Memorandum

Privileged and Confidential

Date: Mar 31, 2022

To: Terry Green

From: Nic LeBlanc

Subject Line: CWDO – Applying an Accessibility Lens: COVID-19 Triage Protocols

Introduction

The research I elected to conduct relates to the potential of applying an "accessibility lens" and whether one can make a legal argument to mandate this perspective in front of any governmental decisions. PBSC at the Bora Laskin Faculty of Law cannot provide legal advice. This document contains a general discussion of certain legal and related issues only. It is not legal advice. Please consult a lawyer if you require legal advice.

Short Statement of Facts

1) A uniform definition of disability does not exist that is applied and recognized. A combination of social, cultural, and political factors tends to significantly influence and define how society perceives disability. The provincial government of Ontario have enacted legislation that aims to protect vulnerable people from discrimination and make society more accessible for people with disabilities. The federal government of Canada have done the same, by enacting statutes with the same aims: unfortunately, people with disabilities still struggle with societal barriers influenced by stereotypical, ableist biases.

2) The medical model of disability suggests that a disability impacts a person's quality of life, and that a medical cure is required for people with disabilities to successfully integrate into society. The social model of disability, in contrast, counters this argument by claiming that disability is a difference, and that societal misconceptions must change to allow society to be more accessible for people with disabilities. These countering viewpoints bring forth questions as to which model best defines disability.

3) In their 2019 re-election promise, the federal government promised to implement an accessibility lens in front of every policy decision they make. However, this promise has not been met. Mandating this lens would ensure that any government policy decisions are inclusive and consider the implications of people with disabilities. In addition, an accessibility lens would prevent arbitrary, ableist, or discriminatory biases from influencing policy decisions.

4) When the COVID-19 pandemic began in March 2020, the health care system became oversaturated with staggering numbers of patients requiring intensive care. As a result, provincial governments were forced to determine solutions for the worsening health care system to ensure the support patients and their needs. This led to the drafting of the Ontario COVID-19 triage protocols.

5) Ontario's drafted COVID-19 Triage Protocols bring forth question of whether a review of the policy with an accessibility lens perspective would illustrates a legal argument for enforcing a mandate of an accessibility lens to be implemented in front of all legislative decisions that the government makes.

Statement of Issues

1. Whether a medical model or social model is more appropriate when defining disability?
2. Would having an accessibility lens benefit a review of the draft Ontario COVID-19 Triage Protocols?
3. Must an accessibility lens be mandated to be in front of everything a government does?

Definitions

6) Disability is not defined in a consistent manner. Two competing approaches have influenced how disability is defined: the medical and social models of disability.[1]

[1] Government of Canada, (last modified 05 August 2013) "Federal Disability Reference Guide", online: <https://www.canada.ca/en/employment-social-development/programs/disability/arc/reference-guide.html#h2.3-h3.1>

Differentiating between both models allows for a better understanding of how best to support and integrate the needs of persons with disabilities to ensure that society is more inclusive and accessible.

A. The Medical Model of Disability

7) The medical model of disability was considered the main approach for defining disability prior to the shift to the socio-political model. The medical model applies a biology-based lens on understanding disability as a medical issue within an individual, without consideration of how other extrinsic factors impact disability, such as biases, stereotypes, or interpersonal interactions. The medical model labels disability as a sickness, defect, and individual limitation, requiring a cure to "live normally." Despite whether the disability causes any pain or illness, the medical model declares the disability as the problem that needs to "be fixed".[2] Assuming that a medical cure is the only way people with disabilities can be normal fosters a terrible environment and quality of life.

8) Society places high regard on members of the medical field, so their medical opinions have obvious detrimental effects that lead to stereotyping, stigmatizing, and discriminatory beliefs towards people with disabilities. Defining disability through an ableist mindset induces much strain on people with disabilities, making them a highly vulnerable population, and creating a power imbalance.[3] It can be argued that these biases and misconceptions are a substantial barrier to a person with a disability to successfully integrate within society. Limiting and devaluing the potential of those with disabilities patronizes these individuals and thereby further discourages their capabilities and inclusion with others.[4]

B. The Social Model of Disability

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[2] Jongbloed, L. (2003). Disability Policy in Canada: An Overview. *Journal of Disability Policy Studies*, *13*(4), 203–209.
[3] *Ibid* at 204.
[4] Ontario Human Rights Commission (2016). Policy on ableism and discrimination based on disability, 1-95 at 10.

