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Editor's Forum

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We have all been differentially affected by COVID-19. Some have become sick, cared for others, or lost loved ones to the virus. Others have faced delays in medical care, surgery cancellations, or changes to the health care system. There has been the experience of working within the healthcare system through the pandemic, and alternatively in other sectors such as education, social services, law enforcement, and retail, to name a few. There have been felt impacts on our social lives and psychological health: seeing our children, family, and friends struggle. There has been living with uncertainty, expectations, achievements, and disappointments.

On the theme of the pandemic, I have yet to read a news story, a research manuscript, attend a committee meeting, or other events which, in some way, do not touch on what I understand as related to the ethics of COVID-19. The pandemic has necessitated that we reflect on the ethics of resource allocation, triage, and rationing; the ethics of medical innovations, challenge studies, or other means of accelerated clinical research; the ethics of information sharing, misinformation, and disinformation; the ethics of balancing individual liberties and societal protections; the ethics of incentives, mandates, restrictions, and exemptions; the ethics of timeliness, action, and inaction; the ethics of equality, equity, and justice; and, the ethics of care, essential care, and who is central in care.

What are the ethics of COVID-19? In political circles, SARS-CoV-2 has been described as an intruder on our lives and livelihoods. It does not discriminate. COVID-19 can happen to anyone, anytime, anyplace. But can

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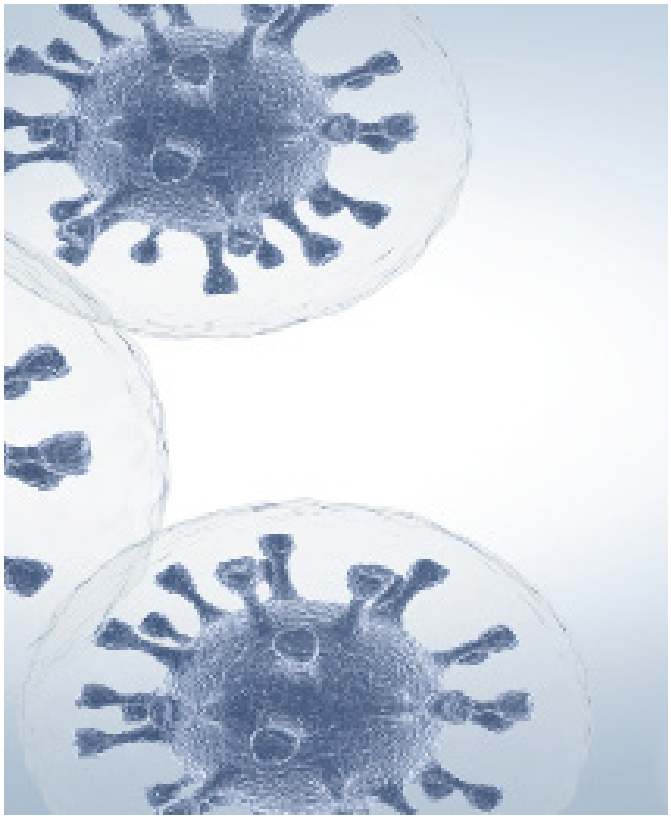
In This Issue…

we speak of a virus as having, or otherwise in and of itself expressing, ethics?

If ethics is a human phenomenon, then we may understand SARS-CoV-2 in the context of how we as individuals within society have responded to it. When we use the language of public health restrictions instead of public health protections, what are we expressing as fundamentally important to us? What value do we place on life and living? How have we safeguarded those who are vulnerable? What structures of privilege have we maintained in vaccination, restriction, or other public health strategies primarily focused on age? How do we as individuals within society continue to prioritize our "own way of life" in our uptake or resistance to measures designed to serve us and protect others? How has our response to SARS-CoV-2 been insular to Canada, recognizing some resources are shared, yet others are kept to our own? How do we understand individual relative to societal health? We have seen enormous investment in scientific/research communities. Are we prepared to make similar investments for environmental health, addictions and mental health, housing and security, and so forth? If not, why are these ethics different? Over the past years, we have seen health care providers and other individuals take advocacy positions in response to government action and inaction. The dialogue around COVID-19 has become polarized in both traditional and social media. For health care professionals, what are our professional responsibilities to public health efforts, and how do they compare to our personal or community responsibilities? What are the responsibilities of our leaders and their followers in a pandemic that has affected everyone, albeit differently?

Now, this issue of *Health Ethics Today* cannot address all of these questions, and yet we ought to at least ask them. More so, we should acknowledge that there is a manifold of ethical perspectives to all of them, recognizing that individuals differ in their values and beliefs and how they understand ethics, respond to ethics, and engage in ethical reflection. This is not unique to the ethics of the COVID-19 pandemic. Every single serious ethical issue provides opportunities for different perspectives.



The articles in this issue are based on presentatations from the John Dossetor Health Ethics Centre's virtual symposium, "Ethics of Living with and Beyond COVID-19" held on November 26, 2021.

Heidi Janz and Gillian Lemermeyer present a thoughtful analysis of the "we" and "they" discourse in the pandemic. They begin by reflecting on the slogan: "We're all in this together." It is worth remembering that the word "slogan" originally derives from the confluence of *sluagh* (army, host, slew) and *gairm* (a cry). As a battle-cry, this phrase does not name an objective. There is no "for the children," "for our country," or even "for humanity." Instead, it simply expresses identity (we), situatedness (are all in this), and solidarity (together). But on reflection, this slogan harbours an aporia. Given our situatedness in the world is an expression of our embodiment, relationships, material resources, and so forth, "we" is in contradiction with "are all in this." This has been expressed in the sentiment "Same storm, different boats." So, it would seem that a "they"

is fated to be fractured from "we" with solidarity existing only as a fantasy. A disability ethics lens responds, "Nothing about us without us." The value of disability ethics as a rights-based approach to ethics is at least twofold. First, it orients us to consider the experiences and perspectives of so-called others (the "us"); and second, it may be a catalyst for societal transformation. The authors' reflections and Janz's personal narrative of navigating COVID-19 restrictions achieve both of these aims.

In "What about the COVID-19 response? Evidence: risk, lockdowns, and vaccine mandates", Ari Joffe offers an analytic ethical perspective to the pandemic response. Public health restrictions (or alternatively, public health protections), just as vaccination mandates, have polarized segments of our society. In the effort to support reflection, I have provided a commentary and Joffe a rebuttal alongside his article. I hope the reader finds these juxtaposed perspectives helpful.

Tracey Bailey and Emily Cook-Bielech provide ethical and legal reflections on how we have navigated the pandemic with considerations for ethical frameworks for justifying decision-making, clarifications on powers of key decision-makers, and changes to legislation. It can be argued that as we are faced with wave after wave after wave, we have ethical responsibilities to learn from our actions and inactions. There is certainly a great deal to learn from Alberta, and hopefully, Alberta can learn from other provinces and elsewhere in the world. Where differences in rationale, frameworks, legislation, and so forth exist, we need to reflect on whether such differences are appropriate.

Finally, Peter Brindley provides a thoughtful reflection on "equanimity" in COVID-19 in his article titled "Christmas time in COVID-healthcare: Bah humbug, bah happiness." Equanimity is not a term that we use on a day-to-day basis in health care. It means "evenness of mind, calmness, good-will, and kindness." It is not simply an outward maintaining of composure but rather expresses a holistic balance, evenness, or harmony. Whether we are a student or a senior healthcare practitioner, a nurse or a physician, or work in the community or critical care, we may aspire to equanimity both in our personal and professional lives. In reading Brindley's narrative, I am reminded that the SARS-CoV-2 has not only disrupted many of our lives but also spurred us to reflect on what is really important to us. How do we want to spend our remaining professional and personal lives? What offers fulfillment and meaning during those events we look forward to today (yes, one day I hope to go on a vacation outside of Edmonton again) and in our day-to-day lives (those everyday weekdays and weekends).

I hope the readers of *Health Ethics Today* reflect on the meaning of living well through and beyond COVID-19. None of these papers are the final say on their chosen topics. Instead, they offer opportunities for reflection on our shared past and future.

What Does it Mean to Say That We Are All in this Together?

