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## Coronavirus (COVID-19): Lessons learned from SARS — A guide for hospitals and employers

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### In this Update

- Lessons learned from the 2003 SARS outbreak and subsequent litigation are key in understanding hospital and government obligations in the context of COVID-19.
- Governments have an overarching *public duty of care* owed to the public at large, not a private duty of care to frontline hospital staff or patients.
- Hospitals have legal obligations during pandemics, including owing a *private duty of care* to their staff, personnel and patients.
- In light of conflicting duties, hospitals must keep in mind the fiduciary duty to act in the best interest of patients and employees, and in particular, the elevated duty of precautionary care, referred to as the “precautionary principle” in planning and taking all reasonable precautions to protect staff.

### BACKGROUND

The designation of a novel coronavirus by the World Health Organization as a global public health emergency has captured headlines in 2020. As of March 3, 2020, there have been 33 confirmed cases of COVID-19 in Canada with 20 in Ontario, 12 in British Columbia and one in Québec.<sup>[1]</sup> The international spread of the virus (63 countries in addition to Canada as of the time of writing) has unsurprisingly stirred memories of the 2003 severe acute respiratory syndrome (SARS) outbreak in Toronto and raised concerns regarding preparedness by hospitals, employers and all levels of government. This Osler Update provides a brief overview of (1) the SARS Litigation (defined below), (2) hospitals’ obligations to have appropriate procedures in place to protect patients and staff and (3) the elevated duty of care which hospitals owe to protect their staff.

## SARS LITIGATION

### SUMMARY

Following the 2003 SARS outbreak in Ontario, affected nurses, patients and their families commenced five actions<sup>[2]</sup> against stakeholders such as the Government of Canada, the Government of Ontario and the City of Toronto, in addition to hospitals, physicians and other stakeholders (collectively, the SARS Litigation).<sup>[3]</sup>

### CLAIMS AGAINST GOVERNMENT

While the SARS Litigation actions varied in their pleadings and choice of respondent, generally the claims against Ontario and Toronto included “*issuing confusing contradictory or otherwise inappropriate directives,*” and the claims against Canada included “*approving or acquiescing in the decision of Ontario and Toronto to reduce infection control systems.*”<sup>[4]</sup>

The only class action by nurses and their families, *Abarquez v. Ontario (Abarquez)*<sup>[5]</sup> included claims against the government of Ontario, the Ministry of Health and Long-Term Care (the MOHLTC, now known as the Ministry of Health), the Provincial Operations Centre (the POC) and the Ministry of Labour (the MOL). The claims included the following:

- that the MOHLTC and the POC failed to provide nurses with timely information about SARS;
- that the directives Ontario issued to hospitals were inadequate, exposing the plaintiffs to the risk of contracting SARS;
- that the MOHLTC or POC was an employer/supervisor under the *Occupational Health and Safety Act* and failed to ensure the nurses’ health and safety in the hospitals;
- that the MOL failed to enforce the directives and occupational health and safety standards; and
- that Ontario breached the nurses’ rights to life, liberty and security of the person under section 7 of the *Canadian Charter of Rights and Freedoms* by exercising discretion in bad faith and for improper motives.<sup>[6]</sup>

### NO GOVERNMENT PRIVATE DUTY CARE

Each level of government brought preliminary motions to have actions against them in the SARS Litigation dismissed because it was “plain and obvious” that there was no cause of action where the government does not owe a private duty of care to staff or patients:

- **The Government of Canada** successfully argued that it was acting in a policy-making capacity during the SARS outbreak (not an operational one), and therefore the Government of Canada did not owe a private duty of care to patients of hospitals.
- **The City of Toronto** successfully argued that it was the Board of Health – an arm’s-length body established under Ontario’s *Health Protection and Promotion Act* – that had issued directives during the SARS outbreak, and therefore the City of Toronto did not owe a private duty of care to patients of hospitals.
- **The Province of Ontario** successfully argued at the Court of Appeal that to find the Province of Ontario owed a private duty of care to staff or patients would place it in conflict with its overarching public duty of care owed to the public at large.<sup>[7]</sup>

## CLAIMS AGAINST HOSPITALS (INCLUDING PHYSICIANS)

The claims in the SARS Litigation pleaded against the hospitals (and physicians) in *Abarquez* stated that the hospitals (including physicians) failed to:

- have any adequate plan of action to deal with the control, diagnosis and treatment of SARS;
- require the use of masks, gowns and gloves by their servants, agents and/or employees during the treatment of patients diagnosed with respiratory symptoms;
- immediately isolate all patients known or suspected to have SARS;
- appreciate and protect members of the public against a disease which they knew or should have known was both readily communicable and potentially fatal; and
- plan or implement a system of measures to protect either patients or visitors from the foreseeable and serious risk of a disease which they knew or should have known was readily communicable and potentially fatal.<sup>[8]</sup>

In contrast to the government, the SARS Litigation established that hospitals have common law and statutory obligations that establish a private duty of care to both hospital patients and staff. This tension between the government's public duty of care and a hospital's private duty of care arose in particular during SARS in response to a number of the directives issued by the MOHLTC to the hospitals. The court in *Williams v Canada* also pointed out that healthcare facilities and professionals are liable for "negligence at the operational level."<sup>[9]</sup> As a result, hospitals have a private duty of care to patients and staff and it would not be sufficient for a hospital to solely rely upon directives issued by government, which only have a public duty of care.