9) The social model of disability, in contrast, highlights viewing disability as a difference instead of as a deficiency.[5] Instead of viewing disability as a disadvantage or a defect, it focuses on determining solutions to make society a more inclusive, accessible setting. In other words, the "problem" has nothing to do with the disability, but instead due to people looking at people with disabilities as inferior.[6] A significant element of understanding disability requires acknowledgement of the discrimination, stigmatization, and prejudice caused by these negative attitudes and how it further disadvantages people with disabilities.[7] People with disabilities evidently face many barriers, as their physical or mental difference may impact their accessibility and self-functioning, but most of all these barriers are reinforced by the societal beliefs of what disability means, and how their difference affects their quality of life.

10) As stated in Preamble 5 of the UN's *Convention on the Rights of Persons with Disabilities* (*CRPD*), the negative interactions between those with disabilities and without are a further hindrance to effective and inclusive societal participation.[8] The courts have acknowledged this social model approach, as the Supreme Court of Canada (SCC) declared that as discriminatory mistreatment of people with disabilities is significantly impacted by societal perceptions and stereotypes, these disadvantages must be considered instead of referring solely on a biomedical definition.[9]

11) The World Health Organization (WHO) correctly defines disability as an umbrella term covering impairments, activity limitations, and participation restrictions. More specifically, an impairment is a difference relating to body function or structure. An activity limitation is encountered by a person struggling to perform a task or motion.

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[5] *Supra*, *note 2* at 205.
[6] The Dawning of the Social Model? Applying a Disability Lens to Recent Developments in the Law of Negligence, (2019) 13:1 McGill JL & Health 1 - 26 / (2019) 13 : 1 RD & santé McGill 1 – 26 at 12.
[7] *Ibid.*
[8] United Nations' Convention on the Rights of Persons with Disabilities, (2006), 13 December 2006, U.N.T.S. vol. 2515, [CRPD], (entered into force 3 May 2008, accession by Canada 11 March 2010), online: <www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf>.
[9] *Quebec (Commission des droits de la personne et des droits de la jeunesse) v Montréal (City); Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Boisbriand (City)* 2000 SCC 27 at paras 76-80

Lastly, a participation restriction is a problem experienced by an individual relating to their involvement in life situations.[10]

12) It is evident that when defining disability, one must consider a person's medical differences while emphasizing the social, cultural, and political elements that strongly disadvantage people with disabilities.[11] Disability is not a medical deficiency, but instead, a difference heavily impacted by societal beliefs, which shapes what it means to have a disability. The medical model definition does not reflect what disability is, nor does it provide any chance of inclusion or success for people with disabilities. Unfortunately, the medical model still has a significant influence on society. This perception of disability must change, such as at the governmental level.

C. Defining an Accessibility Lens

13) Unfortunately, barriers continue to exist for people with disabilities. An argument could be made that the government must apply a lens that utilizes a social model approach to disability that best serves and considers the disability community.[12] This is especially true as policymakers seem to struggle with understanding the needs of people with disabilities to ensure that their voices are heard.[13] For the purposes of this memorandum, an accessibility lens can be defined as a means for inclusion through the understanding and clarification of issues that affect persons with disabilities, whether directly or indirectly. Applying this lens would help policymakers ensure that decisions are not arbitrary, ableist, or discriminatory to vulnerable populations, such as persons with disabilities.[14]

14) Evidently, barriers continue to exist, and both levels of government must draft a tangible framework that ensures the country can become more accessible. One can assume that governmental officials do not understand the adversity and difficulties that

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[10] World Health Organization, "Disabilities", World Health Organization Regional Office for Africa, online: <https://www.afro.who.int/health-topics/disabilities>.
[11] *Ibid.*
[12] McGill, *supra*, note 6 at 12.
[13] McColl, M. A., Jaiswal, A., Jones, S., Roberts, L., & Murphy, C. (2017). A review of disability policy in Canada. *Kingston, Ontario: Canadian Disability Policy Alliance*, 1-212 at 7.
[14] *Ibid.*

vulnerable persons, such as people with disabilities, deal with on an everyday basis. No official lens has been publicized or implemented by either level of government that details a way for policymakers to consider how implementing specific policies impacts people with disabilities. I will now briefly outline relevant federal and provincial jurisprudence related to accessibility for people with disabilities.