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Since March 2020, public health messaging regarding the COVID-19 pandemic has invariably featured the slogan, "We're all in this together." The optimists among us may have initially been tempted to point to this discourse as a sign of a resurgence in the ethic of the Common Good—an increase in the value that our society attributes to the lives of those who are considered vulnerable in and by our society, for example, older adults and people with disabilities.

Unfortunately, it was not long until the first schism in the public conception of "we" emerged. Using the refrain that "we are all in this together,", public health officials urged that "we" needed to come together to "protect elders and those who are vulnerable among us." Inherent in the discourse of this public health imperative is the subtle yet clear distinction between the healthy, majority "we," and the sick and vulnerable minority "they".

This distinction was not-so-subtly reinforced by Alberta premier, Jason Kenney, in May of 2020, during a debate in the provincial legislature, "We cannot continue indefinitely to impair the social and economic as well as the mental health and physiological health of the broader population for potentially a year for an influenza that does not generally threaten life apart from the most elderly, the immunocompromised and those with comorbidities" (Braid, 2020).

As the pandemic continued to unfold, notions of "we" and "they" became further complicated by shifting public attitudes towards public health measures in the form of pandemic restrictions and mandates. Such ongoing slippages between, and redefinitions of "we" and "they" have each added to the collective anxiety in this pandemic insofar as they function as reminders that no one can ever be totally sure of their enduring membership in "we".

In this paper, we will consider several questions in an exploration of the official public health messaging and social discourse that has been prevalent and evolving throughout the COVID-19 pandemic:

1. Who is the "they" implicit in our conception of "we"?
2. How have categorizations of "we" and "they" changed through the course of the pandemic?
3. How have problematic COVID-19 policies resulted in people with disabilities, and other marginalized groups, becoming collateral damage?

The Shifting "We"

At the beginning of the pandemic, we were all hungry for reassurance that everything was going to be okay.

That was long before we knew that millions of people would die worldwide and long before we suspected we would still be navigating a new social life many months later. However, even then, the rallying cry "We are all in this together" from medical officers of health, political leaders, and news anchors, seemed tinged with a tone of trying to convince us, a plea or even a warning from those whose briefings pointed to dark days ahead if the spread of the virus was not contained. Nearly 2 years in, the divisions created, revealed, or exacerbated by the pandemic seem deeper and more antagonistic than ever.

All of this begs the question: Who is "we" anyway? Any reference to "we" necessarily implies a "they." But, given the constantly evolving nature of COVID-19, notions of who is part of "we" and who is part of "they" have been continuously shifting, along with public health measures and public attitudes toward them. When the initial restrictions were implemented, we were the ones staying home ordering food online and baking sourdough. Feeling lonely and afraid perhaps, intending to protect ourselves and make sacrifices for the greater good, with some sense of virtue, for we were told that was the right thing to do. And the first *they* were those still out socializing, denying the severity ("It's just a flu.") and even the existence of the virus.

There were some immediate inconsistencies even in this very first division – for those leaving their house to work at the grocery store or the gas station or a restaurant making food for take-out, an exception was made. In fact, those working these jobs (that happened to be both low paying and low status) were considered brave to be going out into the world. For a moment, the public discourse revealed our hypocrisy around what work is actually essential to our lives.

Other dichotomies developed in response to public health restrictions. Early in the pandemic, as the number of cases continued to climb, it became commonly required in many jurisdictions to wear masks. Reports of sometimes violent antagonism between "maskers" and "anti-maskers" in stores and public places became common (Grummett, 2020). A similar division is occurring between those who have been vaccinated and those who have not - by choice or other reason. Vilified in the media, people who have chosen not to become vaccinated have been lumped together as so-called anti-vaxxers.

As a group, healthcare providers have arguably experienced the most fluctuations in terms of being perceived as either "we" or "they". In some jurisdictions, like Alberta, the restrictions were emphasized as necessary to preserve ICU hospital capacity, personnel, and equipment needed to treat COVID-19. As those initial case counts began to go up and we saw more and more hospital admissions and deaths, the health care providers were lauded as perhaps the most essential of all, celebrated by banging pots on balconies and front porches, by lawn signs, and Twitter likes.

However, at least some public sentiment toward physicians, other healthcare professionals and the healthcare system, in general, has swung to be characterized by mistrust, disbelief, and even accusations of "fear-mongering". After months of heavy workloads, and difficult conditions, which, for some, included separation from their families and heartbreak compounded by unresolved grief, the confrontations outside hospitals seemed particularly cruel. The seeming defiance of people who remained unvaccinated prompted many in the public and the press, including some healthcare providers, to start questioning the provision of care for those who had not been vaccinated.

We note that we are not claiming equivalence in terms of the science that supports each side in the preceding examples, but our focus is on the division and harm caused by the dualities themselves.

Through a Disability Ethics Lens: "We" and "They"

One method of getting a clearer understanding of the how the constructions of "we" and "they" have evolved through the course of the pandemic, particularly concerning people with disabilities and other marginalized populations, is to view them through a disability ethics lens. Disability ethics grew out of the disability rights movement and

shares its central tenet: Nothing About Us Without Us. Thus, while the chief concern of health ethics can most basically be defined as determining how to act rightly in healthcare contexts, the chief concern of disability ethics is ensuring that the perspectives and rights of people with disabilities are central to ethical discussions and debates involving disability and people with disabilities. Related to this, a core principle of disability ethics is to affirm the equal worth and worthiness of all human life, regardless of the presence or absence of disability. Adherence to this principle during a global pandemic which is widely triggering responses based on ableist utilitarian ethics is as vital as it is challenging.

Viewed through a disability ethics lens, therefore, the fault-lines which mark the divisions between "we" and "they" are made clearly visible and readily identifiable as being rooted in ableism. Disability scholar Gregor Wolbring notes, "Ableism is one of the most societally entrenched and accepted isms" (Wolbring, 2008). Unlike sexism or racism, however, ableism remains a largely unacknowledged form of discrimination.

Problematic Policies

The constant defining and re-defining of "we" and "they" that has occurred through the course of this pandemic has resulted in many kinds of marginalization, which, in turn, has left a lot of collateral damage in its wake. For example, the prevalence of medical ableism has resulted in the creation and implementation of several pandemic policies which have had disproportionately negative impacts on people with disabilities. One such pandemic healthcare policy which has been very troubling for people with disabilities, particularly people with communication disabilities, since the earliest days of the pandemic is hospital visitor policies.

A View of Pandemic Ableism: Breathless in the Emergency Department

As someone whose disabilities include a significant speech impairment, I (author HJ) have made it a rule never to go into the Emergency Department (ED) without an aide or a friend with me to assist me with communication. This is because the risk of my not being able to make myself understood to clinicians and other healthcare personnel is great, and my chance of having an adverse outcome due to a combination of miscommunication with the medical team and the high probability that the prevalence of medical ableism could result in erroneous judgments being made about my quality of life is even greater. But the advent of COVID-19 suddenly rendered my policy of never going to ED alone not applicable. Thus, it was that, in November of 2020, I entered ED entirely alone, in respiratory distress, and, frankly, terrified.

Why was I terrified? Well, first, of course, there was the whole having-trouble-breathing thing! But also, there were memories of the numerous first-hand accounts that I'd heard over the years from friends and colleagues with disabilities who have had Do Not Resuscitate (DNR) orders arbitrarily placed on their charts without their knowledge, and who have consequently needed family and friends to monitor their charts for the appearance of unauthorized DNR orders, and to advocate for their removal. Similarly, there were more recent anecdotal accounts that I'd heard from friends and colleagues with disabilities about physicians asking them, repeatedly, whether they would want interventions that would generally be considered routine for nondisabled people, interventions such as receiving supplemental oxygen through nasal cannula. And then being asked, again, "Are you, sure?" It was having all these things percolating in my mind that caused me to pre-emptively respond to the ED physician's inquiry about Goals of Care with all the clarity and force that my 82% oxygen-saturated lungs could muster "R1!"