## HOSPITALS ARE REQUIRED TO HAVE A PANDEMIC PLAN

Under the Hospital Management Regulation of the *Public Hospitals Act* (PHA),<sup>[10]</sup> the board of every public hospital in Ontario must ensure that management develops plans to deal with (a) emergency situations that could place a greater than normal demand on the services provided by the hospital or disrupt the normal hospital routine (i.e., a coronavirus outbreak), and (b) the failure to provide services by persons who ordinarily provide services in the hospital.

## OCCUPATIONAL HEALTH AND SAFETY ACT

A hospital's obligations under the PHA need to be balanced with the paramount obligations on hospitals as "employers" and their supervisors, officer and directors under the *Occupational Health and Safety Act* (OHSA).<sup>[11]</sup> The OHSA expressly includes provisions that "prevail" over any general or special Act in Ontario and includes the obligation to take "every precaution reasonable in the circumstances for the protection of a worker."

It is therefore arguable that the duty of care owed by hospitals to protect staff under the OHSA is paramount to the duty of care owed by hospitals to patients under the PHA. This paramountcy, when considered in light of use of the word "precautions" in the OHSA, suggests that the OHSA incorporates the precautionary principle (described in more detail below) into the standard of care which hospitals must meet in discharging their duties to protect staff under the OHSA.

Hospitals and other health care and residential facilities have a specific statutory requirement to develop, establish and put into effect measures and procedures for the health and safety of workers.<sup>[12]</sup> Such measures and procedures may deal with, but are not limited to, the (a) safe work

practices; (b) safe working conditions; (c) proper hygiene practices and the use of hygiene facilities; (d) the control of infections; (e) immunization and inoculation against infectious diseases; (f) the use of appropriate antiseptics, disinfectants and decontaminants; (g) the hazards of biological, chemical and physical agents present in the workplace, including the hazards of dispensing or administering such agents; (h) measures to protect workers from exposure to a biological, chemical or physical agent that is or may be a hazard to the reproductive capacity of a worker, the pregnancy of a worker or the nursing of a child of a worker; (i) the proper use, maintenance and operation of equipment; (j) the reporting of unsafe or defective devices, equipment or work surfaces; (k) the purchasing of equipment that is properly designed and constructed; (l) the use, wearing and care of personal protective equipment and its limitations; and (m) the handling, cleaning and disposal of soiled linen, sharp objects and waste.<sup>[13]</sup>

There is a requirement for employers to review and revise the above measures and procedures in the light of current knowledge and practice at least once a year and more frequently than annually if the employer, on the advice of the joint health and safety committee or health and safety representative, if any, determines that such review and revision is necessary or there is a change in circumstances that may affect the health and safety of a worker<sup>[14]</sup> (such as an outbreak of a novel coronavirus). This ongoing obligation reiterates the importance of hospitals remaining vigilant and reacting to quickly changing circumstances, reminiscent of the cautionary statement made by Dr. Richard Schabas, Chief of Staff, York Central Hospital regarding the second wave of SARS: “SARS I was not avoidable. We were struck by lightning. Everything after that was.”<sup>[15]</sup>

## ELEVATED DUTY OF CARE: PRECAUTIONARY PRINCIPLE

Following the SARS outbreak, the SARS Commission’s Final Report established that hospitals are expected to exercise an elevated duty of care in accordance with the “precautionary principle,” meaning that scientific proof of a particular risk (e.g., airborne transmission of SARS and, therefore, the need for the N-95 mask) is not required before taking precautionary measures against that potential risk.<sup>[16]</sup> In our view, this sets out a higher standard for the duty of care and expands the scope of the meaning “every precaution reasonable” as required under the OHSA. As Honourable Mr. Justice Archie Campbell stated in the SARS Commission’s Final Report, “[t]he point is not science, but safety ... We should be driven by the precautionary principle that reasonable steps to reduce risk should not await scientific certainty.”<sup>[17]</sup>

The SARS Litigation showed that the precautionary principle must guide hospitals in ensuring that staff safety concerns are taken seriously, and that staff are made to feel safe, even if that means implementing or continuing heightened safety precautions that some experts may argue are not scientifically proven as being “necessary.”<sup>[18]</sup>

Recently, Linda Silas, the President of the Canadian Federation of Nurses, has publicly raised concerns that the Public Health Agency of Canada guidelines require a lower standard of care than those set by the Province of Ontario, the Centre for Disease Control in the U.S., as well as comparable agencies in the U.K. and the European Union.<sup>[19]</sup> Each of the latter agencies are recommending the use of N-95 respirator masks for all health care staff working with a potential COVID-19 patient.<sup>[20]</sup> The Public Health Agency of Canada does not recommend the use of N-95 masks in most situations.<sup>[21]</sup> This is the same issue that was addressed in the SARS Commission’s Final Report and was also raised by Linda Silas in response to the Ebola outbreak in 2014.<sup>[22]</sup> The precautionary principle suggests that if there is conflicting or uncertain evidence as to the efficacy of a particular measure, that measure should be implemented if it is reasonable to do so.