Relevant Law

Charter of Rights and Freedoms

15) All individuals in Canada have constitutional protections through the *Charter of Rights and Freedoms*. As per s.7 of the *Charter:*

> "Everyone has the right to life, liberty, and security of the person. Therefore, any laws or state actions that interfere with life, liberty and security of the person must conform to the principles of fundamental justice." [15]

16) Likewise, the courts have previously declared that physicians have a responsibility to their patients which must take precedence over the physician's duty to the medical system when the patient is at risk of harm.[16]

17) In addition, the *Charter* outlines additional protections for vulnerable individuals, such as people with disabilities. For example, section 15(1) of the *Charter* guarantees rights of equality without discrimination by explicitly referring to people with disabilities as a prohibited ground.[17] The courts are clear that the government must adhere to the *Charter* when administering any policy decisions.[18] As per s.15(1) of the *Charter,*

> *"*Every individual is [to be] equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and without

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[15] *Canadian Charter of Rights and Freedoms*, s 7, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11 [Charter]
[16] *Law Estate* v. *Simice* (1994), 21 CCLT (2d) 228 (BCSC), aff'd (1995), 27 CCLT (2d) 127, 17 BCLR (3d) 1, [1996] 4 WWR 672, 67 BCAC 89, 111 WAC 89 (BC CA).
[17] *Canadian Charter of Rights and Freedoms*, s 15, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11 [Charter]
[18] *Supra*, note 17.

> discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."[19]

18) Section 15(2) ensures that any government action aimed to improve the accessibility conditions of disadvantaged groups, such as those with a disability, will not be discriminatory.[20]

19) In the landmark decision, *R v Kapp*, it was determined that the test to determine a section 15(1) *Charter* infringement is if it can be determined that an individual or group have received: differential treatment based on a protected ground (which are stated in the paragraph above) and are subject to significant discrimination as seen through arbitrary, prejudicial disadvantage or stereotyping.[21]

Federal Statutes Relating to Accessibility

20) One can argue that the government must be mandated to apply a perspective that removes any preconceived bias or discrimination towards people with disabilities when drafting policies and standards to ensure s.15 *Charter* rights are met. The courts echo this sentiment, as the Supreme Court of Canada held in *British Columbia (Public Service Employee Relations Commission) v. BCGSEU* that accessibility must be readily available and equal for everyone, regardless of their physical or mental difference.[22]

21) The federal government have passed statutes that relates to concerns on accessibility and equity. In 2018, the federal government implemented *Bill C-81*, the *Accessible Canada Act.*[23] The purpose of the *Accessible Canada Act* is to ensure that Canada is barrier-free by the year 2040 so that Canadians, regardless of their differences, are autonomous and able to participate in society, without discrimination.[24]

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[19] Supra*, note 15.*
[20] *Ibid*.
[21] *R v Kapp 2008 SCC 41,* at para 17.
[22] *British Columbia (Public Service Employee Relations Commission) v. BCGSEU*, [1999] 3 S.C.R. 3 at para. 68.
[23] *Accessible Canada Act* (S.C. 2019, c. 10).
[24] *Ibid.*

22) Bill C-81 aims to address barriers such as employment, communication, and the design and delivery of federal-mandated programs and services with the involvement of people with disabilities.[25] In 2019, the federal government made a re-election promise to implement an accessibility lens in front of every policy decision they make[26]. This has not been implemented as of this writing.

23) Despite Bill C-81's aims of making Canada more accessible, it does not define a type of analysis or lens that explains how this can be accomplished. More specifically, the statute does not define a type of perspective that can be applied by the government to ensure their policy decisions consider how it would implicate people with disabilities, as well as other vulnerable groups. The *Accessible Canada Act* seemingly does not provide a lens or perspective that can be applied to potential policy decisions to ensure that any policies implemented do not express any discriminatory or ableist biases towards people with disabilities.