Fortunately, I had two saving graces during my first 18 hours in ED that helped mitigate the potential hazards of going into hospital alone. Firstly, all of the friends, aides, and "fraides" (combination friend and aide) who would normally have been taking shifts being with me in the hospital were now calling the

hospital to check on me. This alerted the nursing staff to the fact that I was very much connected to a community of support outside the hospital. Secondly, I had the blessing of an exceptionally attentive nurse who combined my care with assisting me to make and receive phone calls and text messages. One such phone call was from my brother, saying that he had just received a phone call from my doctor to discuss my diagnosis. With some consternation, I told my brother that I had yet to see said doctor. However, a couple of hours earlier, a resident had come in to take my medical history. Or rather, he *attempted* to take my medical history. From my very brief interaction with him, it was clear that none of my responses to his questions had registered. This, I surmised, was what prompted my attending physician to call my brother. A relevant piece of information about the division of labor in my family is that I have long been the go-to person for all medical decisions involving our ageing parents, and, of course, myself. In return, my brother, the engineer, deals with all things logistical, practical, and not involving human emotion. But now, my poor brother, with all the tranquility of a deer caught in headlights, was compelled to relay the information he was given about my rather complex medical condition, as it had been related to him by my attending physician, who I had yet to meet! After I finished the call, I exclaimed to my nurse, who looked, almost, as exasperated as I felt, "You know, I'm a prof at the ethics centre at the University of Alberta. I can handle conversations about my condition!"

After uttering an expletive, the nurse said, "I'm going to go find your doctor and make him come talk to you!" (I didn't actually see this, but I could envision her dragging the doctor by the ear to my bedside!) At any rate, the doctor did come and have an actual conversation with me about my condition and treatment plan. And I'm happy to report that, for the remainder of my hospital stay, everyone on my treatment team interacted and engaged with me as they would with any other patient. Nevertheless, my experience has left me deeply concerned about what happens to people with physical and/or communication disabilities who are forced to go into ED alone, due to pandemic restrictions, but who do not have the benefit of either an exceptionally observant and attentive nurse, or the status of having a healthcare-related job. In my view, this is an issue that the healthcare system urgently needs to address, even (especially) during the COVID-19 pandemic. This is because the chances of people with disabilities suffering adverse consequences due to ableist assumptions about their condition are too great.

Concluding Thoughts

The dichotomies and divisions that have developed through the course of the pandemic have been stacked on top of already long-standing issues of discrimination, a precarious stack.

The inclination to dismiss, caricature, and summarize groups of people creates deep divisions that engender more hurt and distance between us. As we may yet see new dichotomies and deeper divisions emerge and even the most diligent are COVID-fatigued.

The irony of critically examining the rallying cry "we *are* all in this together" is that, of course, the physical reality is that we are all in this together. Not as an attempt to convince people to wear masks, keep distanced and get vaccinated, not as an exclusionary or inclusionary construct, but as a reality of our existence. It has been said before, the virus itself knows no borders, and does not discriminate in its biological imperative to live and replicate.

We hope that by being awakened to the divisions exposed during the pandemic and the pre-existing discrimination more fully revealed by the pandemic that we cannot possibly go back to ignoring the inequities that exist within our healthcare system and our world. As we go forward with and eventually beyond the pandemic, can we remember enough to consider shaping—not a *new normal* —but a new way of living and being that is truly inclusive in that it recognizes that we *really are* all in this together?

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What About the COVID-19 Response? Evidence: Risk, Lockdowns, and Vaccine Mandates

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I aim to address the moral permissibility of some of the SARS-CoV-2 pandemic responses that have occurred, and that continue to occur. My main empirical claim is that evidence can help us assess the moral permissibility of these responses, such as broad lockdowns and vaccination mandates. Without a sound evidence basis, public health measures should not be judged as moral. Therefore, I focus on reviewing some of the evidence that is, in my view, most important for this determination.

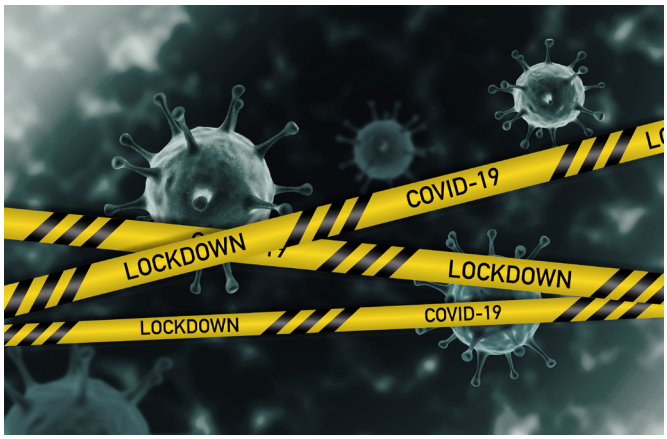
My first point is that the risk of severe outcomes from SARS-CoV-2 infection is extremely age-dependent – *it is not the case that we are all at high-risk from the virus* (Joffe & Redman, 2021). Children and young adults are at extremely low-risk for death from infection, with an infection fatality rate of less than 0.003%; this is lower than the infection fatality rate from influenza in past years. Although there are higher-risk children with severe life-threatening comorbidities, especially neuro-disabilities, their risk is still extremely small, with less than 3% of their deaths overall during the pandemic being attributable to COVID-19 (Smith, et al., 2021). Adults under the age of 50 years are not at high risk of death from infection, with infection fatality rates lower than from influenza in past years. At age 45-49 years the median infection fatality rate is about 0.1%, meaning that 99.9% survive the infection. The infection fatality rate from SARS-CoV-2 rises dramatically in those age 70 years and older, and in those age 60-69 years with multiple co-morbidities. In non-nursing-home adults aged 70-80 years the infection fatality rate is about 2-3%, and for those in nursing-homes can rise to even 25%. These global numbers from review articles are similar in Canada, with *case* fatality rate in those under the age of 70 years about 0.3%; it is important to note that *infection* fatality rates (proportions of deaths among all infected people) are almost always 5-10X lower than *case* fatality rates (proportions of deaths among people diagnosed with a disease), because many infections are not identified as cases,

particularly among those who are asymptomic or have mild symtoms. The case hospitalization and ICU admission rates in Canada for those under the age of 70 years are about 3% and 0.7%; again, the infection hospitalization and ICU admission rates can be expected to be 5-10X lower. For children aged 0-19 years these case rates have been about 0.5% and 0.1%. Case ICU admission rates do not rise above 3% until the age of 70 years and older. Of importance, the main risk factors for higher severity of illness, apart from age, are obesity and physical inactivity (Sallis, et al., 2021). Children and teachers at school did not have a higher risk of infection or hospitalization than other working-age adults, having similar risks as those in the community; outbreaks at schools have been uncommon, small, and usually due to an infected adult (Goldfarb, et al., 2021).

Many are concerned about the risk of long-COVID symptoms lasting for months. My reading of the evidence suggests that this risk has been exaggerated. Long-COVID in children is rare. In studies of children with a control group, the incidence of persistent symptoms was not different between those infected with SARS-CoV-2 and those not infected; if long-COVID occurs, it would be in less than 1% of infected children (Molten, et al., 2021). In adults the incidence of persistent symptoms is likely less than 3% (Office for National Statistics, 2020-2021). A recent large study found that persistent symptoms were associated with the belief that one had had COVID-19, but not with serology-confirmed COVID-19, meaning that some cases may be from a Nocebo effect (i.e., negative expectations, Matta, et al, 2021). Keep in mind that during the pandemic there has been about a 30% prevalence of anxiety and depression symptoms in the adult population, making it difficult to discern long-COVID from pandemic-associated symptoms.

