the determination of priority access. As the Toronto surveys and interviews reveal, homeless individuals

⁵³ The Government of Canada identifies several priority groups (although they are not rank ordered); none of the groups are derived from a social vulnerability analysis (Government of Canada, 2015).

experience significant social vulnerability: they report high levels of poor health (33.6% described their overall health as fair, 7.4% as poor/bad, and 3.4% as very poor/bad). More particularly, 21.5% reported chronic lung disease, 58.75% fatigue, 43.6% depression, and 47.5% a disability. This combination of poor health, inadequate nutrition, overcrowding, and, in many shelters, poor ventilation, renders the homeless particularly vulnerable to the acquisition of communicable disease. While a medical lens of vulnerability may identify some of the homeless for priority access, a consideration of social vulnerability would shift significantly more resources towards the homeless population.⁵⁴

A consideration of social vulnerability not only expands the range of ethical considerations necessary to deliberations about prioritization but also requires that we consider the more pragmatic logistical challenges of ensuring access to vaccines for marginalized groups. During the H1N1 pandemic, for example, a concerted effort to create accessible, community-based vaccination clinics for the homeless was undertaken through a partnership between Toronto Public Health and shelters, drop-in centres, and community-based health centres. This effort resulted in a sizeable increase in homeless people's vaccination rates for H1N1 compared to seasonal flu, from an average of 25% for the seasonal flu vaccine to 38% for the H1N1 vaccine as reported by participants in the Toronto study (a rate similar to that of the general population) (Buccieri & Gaetz, 2013).

Preventing discrimination

Stereotypes of the poor, the homeless, Aboriginal people, racialized peoples, and people with disabilities are pervasive and contribute to the discrimination that limits access to meaningful employment, to education, and to political participation. As noted above, there is considerable evidence from past

⁵⁴Gostin & Berkman note that the criteria frequently employed to determine access prioritization protect relatively high-income earners — those who produce vaccines, first responders, medical personnel — and utterly fail to attend to those who are socially disadvantaged (2007). There are profoundly important issues related to the global access to vaccines and anti-virals; for example, during the 2009 H1N1 pandemic, developed countries bought virtually all the vaccines that companies could manufacture. See Fidler, 2010; Rothstein, 2010; Coleman, 2009.

pandemics and other disasters that these events exacerbate discrimination.⁵⁵ Particular groups have been identified as sources of contagion, scapegoated, demeaned, and disrespected. Pandemic planning informed by social justice requires, as Keil and Ali have argued, planning how to avoid the “identification of infection with race, ethnicity or other socio-physical appearance,” and to develop “safeguards against racist victimization of infected people and those who are targeted as potential risk groups” (Keil & Ali, 2006, p. 25).⁵⁶ As the Campbell Commission cautioned regarding orders against a class of persons, it is “all too easy for officials with lesser sensitivity to act immediately, without consultation, and to think only later of the ensuing stigmatization, disruption, and confrontation” (Government of Ontario, 2005a, p. 320-21).⁵⁷

Conclusion

The evidence to date suggests that the voices of those who are socially marginalized, including the homeless, have been largely silenced in the pandemic planning process. They have not been identified as requiring priority access to treatment or vaccinations, notwithstanding their vulnerability to communicable diseases, their need to travel to access basic necessities, and their lack of access to resources required to take measures to protect themselves. The recommendations of the Campbell Commission regarding the obligations of the state to guarantee safe shelter, food, and water, and to be absolutely clear about available compensation, have been ignored. Social vulnerability finds no place in the national security narrative that reduces individuals to risks, dehumanizing them in the process.

⁵⁵ Selgelid reminds us that “infectious diseases are prone to promote fear, panic, stigma, discrimination, and emotional and irrational decision and policy making” (2009, p. 255).

⁵⁶ Similarly the American Civil Liberties Union suggests that a governing principle must be the protection of minorities and the socially disadvantaged from discrimination (Annas, Mariner & Parmet, 2008). Gostin & Berkman similarly address concerns regarding the discriminatory use of social distancing, quarantine, and isolation (2007).

⁵⁷ To guard against this, the Commission recommended that “the power to order and enforce isolation of a group must, wherever practicable, be preceded by such degree of consultation with the group as is feasible in the circumstances” (321).

Against the dominant narrative of national security, the social justice approach to planning struggles for a place. There are, however, signs of change. There is a growth in scholarship that engages social justice in public health generally, and in pandemic planning more specifically. O’Sullivan and Bourgoïn, in a recent review of the pandemic literature, discern a shift from a focus on medical vulnerability to social vulnerability (2010). Ontario’s Pandemic Influenza Plan for the Health Sector has recently been updated to incorporate “health equity” as a defining principle, promising a strategy that “strives to reduce or eliminate socially structured differentials in health outcomes, building on broader ideas about fairness, social justice and civil society,” and noting that:

For example, the implementation of system-wide school closures has different impacts on groups in society such as single parents/ caregivers, children who participate in school-based nutrition programs, families with low or fixed incomes who cannot afford increased child care costs, and parents who do not have flexible work arrangements, paid vacation or short term leave policies (Government of Ontario, 2013, p. 8).

Equity principles have not, however, moved into action and there are worrying trends in the opposite direction. Income inequality continues to grow in Canada. The Organisation for Economic Co-operation and Development (OECD) ranks Canada as one of the developed countries with the worst income gap (OECD, 2011). After close to three decades of neo-liberal reforms, Banting and Myles describe Canada as a “fading redistributive state” wherein the tax transfer system no longer offsets the growth in inequality generated by the market, and where ideational shifts have replaced equality with efficiency (2013). In this context of growing inequality, how ought we to think about legal preparedness?

As former Chief Justice Roy McMurtry urged in the context of anti-terrorism measures, no doubt there is a role for law and for lawyers to “uphold the rights of the individual in the face of increased security concerns” (Toope, 2002, p. 295). As outlined above, a number of obstacles impede access to an adjudicative forum to review orders made under the HPPA, and procedural

reforms would go at least some distance in protecting the rights of individuals to liberty, privacy, and security of the person in the context of a pandemic. But that distance, in light of the power of the national security narrative, will be very short indeed.

Beyond these measures there is a role for law and lawyers in advancing the social justice approach to pandemic planning. Here the emphasis is upon creating positive state obligations, rather than keeping the state out of the lives of its subjects. Such obligations range from those tied to an actual pandemic — the creation of enforceable employment protections, guaranteed compensation packages, the right to safe quarantine or isolation facilities and to food and water — to more expansive and longer-term measures designed to diminish social inequality. Securing a right to health — not to health care but to health with all that entails in relation to its social determinants — will be our best protection against a pandemic. As legal professionals, our efforts cannot be confined to the contestation of particular and specific deployments of state power to detain, contain, and treat. In isolating justice concerns to this narrow band of activity, the social and participatory domains of justice are ignored.

Baylis, Kenny and Sherwin suggest that the threat of a pandemic has created a “window of opportunity” to think creatively about “an ethics framework that is firmly grounded in our common interest in preventing illness, building physically and socially healthy communities and eliminating health inequities” (Baylis, Kenny, & Sherwin, 2008, p. 196). Perhaps equally so, it presents an opportunity for us to rethink the necessary legal framework, one constructed with the full participation of those traditionally excluded and marginalized.

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