## CONCLUSIONS

We recommend that all hospitals review their pandemic plans to benchmark to current best practices and to ensure that they reflect the legal lessons learned from the SARS outbreak, including the SARS Commission's Final Report and the SARS Litigation, with the goal of ensuring that procedures established follow appropriate precautionary measures and include the measures and procedures for the health and safety of workers required by the OHS Act. Where there is conflicting evidence as to whether a certain precautionary measure is required or not, hospitals should adopt the elevated precautionary measure(s).

Hospitals should be cognizant that it will be the hospital (and potentially the hospital's officers, directors, supervisors or other personnel) that will be legally liable for any failures to protect patients and staff from harm, even if hospitals have relied on federal, provincial or municipal government directives in establishing its own plans, policies and procedures. Where there are directives issued by public bodies, the hospital should review such directives with an independent perspective as to whether adhering to such directives will enable to the hospital to discharge its duty to exercise elevated reasonable care, skill and diligence to protect its patients and staff.

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[1] Updates are available from the Government of Canada [here](#).

[2] *Williams v. Ontario*, 2009 ONCA 378 (CanLII) [*Williams 2*]; *Jamal Estate v The Scarborough Hospital*, 2009 ONCA 376 (CanLII); *Henry Estate v The Scarborough Hospital*, 2009 ONCA 375 (CanLII); *Abarquez v Ontario*, 2009 ONCA 374 (CanLII) [*Abarquez*]; *Laroza Estate v Ontario*, 2009 ONCA 373 (CanLII).

[3] *Williams v. Canada (Attorney General)*, 2005 CarswellOnt 3785 (ONSC) [*Williams 1*]; *Jamal Estate v Scarborough Hospital - Grace Division*, [2005] OJ No 3506 (ONSC); *Henry Estate (Trustee of) v Scarborough Hospital*, 2005 CarswellOnt 3758 (ONSC); *Abarquez v Ontario*, 2005 CarswellOnt 3782 (ONSC); *Laroza v Ontario*, 2005 CarswellOnt 3784 (ONSC).

[4] *Williams 1*, *ibid* at ¶¶15-14.

[5] *Abarquez*, *supra* note 3.

[6] *Ibid*.

[7] *Williams 1*, *supra* note 3 at ¶¶89-90; *Williams 2*, *supra* note 2 at ¶¶9-36; *Abarquez*, *supra* note 2 at ¶¶26-27.

[8] *Jamal Estate v. The Scarborough Hospital*, Statement of Claim [2005] OJ No 3506 (ON SC), Court File No. 03-CV-257585CM 1.

[9] *Williams. 2*, *supra* note 2.

[10] RRO 1990, Reg 965.

[11] RRO 1990, c O1.

[12] O. Reg 67/93 Health Care and Residential Facilities Regulation to the OHS Act s. 8.

[13] *Ibid* s. 9.

[14] *Ibid*.

[15] Dr. Richard Schabas, Chief of Staff, York Central Hospital was quoted in Health Canada: “Renewal of Public Health in Canada – A Report of the National Advisory Committee on SARS and Public Health” October 2003, available:

<https://www.canada.ca/content/dam/phac-aspc/migration/phac-aspc/publicat/sars-sras/pdf/sars-e.pdf>.

[16] 2003-2007 Commission to Investigate the Introduction and Spread of SARS in Ontario, “The SARS Commission, Final Report” (December 2006), available:

[http://www.archives.gov.on.ca/en/e\\_records/sars/report/index.html](http://www.archives.gov.on.ca/en/e_records/sars/report/index.html). [SARS Commission]

[17] *Ibid*.

[18] SARS Commission, *supra* note 16.

[19] Osman, Laura, “Nurses’ unions warn Canadian standards for coronavirus protection are too low”, (February 16, 2020) The Globe & Mail, available: <https://www.theglobeandmail.com/canada/article-nurses-unions-warn-national-standards-for-coronavirus-protection-too/>.

[20] Centers for Disease Control and Prevention, Considerations for Selecting Protective Clothing used in Health for Protection against Microorganisms in Blood and Body Fluids

[21] Public Health Agency of Canada, “Coronavirus disease (COVID-19): For health professionals”, (March 1, 2020) Government of Canada, available: <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals.html>; Public Health Agency of Canada, “Coronavirus disease (COVID-19): Frequently asked questions”, (March 1, 2020) Government of Canada, available: <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/frequently-asked-questions.html>.

[22] Kirkey, Sharon, “Risk Ebola will reach Canada increases the longer the outbreak persists: Study”, (October 20, 2014) Canada.com, available: <https://o.canada.com/news/national/risk-ebola-will-reach-canada-increases-the-longer-the-outbreak-persists-study>.

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