My second point is that broad lockdowns are based on *three assumptions that fail to withstand critical scrutiny*. First, it is assumed that lockdowns are highly effective to reduce transmission and hence cases of SARS-CoV-2. However, there are now over 25 studies comparing the stringency of lockdown between different locations that find lockdowns are either ineffective or have very little effect (Joffe & Redman, 2021). This may be because broad lockdowns do not focus protection on the highest-risk, shifting the burden to the working class and underprivileged, forcing young people to move back home with older parents, failing to protect seniors in nursing-homes, and forcing congestion at other points in social networks. Broad lockdowns also do not consider endogenous behaviors, and thus may have minimal incremental benefit over endogenous behavior changes, and worsen risk factors like obesity and physical inactivity. Second, it is assumed that if lockdowns were highly effective at reducing cases they would have a favorable cost-benefit balance. However, there are now at least 11 studies finding that even effective lockdowns have at least 5-10X higher cost than benefit on population wellbeing and mortality (Joffe & Redman). Many important costs must be considered (Joffe, 2021). Recession and government debt will mean reduced government spending on social determinants of health [e.g., healthcare, education, roads, sanitation, housing, nutrition, vaccines, safety, social security nets, clean energy] with future "statistical deaths". Loneliness and unemployment with deterioration in mental health have not just short-term costs on wellbeing and substance use, but long-term costs on population lifespan and chronic diseases. Lost education will widen gaps between rich and poor, and reduce future earnings and lifespan. Disrupted healthcare with missed diagnoses and treatments will result in excess morbidity and mortality. Vulnerable groups have been disproportionately harmed, with effects on hunger, poverty, missed immunizations, intimate partner violence (including unwanted pregnancy, unsafe abortion, genital mutilation, child marriage, child abuse), and exacerbation of inequality. Third, at times, it is assumed that lockdowns are the only response available. However, even if true, even if all alternatives have been applied, if lockdowns don't work and cause harm, they should not be used. In addition, there is the option of using Emergency Management principles to respond to the public emergency affecting all of society (Joffe & Redman, 2021). Some

affecting all of society (Joffe & Redman, 2021). Some priorities include: don't induce fear; focus protection on the most vulnerable [older adults, especially those with comorbidities]; create healthcare surge [instead of reallocating existing capacity by shutting down healthcare for all conditions except COVID-19]; improve vaccine education and access [especially for hard-to-reach groups], and maintain functioning of critical infrastructure [e.g., don't lockdown, don't close schools, and don't mandate vaccines (discussed next)].



My third point is that high vaccination rates are important, *with the aim to prevent severe disease* (e.g., hospitalization, ICU admission, and death). As such, vaccination should be strongly encouraged in adults, particularly those at high-risk of adverse outcomes. The question is whether vaccine mandates are morally permissible to achieve this aim. The efficacy of vaccine mandates to reduce cases in the population (by reducing transmission and providing herd immunity) is unclear at best. Increases in COVID-19 cases were unrelated to levels of population vaccination across 68 countries and 2947 US counties (Subramanian & Kumar, 2021). There are reasons that may explain this lack of efficacy. First, vaccine efficacy, especially for infection and transmission, is waning over time. Many observational studies find that by 4-6 months vaccine efficacy for infection waned to less than 50%, and in some studies, by 6-7 months was negligible (Chemaitelly, et al., 2021; Tartof, et al., 2021). Several studies find that breakthrough infections in vaccinated people have similar viral load to the unvaccinated, with vaccine efficacy on transmission waning substantially (Eyre, et al., 2021; Singanayagam, et al., 2021). Moreover, vaccination may reduce severity of symptoms such that breakthrough infections are not recognized and may be associated with behaving with a false sense of security. Even with 100% population vaccination rates herd immunity is not possible, and SARS-CoV-2 is (or will be) endemic. The reality is that "no amount of community vaccination will produce elimination of transmission. *Vaccinated adults will be infected sooner or later*…(Gur-Arie, et al., 2021). Second, in previously infected people there is no need to mandate vaccination, as natural infection provides immunity at least as good as vaccine-induced immunity (Alexander, 2021). So far, evidence suggests that natural immunity has not waned in efficacy, estimated at 80-100% against re-infection (and re-infections are in general milder). Natural immunity, even after mild infection, is likely broader [i.e., to the complete virus, including mucosal immunity and long-lived B-cell, Plasmablast, and T-cell memory] and more likely to include variants of concern. Theoretically, vaccination is unlikely to stop emergence of variants of concern: there is enormous evolutionary pressure on the virus to continue mutating to evade the immunity of the vaccinated, while there is less immunity to evade in the unvaccinated.

There are also concerns with mandating vaccine in children. First, children are at very low individual risk from COVID-19, and therefore the vaccine is of little benefit to children (Joffe & Redman, 2021). Second, the low risk from COVID-19 in children makes assessment of potential vaccine risks even more important. There is a known risk of myocarditis/pericarditis with mRNA vaccines in young males, with most reports suggesting this occurs in over 1/5000 male vaccinees age 12-24 years. One study estimated that this will cause more hospital admissions in young males than even high community rates of COVID-19 cases (Hoeg, et al., 2021). The potential for rare long-term vaccine harms is also concerning given that there is lack of data (Gur-Arie, et al., 2021). If any serious events occur this may affect vaccine confidence in general, not just for COVID-19. It is important to note that it is unknown whether vaccine can prevent, or actually cause Multisystem Inflammatory Symdrome (MIS-C), given that mRNA vaccine is a biological treatment that induces production and circulation of the S-protein.

Third, given that mRNA vaccine is a biological treatment that induces production and circulation of the S-protein. Third, given that adults in Canada can be protected from severe COVID-19 by getting their own vaccine, it is unclear that vaccinating children is necessary for their protection. Only 2-5% of people in low-income countries have been vaccinated, and prioritizing vaccines for high-risk adults in these countries likely far outweighs the benefit of vaccinating healthy children in high-income countries.

Unvaccinated people should not be pejoratively labelled "anti-vax", with the resulting dehumanization of 'them' as an out-group. The majority are vaccine 'hesitant' or 'deliberating', largely due to (often deserved) loss of trust in the system of public health and Big Pharma (Doidge, 2021). Lower vaccination rates are present in racial/ethnic minorities and lower income groups, often due to historical and persistent underinvestment in public health that has resulted in unequal access, structural racism, and increasing inequality. Many lack the luxury of transportation, time off work, and internet access, and have language barriers. Vaccine hesitancy is not a stable trait precluding vaccination, and people often become willing to be vaccinated. One approach to encourage vaccination is punishment (i.e., vaccine mandates). Punishments for not being vaccinated include economic deprivation (losing jobs and education), social deprivation (losing access to society, including to public spaces, travel, restaurants, and gyms that are labeled 'nonessential', with increasing isolation), and surrendering rights (to security of the person, bodily integrity, informed consent, and refusal of medical treatment). This coercion may not work well, especially in those who already distrust authorities (for good historical reasons) and who value their autonomy. Rather, this may generate resentment and further loss of trust, and reduce the workforce, including in healthcare. A better approach may be to demonstrate trustworthiness by engaging and persuading hard-to-reach groups, with a commitment to equity of access (e.g., help with appointments and travel, mobile vaccine units, community leader engagement) and better messaging (e.g., emphasizing personal health benefits rather than exaggerated claims of 'herd immunity' or for 'the safety of the vaccinated').

Now for my conclusions based on this evidence. Are broad lockdowns morally permissible? No. The benefits are very little, if any; the costs are very large, and outweigh any benefit; and due diligence to demonstrate the necessity of giving up Charter Freedoms has not occurred. Are vaccine mandates morally permissible? No. The benefits are unclear at best. In adults this is especially so given that vaccine efficacy for infection and transmission is waning and cannot provide herd immunity, and natural immunity is likely superior and does not necessitate vaccine. In children this is especially so given their very low risk from COVID-19, known vaccine side-effects (e.g., myocarditis), unknown long-term safety, and that adults can be protected from severe disease with their own vaccine. The costs are high. This includes labelling 'others' as 'anti-vax' with resulting 'us vs. them' attitudes and dehumanization; invoking coercion (instead of bringing vaccine and education to hard-to-reach marginalized populations); and neglect of global equity (what about high-risk older adults in less fortunate countries?). A better response is possible, using the Emergency Management process, but that is a topic for another day (Joffe & Redman, 2021).

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Editorial Commentary

Michael van Manen, MD, FRCPC, PhD

Ari Joffe offers an analytic ethical perspective to the pandemic response. In reading this form of writing, the reader needs to consider the evidence presented and how it is used to form arguments. From an evidence perspective, there has been a flood of research in response to the COVID-19 pandemic. It is challenging to grapple with both the volume and, at times, quality of evidence. I say this not to take away from Joffe's review of the literature, but rather to point out that these forms of argument need to be read as tentative rather than definitive in their conclusions as evidence is gained.

Regarding premises in Joffe's article, some are quite explicit, while others may be less obvious to the reader. For example, Joffe provides evidence for the statement that SARS-CoV-2 infection is age-dependent, explaining how the risks of serious illness and death are low in children and young adults using epidemiologic data. What is unspoken is whether SARS-CoV-2 infection presents other significant risks to them. For example, if a child acquires and transmits SARS-CoV-2 to those at higher risks of serious illness and death, such as older parents, grandparents, and other individuals in their lives, does this not

also meaningfully affect them? It is important to acknowledge such risks recognizing not all families have the ability to change their living arrangements in response to SARS-CoV-2; parents may rely on grandparents for childcare or, alternatively, families provide care for those who are elderly or otherwise at increased risk in their shared home.

Underlying Joffe's arguments about lockdowns is proportionality: whereby the morality of a public health action is judged based on the calculable burdens imposed by the act itself and its consequences. Joffe aptly shows that lockdowns are not without significant harms, which may disproportionately affect individuals who are already disadvantaged within society. And, he calls into question the efficacy of lockdowns in preventing outcomes such as disease transmission. Pandemic responses should be timely and proportionate in risk when measures are applied. The question is whether the direct and indirect harms of SARS-CoV-2 infection ever exceed those of broad lockdowns. It is important to highlight that lockdowns do not necessarily entail an "all or nothing" approach such that clarification is needed in terms of what constitutes a lockdown. There are the host of capacity limits, curfews, and other public health measures that can be applied without so-called locking down. In fact, it could be argued that in Alberta, and elsewhere in Canada, we have yet to actually have a true lockdown recognizing measures have been only partially applied with varying stringency and enforcement.

Regarding vaccination mandates, it is important to note that Joffe is not arguing against vaccination. Vaccination reduces the risk of severe illness and death in those at high risk. While vaccinated people can transmit infection, reducing the number of infected people, in turn, reduces transmission. The scientific evidence around how much vaccination reduces transmission beyond reducing the number of infected individuals is evolving, especially with the emergence of new variants of concern. And it does need to be acknowledged that vaccine mandates are associated with increased vaccination rates as observed by increased vaccination rates in provinces within Canada and other jurisdictions following introduction of vaccination exemption programs (aka passports). The question is: are vaccination mandates an appropriate means of promoting vaccination? If one starts with a stance that vaccination should eliminate rather than reduce transmission, a parallel argument can be made to seatbelt mandates. Seatbelts reduce the risk of injury and death in motor vehicle collisions. However, in themselves, they do not reduce the number of motor vehicle collisions. So, is it morally justifiable to mandate seatbelts when they do not reduce collisions? Now, to be clear, one should recognize that seat belts are certainly different than vaccinations. That being said, this comparison does show the danger of forming argument based on dichotomies that consider selective outcomes. This also does become a question of what kind of a society we want to live in, and also whether we appreciate that reducing risks of illness, injury, and death preserves health care resources for society at large.

Finally, Joffe questions the utility of vaccines specifically in children, and with regards to children, this does come back to asking whether vaccination protects children against indirect risks of SARS-CoV-2 infection. We should ask what it says about us if we vaccinate those who are unable to give consent to boost our population vaccination numbers in response to a segment of adults not wanting to give their consent. We should also consider how such strategies detract from the global need for vaccination of those individuals at high risk in low-income countries.

The evidence has shifted through the COVID-19 pandemic as we have learned from the virus, and the virus itself has changed. The pandemic has also illuminated the various lenses through which individuals and commentators view society and science, and establishes the need to consider evidence and the how argument is made to provide a comprehensive understanding of our situation. As we live with SARS-CoV-2, we are afforded the opportunity to reflect and learn about ourselves.

Response to Editorial Commentary

Ari R. Joffe, MD, FRCPC

I thank Michael van Manen for his interesting commentary about evidence I discussed, and for this opportunity to respond.

First, van Manen suggested that evidence is necessarily tentative. While this is true as it applies to any evidence, I do not believe evidence I apply is tentative in any pragmatic sense. My main points that the risk from SARS-CoV-2 is extremely age-dependent, that lockdowns are based on three flawed assumptions, and that vaccines have markedly waned in efficacy, natural immunity is as good as vaccine-induced immunity, post-vaccine myocarditis in young males is concerning, and that vaccine mandates involve coercion, dehumanization, and vaccine inequity, still stand. The extreme age-dependent risk was known early on based on data from China, prior to cases in Canada, and the lack of efficacy of non-pharmacologic interventions [and their collateral effects] was also known pre-pandemic (World Health Organization, 2019).

Second, he suggested that the risk of children transmitting to high-risk older adults should be considered. This is true, and evidence can inform how to manage this risk. Adults under age 65 living with school-aged children, including children attending school, were not at higher risk of COVID-19 nor of intensive care admission or death from COVID-19 (Wood, et al., 2021); Forbes, et al., 2021). School closure or opening was not consistently associated with changing community transmission of SARS-CoV-2, nor with increased risk of COVID-19 among students or teachers. In fact, school closures forced childcare arrangements to be made which likely increased the exposure of older adults to infection in the children they were asked to assist in caring for. Lockdowns did not protect older adults living in multigenerational homes, often forcing them to be exposed to more people for longer periods in the home, and forcing "essential workers" of all ages in their home to be exposed to the virus. This is because lockdowns are not a focused response, and emergency management principles prioritize focused protection: remove those most at risk from exposure to the hazard. Finally, older adults now have the option of vaccine which can well-protect them from severe disease, and they can make informed choices on how much potential exposure they are willing to risk.

Third, I do not think it realistic to suggest that in Alberta "we have yet to actually have a true lockdown." Businesses have been closed, events cancelled, gatherings in private homes restricted, schools closed to in-person learning, travel restricted, and visitors of dying adults and hospitalized children restricted. Moreover, the studies I referred to compared stringency of lockdowns between jurisdictions, and found that lower or higher stringency did not make a difference to the pandemic. Again, this was known from pre-pandemic plans published by the World Health Organization as late as 2019.

Fourth, van Manen suggested that the "evidence around how much vaccination reduces transmission" is evolving. This is true. In fact, with the Omicron variant of SARS-CoV-2 evidence suggests that vaccine efficacy has waned even more markedly, with several studies reporting negative two-dose-vaccine efficacy in preventing infection, and waning of protection within 10 weeks of booster dose. The phenomenon of "original antigenic sin" may account for negative vaccine efficacy, with Omicron antigenicity having drifted far enough from the vaccine spike-antigens that the "back-boosting" of the original immune response by Omicron may be detrimental (Zhang, et al., 2019). Finally, vaccine still protects adults from severe disease; however, if this results in those infected having mild symptoms and thus not

recognizing to isolate themselves, then it may increase transmission.

Fifth, van Manen asserted that vaccine mandates increase vaccine uptake. I am not so sure, and this has been little studied. In some countries vaccine mandates have not increased vaccine uptake, and in others where they may have, increased uptake occurred in very low-risk younger age groups and not in the vulnerable older age groups that require protection (Mills & Ruttenauer, 2021).

Sixth, the analogy of vaccine mandates and seatbelts I suggest is misleading. Seatbelt laws are different from vaccine mandates in morally relevant ways. Seatbelt laws involve much less severe restriction on autonomy – they do not restrict participation in all of society, and do not mandate injecting a foreign material into one's body that then leads to production of the S-protein associated with severe side effects including myocarditis. Seatbelt laws have been shown to save lives, while vaccine mandates have not, and at least the same study and scrutiny should be required before vaccines are mandated. There is not a better option to seatbelt laws to prevent injury and death, while there is for vaccine mandates – targeted outreach, education, and access in hard-to-reach groups. Seatbelt laws do not increase inequality in society, and seatbelt users will not all be killed in a motor vehicle collision sooner or later! I argued that vaccine mandates do increase inequality, and that everyone, vaccinated or not, will be infected sooner or later by this endemic virus.

Finally, the issue of preserving healthcare resources "for society at large" is mentioned. We need to remember that the pandemic is a society-wide emergency. Preserving healthcare capacity is not the mission; rather, the mission is to ensure the minimal impact of SARS-CoV-2 on Alberta society, with healthcare capacity only one of those impacts, and with many other collateral effects to consider. There have been two years for hospital administrators and medical officers of health to innovate and produce surge-capacity in our healthcare system [rather than simply reallocating existing capacity] – surely it is not up to children and the public to bear this responsibility. If this really was the public's responsibility, a better analogy would be that of mandating healthy diets, exercise, no smoking, and no alcohol, as these would translate into far fewer hospitalizations.

Pandemics do not end when a virus goes away – the virus becomes endemic with ongoing seasonal waves. "[P]andemics gradually fade as society adjusts to living with the new disease agent and social life returns to normal… [The] Covid-19 pandemic will be over when we turn off our screens and decide that other issues are once again worthy of our attention." (Robertson & Doshi , 2021) I believe that the pandemic has ended, if only we can accept living with the [now far-less-virulent] virus.

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Decision-Making During the COVID-19 Pandemic: Ethical and Legal Considerations

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The COVID-19 pandemic has required those in positions of authority to make difficult decisions with wide-reaching impacts. Managing the consequences of the pandemic has been no easy task due to the ever-evolving nature of the SARS-CoV-2 virus. While both knowledge of other similar viruses, as well as evidence gathered respecting this virus, may be used to base decisions on, there have been many instances where the evidence has not been conclusive; decisions must be made nonetheless. As a result, whether explicitly stated or not, decisions have also had to be made based on values, ethical choices, assessments of the anticipated risks, and a weighing of the estimated benefits and harms of measures proposed to contain the spread. Public health decisions often utilize the precautionary principle. However, it is overly simplistic in the context of this pandemic to say that all decisions should have a precautionary basis given the assessment of the virus' risk combined with the many, significant negative impacts on the health of the population a number of measures of containment carry with them.

If social determinants of health[1] are acknowledged as fundamental to the health of populations, decisions that fail to take these factors sufficiently into account are likely to be fundamentally flawed. Decisions about the containment of the SARS-CoV-2 virus and COVID-19 are all decisions about health, but they are not solely health care decisions.

As the relative risks of COVID-19 decrease for an increasing number of individuals, thanks in large part to increasing vaccination rates and the mutation of the virus, it becomes timely to look more closely at past actions with an eye to the future. How could society and its key decision-makers do better during the next pandemic? With acknowledgement of the enormous efforts of our governments, public health officials, key health system organizations, health professionals, and many persons who have contributed outside of the health care system, we can learn from this pandemic and be better prepared for the future. While debriefs will hopefully occur on many fronts, here we briefly discuss three suggested areas of further work: (1) more wide-spread publication of and consultation on Alberta's Ethical Framework for Responding to Pandemic Influenza (modified to be applied to any pandemic and not only influenza); (2) further education on the roles, accountabilities, duties and powers of key decision-makers; and (3) additional amendments to *Alberta's Public Health Act* (*"Act"*)[2] to provide for clear legislative authority for powers determined to be required during a pandemic or other public health emergency, as well as to provide for accessible, effective mechanisms of appeal or review.

Ethical Framework for Pandemic Decision-Making Required

It would have been impossible to completely prepare for the COVID-19 pandemic. However, past experiences, including lessons learned from the previous SARS epidemic in parts of Canada and elsewhere, have indicated that a pre-determined ethical framework is one tool that can guide decision-making and allow for more effective discourse respecting decisions made. The World Health

Organization published a checklist for influenza pandemic preparedness planning in 2005 and one of the recommendations was the adoption of an ethical framework that can be used during the response to an outbreak to balance individual rights and the interests of populations.[3] Alberta has an ethical framework for pandemic influenza published in 2016.[4] Other Canadian ethical frameworks for COVID-19 decision-making[5] are based on ideals including proportionality, fairness, accountability, reciprocity, and procedural justice or transparency. Most of these concepts are also included in Alberta's pandemic influenza ethics framework, which states that will be updated regularly.[6] However, it is unclear whether this framework has been re-examined or is being utilized. If it has been explicitly referenced as in place or foundational to decision-making during the COVID-19 pandemic, despite closely following COVID-19 decision-making in Alberta, that has not been apparent.

Past research has supported the use of such frameworks during pandemics as an essential component of a complete pandemic response because, through pinpointing and analyzing collective values, decisions are more likely to evince a balanced regard for precaution and protection of the rights of the individual. In other words, an ethical framework helps "people understand in advance the kinds of choices that will have to be made,"[7] and can help to avoid rationale that may very well be based in an ethical framework appearing as *post hoc* justification. With a published ethical framework where the underlying values upon which decisions are based are transparent, it also becomes more clear whether and to what extent society shares such values. The presence of explicit ethical principles is especially important when governments resort to the use of legal powers which impinge upon rights and freedoms normally enjoyed in our free and democratic society. The consequences of failing to have a current, published set of values or bases for decision-making can result in, at the very least, the appearance that decisions are instead based on the values of particular decision-makers. There is no framework against which to examine or critique such decisions and, by extension, the use of legislative powers in support of them. This can contribute to a lack of public trust, low morale, fear, and a potential increase in the spread of misinformation. Having a framework does not guarantee the absence of these issues but may help to prevent them from occurring to the same extent.

From the beginning of the pandemic and throughout its duration, we have witnessed an unprecedented, widespread use of legal tools without the normal recourse to utilizing voluntary measures coupled with public health advice. While arguably some of these steps were necessary in an initial attempt to contain the spread of COVID-19 when less information was available about the virus or its impacts, to a large extent the use appears to have been a reactionary matter of trial and error focussed on containment, but without fully considering or understanding the unintended negative consequences. Much of the debate about such measures has been framed as evidentiary, and to a large extent, it is. However, underlying many decisions, or critiques thereof, are differences of values – though that is not often explicitly stated.

While a published ethical framework would not have eliminated many of the pandemic's challenges, it could have formed a more transparent basis on which greater clarity of discourse could have been achieved. For example, if a provincial ethical framework clearly states that the primary underlying aim or value is containment of the spread of the virus and resulting illness, decisions to contain the spread of COVID-19 at the expense of other societal aims could be explained and justified (and the values framework independently debated). By contrast, if a framework makes clear that the basis for decision-making is to contain the spread while minimizing disruption to society, resulting decisions will differ and also be justifiable and debated on the basis of those different, but explicit, underlying values. What becomes more evident is that, to a greater or lesser extent, differing views about decisions made will be

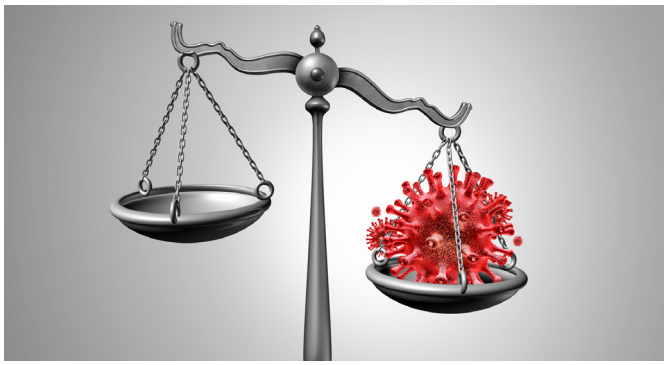
as a result of differing values or differing tolerance for various risks. While that does not eliminate differences of opinion, it does provide for greater clarity and focus on the extent to which we share certain values and whether the underlying ethical framework needs to change based on public consultation. It can also help us better find and understand our common ground where such exists.

Nearly two years into the pandemic, Alberta's lack of a published ethical framework in use for public health decision-making, combined with an unprecedented use of power to implement public health restrictions, is becoming harder to justify. At this stage, it is timely to consider the broader publication of such a framework, and to consider whether and to what extent it reflects the shared values of Albertans. Further, critique of decisions made is best put forward based in part upon such a framework.

Education on the Roles, Accountabilities, Duties, and Powers of Key Decision-Makers

In Alberta,[8] as in other Canadian jurisdictions, numerous key decisions with wide-reaching impact have been made by the provincial government, municipalities, public health officials, and health system decision-makers. Each of these parties has a unique role, accountabilities, duties and powers, and arguably differing expertise and considerations to take into account. While these functions are set out largely in provincial legislation, the understanding of the respective roles, etc. varies. While discourse may continue about whether any such roles should be altered, it is more challenging to have an informed public exchange of ideas when there is a lack of education or resources to explain in clear and simple terms the current state. It is essential that further education occur as we reflect as a society what changes, if any, are needed prior to the next pandemic.

For example, elected members of the legislative assembly and elected government officials are accountable directly to the electorate, and have the responsibility to take into account all relevant factors (i.e. those related to the social determinants of health) and make decisions that will impact society as a whole. By contrast, the role of the Chief Medical Officer of Health ("CMOH") is clearly advisory vis-à-vis government under the *Act*.[9] Further, while medical officers of health (which includes the CMOH) have significant duties and powers under the *Act*, they are not nearly so broad as the public currently understands them to be, largely as a result of the numerous orders issued during the COVID-19 pandemic by the CMOH. Further education will better support the important societal discussions that will hopefully occur about the respective roles, and who should make which decisions during future public health emergencies.



Further Changes to Alberta Legislation, Including its *Public Health Act*

For many of us, what has been most important during the last two years has been whether decision-makers are making the best decisions (i.e. the decisions we think make sense and are needed to protect us, those we care about and the society in which we live). However, if we value living in a free and democratic society, which is necessarily founded on the rule of law, then whether we turn our minds to it or not, we should care about whether public health orders and other legal steps have been made based on clear legal authority. A failure to care and to safeguard the rule of law will fundamentally erode over time the necessary foundations of our democracy.

Never before the current pandemic have we seen such a widespread use of legally enforceable orders and other legal tools. Further, in our opinion, a number of them have been made without clear legislative authority. This may sound like a critique

of government or the province's CMOH. To be clear – it is not. In an unprecedented crisis, we are empathetic to decision-makers who have done their best with the legal and other tools at their disposal – or that they believed to have been at their disposal – to manage the crisis. Courts show a great deal of deference to public health decision-making, particularly during a public health emergency, and we believe that is often appropriate.[10]

However, while the pandemic is not at an end, circumstances have changed significantly and, in a number of respects, the threats that COVID-19 poses are decreasing for many populations. If that is accurate, then we believe the time is coming to begin considering further legislative amendments to provide clear legislative authority for key decision-makers, including Cabinet and the CMOH, as well as a re-examination of providing for accessible, effective avenues of appeal or review when public health orders are made.

While the scope of this paper does not allow for an examination of the myriad of legal issues in detail, we will briefly discuss one example in an attempt to better illustrate this suggestion. That example is the use of section 29 of the Act by the CMOH during the pandemic.

Section 29 empowered, until recently, any medical officer of health ("MOH") to "take whatever steps the medical officer of health considers necessary" to contain a disease, or to prohibit by order a person from attending school, engaging in their occupation, or having contact with "other persons or any class of persons."[11] In other words, this section did not only authorize the CMOH to take steps or issue the prescribed types of orders. Further, an MOH (including the CMOH) has these same powers whether or not there is a state of public health emergency.[12] During the COVID-19 pandemic, countless orders on a broad range of matters have been issued by the CMOH under the authority of section 29. However, the section specifies only three types of order-making authority. Based on the legal rules of statutory interpretation, the Legislative Assembly clearly distinguished between taking steps and issuing orders respecting the specified matters. If the section intended to provide limitless order-making authority, it could and presumably would have said as much.

Additionally, the language used in the order-making part of this section was person-specific: an MOH could prohibit *a person* from engaging in the activities listed in the section. However, section 29 was relied on, for example, as the authority for isolation and quarantine requirements in Alberta, potentially applicable to every person in the province.

Part of the court's role in examining whether legislative authority has been used appropriately is to interpret statutes, such as the *Act*, in order to determine whether decision-makers such as the CMOH are acting within the bounds of the authority granted to them by the legislation. As noted, courts have generally shown deference to the use of public health orders.[13] There is, of course, often a rationale behind the deference courts have shown to decisions of public health authorities, as they are presumed to have specialized knowledge that the courts do not.[14] However, deference must meet its limit where the legislative authority grounding certain public health decisions is highly questionable. If the courts defer completely to the decisions of unelected public health authorities, even when they are likely to be acting outside the scope of their powers, this effectively creates a system where there is no effective check and balance on power delegated to decision-makers by the legislative or executive branches of government.

In the *Ingram*[15] decision, the Alberta Court of Queen's Bench upheld a public health order made under the previous iteration of section 29. The court referenced the power, specifically that of the CMOH, to take "whatever steps are necessary to lessen the public health emergency" and further found that "while the powers are broad and are exercised by a government appointee rather than an elected representative, these powers are nonetheless clearly granted by the statutory scheme that was passed by the Legislative Assembly."[16] While the court chose to defer to the public health order in this case, we respectfully disagree that the powers utilized were "clearly granted" by the *Act* at the time.[17]

When examined closely, it is apparent that the phrase "whatever steps necessary" in section 29(2)(b)(i) was clearly distinct from the order-making powers contained in section 29(2)(b)(ii) of the *Act*. The legislation expressly referenced a "class of persons" differentially from the word "person" in section 29.[18] The principles of statutory interpretation illustrate that "it is possible to infer an intended difference in meaning from the use of different words," especially in relation to the same subject.[19] When looked at in the context of section 29(2), the legislators specifically did not include in this section the power to prohibit "a class of persons" from attending school etc. – holding out this section as authority to direct the activities of classes of persons was therefore highly questionable.

The interpretation also appears to have failed to consider the section in the context of the *Act* as a whole, including Cabinet powers to close public places, and other sections granting specific powers and duties to MOHs, including powers of quarantine. Among the principles of statutory interpretation is that sections of a statute should not be interpreted in isolation from one another.[20]

The particular issue of class orders has now been rectified by amendments to the Act in Bill 66, the Public Health Amendment Act, 2021, which came into force on December 15, 2021[21]. However, while it was highly questionable whether section 29 previously granted the authority to impose restrictions on the entire province, additionally problematic was the lack of a path outlined in the Act enabling a person subject to a section 29 order to appeal such an order. While some legal mechanisms were technically available, they were not prescribed in the Act. And while additional amendments to the Act in Bill 66 have broadened the types of orders which may be appealed under the Act, this does not provide meaningful access to an appeal for persons under certain types of orders. For example, if a person subject to a section 29 order, enforced by a second order, appeals to the prescribed board, upon receipt by the board of the required notice of appeal, the board must hear the appeal within 30 days (or longer if the board unilaterally extends the time). For a person under a quarantine order for a shorter period of time, this is an ineffective mechanism to have the decision reviewed.

A proportionate use of public health power should have as its aim the protection of the health of the population while also protecting, to the greatest extent possible, civil liberties of individuals and other aspects of daily life that contribute to the health of the population.

Moving Forward

In the words of Justice Jack Watson of the Alberta Court of Appeal, the rule of law is "our common consensus, our acquired wisdom, our belief in shared values and our willingness to support and respect one another."[22] Regardless of our views of decision-making during the COVID-19 pandemic, or of specific decisions, our shared belief in the value of living in a free and democratic society will hopefully lead us, as a society that shares so many values, to learn from the experience of the last two years and plan ahead for future common challenges in solidarity.

We suggest that updating, widely publishing and conducting broad public consultation on an updated ethical framework is one important next step. Education about the roles, accountabilities, duties and powers of key decision-makers is also essential and a key precedent to our last recommendation. And while we commend the government for being responsive to experience and feedback in terms of certain key amendments to the Act made to-date, we suggest that proactive consideration of further legislative amendments in the foreseeable future is important. Proposed changes to the law based on an ethical framework, with informed public discourse, will provide a sound foundation for improved means to manage future public health emergencies, while providing for improved protection of individual rights and freedoms.

If it is determined that broader and/or different public health powers are necessary, then Alberta should amend its public health legislation to allow for the use of those types of powers by the decision-makers determined most appropriate, to ensure that the rule of law and our democratic process is maintained. Alberta must learn from its collective experience, and work towards a greater ability to respond in the future with a proportionate, ethical response grounded in clear legislative authority. Some decisions will restrict civil liberties – and justifiably so – but the rule of law must govern, which means that the checks and balances between the branches of government must be preserved by each branch fully enabled to fulfill its specific role. As Alberta enters this later stage of the COVID-19 pandemic, the timing will be ideal to further consider and amend public health legislation, if necessary.

Endnotes:

1 World Health Organization, "Social Determinants of Health" (2021), online: <https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1>.
2 RSA 2000, c P-37 [*Act*].
3 Post-SARS research in Canada also references this and the recommendation and rationale for having an ethical framework in place. For example, see University of Toronto Joint Centre for Bioethics, "Stand on Guard for Thee: Ethical Considerations in Preparedness Planning for Pandemic Influenza – A Report of the University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group" (November 2005), online: *Pandemic Ethics Dashboard* <https://pandemicethics.org/consensus-documents/university-of-toronto-joint-centre-on-bioethics/> [University of Toronto Report].
4 Alberta Health, "Alberta's Ethical Framework for Responding to Pandemic Influenza" (January 2016), online: *Alberta Government* <https://open.alberta.ca/publications/alberta-ethical-framework-for-responding-to-pandemic-influenza> [Ethical Framework (Alberta)].
5 See for example: Government of Canada "Public Health Ethics Framework: A Guide For Use in Response to the COVID-19 Pandemic in Canada" (16 February 2021), online: <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/canadas-reponse/ethics-framework-guide-use-response-covid-19-pandemic.html>; Provincial COVID-19 Task Force, "COVID-19 Ethical Decision-Making Framework" (28 March 2020), online: *BC Centre for Disease Control* <https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/ethics_framework_for_covid_march_28_2020.pdf>.
6 Ethical Framework (Alberta), *supra* note 4 at 2.
7 University of Toronto Report, *supra* note 3.
8 This paper focuses on the pandemic response in Alberta. However, similar issues have arisen in other jurisdictions.
9 *Act*, *supra* note 2, s 14.
10 For example, see T*aylor v Newfoundland and Labrador*, 2020 NLSC 125.
11 *Act*, supra note 2, ss 29(2)(b)(i)–(ii); version prior to December 15, 2021 (see note 21).
12 *Ibid*, s 29(2.1).
13 *Nova Scotia (Attorney General) v Freedom Nova Scotia*, 2021 NSSC 170; *Hudson's Bay Company ULC v Ontario (Attorney General)*, 2020 ONSC 8046 (a regulation was at issue as opposed to a public health order, but the case shows deference to pandemic policy); *Gateway Bible Baptist Church et al. v Manitoba et al.*, 2021 MBQB 219; *Springs of Living Water Centre Inc. v The Government of Manitoba,* 2020 MBQB 185.
14 This concept pre-dates the COVID-19 pandemic. Pre-COVID-19, courts have been especially willing to show deference when public health officials used orders as a last resort – and only after volunteer measures, such as counselling and education, had been attempted and had failed: see for example: *Toronto (City, Medical Officer of Health) v Deakin*, [2002] OJ No 2777, 2002 CarswellOnt 2401 (WL Can) (Ont Ct J) (*sub nom Basrur v Deakin*).
15 *Ingram v Alberta (Chief Medical Officer of Health)*, 2020 ABQB 806 [*Ingram*].
16 *Ibid* at para 71.
17 We note that the province of Ontario, after dealing with the limits of person-specific order making authority of MOHs during the SARS outbreak, amended its public health legislation to allow for an MOH to exercise broader powers to order a class of persons to take or refrain from taking certain actions.
18 The legislation referred to "class of persons" once in section 29(2)(b)(ii)(C).
19 Ruth Sullivan, S*ullivan and Driedger on the Construction of Statutes*, 4th ed (Ontario: Butterworths Canada Ltd., 2002) at 164.
20 *Ibid* at 1.
21 Note, at the date of publication, section 29 has been amended to allow for an MOH to issue orders to "classes" of persons. These amendments were as a result of Order in Council 335/2021 (1 December 2021), which declared sections 9 and 10 of the *Public Health Amendment Act*, 2021, SA 2021, c 15, in force as of December 15, 2021. Section 9 of the *Public Health Amendment Act*, 2021 amends section 29 of the *Act*, as does section 10, which retroactively validates all orders previously made under section 29 when section 29 powers were person-specific.
22 Jack Watson, "Introduction" (2014) 52:1 Alta L Rev 1 at 3.

Christmas Time in COVID-Healthcare: Bah Humbug, Bah Happiness

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The holiday season is about rituals, and mine includes Dicken's *A Christmas Carol* (Dickens, 1843). I'm a sucker for its three-part arc of youthful energy, mid-life crisis, and eventual redemption…all in the (Saint) nick of time. What I didn't realize until this year was how much I can now relate to its protagonist; perhaps you can too. Regardless, with head-in-hands, let me share the COVID-Christmas story of this Dr. Ebenezer Scrooge, MD. This resemblance is not strictly because of my, uhm, financial parsimony, though there have no doubt been times when my pockets were too long and hands too short. Instead, just like that Eber-geezer (ouch), it's my complicated relationship, especially during COVID, with frustration and impatience: my excitable past, my agitated present, and my fear for the future. Unlike Scrooge, I suspect redemption will take more than just buying Tiny Tim a large Christmas Goose.

Our twin adrenal glands are a blessing, but, at times, a curse. These two orange hats, perched atop red-brown kidneys, weigh only 20 grams and measure only 5 cm. However, they also receive about a fifth of my/your/our total cardiac output, and, accordingly, influence much of how we think, or don't think; react, or don't react. The adrenals are literally "vital" (i.e. life- giving) because they perfuse perpetually thirsty organs and engage distraction-prone minds. Regardless, if you work in healthcare like me, there is every possibility that your adrenals are excessively large and in-charge. Adrenaline and cortisol routinely help me as an ICU doctor to overcome fear and fatigue. However, it's time, however, to accept that our (okay, my) stress hormones can also make us (okay, me) inpatient with in-patients, inapproachable to colleagues, and short with my loved ones. My must-have gift should be one of peace and quiet. This 50-year-old man wants a less intense relationship with his endocrinology: 'Tis the season for *equanimity*.

Obviously, it's nonsense to wholly blame endocrine glands for intemperance, just as it was nonsense for Ebenezer to blame "indigestion" for his dreams. Like Mr. Scrooge, I want to take responsibility, and that starts with a sincere second-act apology. What's more, there's no time like the holidays for getting to grips before it's too late. The same mental short-cuts that make me (hopefully) useful during medical crises are far less welcome when it comes to personal happiness, family relationships, and career longevity. Once again, though, I'm past trite excuses. Therefore, for every time I've been an a**, let me issue an apology that is loud, even if it's unproud. If others can relate, I am sorry for you too, because I know firsthand that unhappiness can be its own punishment.

While Scrooge eventually gets to dance his Christmas jig, healthcare workers' feet are still stuck in COVID snow. For example, I know some of you are still hair-trigger-annoyed by anti-vaxxers and overconfident sages. Fortunately, in this regard, most people working in ICU long-ago re-found our game face. We have learnt that doing this job requires accepting others' freedom, and not just dismissing it as "free-dumb". Heck, as the ICU enters COVID-year-three, we are learning to tolerate "backseat science" (those who tell others what to think), "pick and mix scientists" (those who comb the science, and exclude anything they don't like), and "epistemic trespassers" (those that just can't stay in their lane). It's still especially tough to take when it comes from our own medical ranks, but let's eat this Christmas Cake one bite at a time.

Healthcare is still the best job going, and that's worth remembering, but I have long found its bureaucracy as tough as a week-old turkey. We want to be on the "cutting edge", not the "complacent edge", but I worry more and more that we are entering the "cussing edge".

Sure, we are right to be peeved when medical culture seems sclerotic, but we can make easy improvements right now. For example, there's a courtesy deficit in medicine, in the same way that there's an oxygen deficit on the moon. Many of us claim to be egalitarian, but too often our profession is more "ego-litarian". We act like we're irreplaceable, when it would help to accept we're not. As a wise, albeit irascible, colleague of mine shared: "Once in a lifetime a truly gifted man comes along. More often, it's flawed humans like you". This otherwise great doctor regrettably also regularly demonstrated the truth of his words: "it takes twenty years to build a reputation, and five minutes to lose one".

In an effort to avoid Marley's fate, I better get to work. My 2022 resolutions include working less: after all, none of my family should miss me while I'm still alive. I plan to smile more, even when I truly don't feel like it. I also plan to sleep a lot more, as the evidence suggests there really is no single intervention that offers more. I also need to stop climbing through the boxing ropes, looking for a fight, even if the system did raise me to be a fighter. I need to accept that we only get 4000 weeks of life (Burkeman, 2021), and use that allotment as much for fulfillment, as for productivity. I should forego the exaggerated certainty of outrage, and stop reverse engineering facts to fit my preferred worldview. I need to stop speaking when I have nothing wise to say, simply because I wish I did. I need to accept that happiness is not a permanent sugar-rush but a precious treat. In short, life is more complex than a Christmas play, even if the cost of doing nothing is no less dire.

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