24) Similarly, the *Canadian Human Rights Act* (CHRA) ensures that every person has an opportunity to be autonomous without discrimination.[27] The CHRA protects vulnerable individuals, such as people with disabilities, who may be at higher risk of discriminatory practices. Examples of prohibited means of discrimination include employment, denial of goods, services, or accommodations, and wage equality.[28]

Provincial Legislation Relating to Accessibility

25) At the provincial level, both the *Ontario Human Rights Code* (*OHRC*), the *Accessibility for Ontarians with Disabilities Act (AODA*), and the *Health Care Consent* Act all detail accessibility mandates that must be followed to ensure equal treatment for vulnerable groups such as people with disabilities.

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[25] *Ibid.*
[26] McQuigge, Michelle. (2019). "Liberals vow to implement disability lens for all government policies if re-elected." *The Canadian Press,* online: <https://nationalpost.com/pmn/news-pmn/canada-news-pmn/liberals-vow-to-implement-disability-lens-for-all-government-policies-if-re-elected>
[27] Canadian Human Rights Act (R.S.C., 1985, c. H-6)
[28] *Ibid.*

26) The *OHRC* refers to the duty to accommodate for equal treatment for people with disabilities in accessing services, and how a failure to do so is a means of discrimination.[29] Section one of the *Ontario Human Rights Code* states*:*

> Every person has a right to equal treatment with respect to services, goods, and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.[30]

27) The purpose of the *Health Care Consent Act*, as stated in section 1, is to ensure that the rights of health care patients are protected, their autonomy is prioritized, and that rules regarding consent to treatment are consistently applied.[31]

28) The purpose of the *AODA* is to improve public accessibility standards by 2025, specifically for those with physical and mental disabilities.[32] In section 1(a) and (b) of the *AODA*, the legislation outlines a recognition for the discrimination and mistreatment of people with disabilities, with goals of developing and applying accessibility standards to break down these societal barriers.[33] Similar to federally enacted statutes mentioned above, the government of Ontario underscores the requirement of working with vulnerable groups such as those with disabilities to accommodate the enforcement of this legislation better.

29) Overseers of the *AODA* require the provincial government, public-sector businesses, and not-for-profit organizations to submit self-compliance reports, which become available to the public, to determine whether they are meeting the required standards of accessibility.[34] As per the 2019 annual report of the *AODA (*the most recently released report), the province of Ontario has had some success in increasing accessibility for people with disabilities. For example, high levels of compliance were reported specifically in businesses establishing accessibility-related policies (92%) and

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[29] *Human Rights Code*, RSO 1990, c H.19. Available: https://canlii.ca/t/5574j
[30] *Ibid at s.1.*
[31] *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A at s.1.
[32] Accessibility for Ontarians with Disabilities Act, 2005, S.O. 2005, c. 11
[33] *Ibid*.
[34] *Ibid*.

the use of service animals and support persons (92%).[35] These statistics suggest that the province of Ontario has become more accessible and inclusive for people with disabilities in some areas.

30) However, the lowest compliance rates as per the 2019 report related to documented individual accommodation plans (77%) and workplace emergency response information for people with disabilities (78%).[36] In his 2019 annual report of the *AODA,* the Honourable David Onley outlined that enforcement of the *AODA* has been insufficient. *T*he Accessibility Directorate of Ontario (ADO), overseers of the AODA, must do more than simply mandate organizations to file compliance reports.[37] This is especially clear when considering that ADO had an audit rate of 3% in 2017, with 1730 audits conducted out of 56 000 organizations that filed reports.[38] More concerning is that an upwards of 350 000 private sector organizations did not file compliance reports.[39] Overall, Mr. Onley determined that the non-compliance rate was approximately one-third of the standard required for public and private sector organizations.[40]

31) This report suggests a significant level of non-compliance for public and private sector organizations. Organizations achieving a non-compliance rate of one-third is not good enough. Most of all, the report urges that citizens still face major roadblocks with disabilities, and change is desperately needed if the government of Ontario aims to achieve its goal of an accessible Ontario by the year 2025.[41]

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[35] Accessibility for Ontarians with Disabilities Act annual report 2019. Available: https://www.ontario.ca/page/accessibility-ontarians-disabilities-act-annual-report-2019#section-0
[36] *Ibid.*
[37] Onley, David. (2019). 2019 Legislative Review of the Accessibility for Ontarians with Disabilities Act, 2005, online: <https://www.ontario.ca/page/2019-legislative-review-accessibility-ontarians-disabilities-act-2005#section-6>.
[38] *Ibid* at “Rolling Implementation”.
[39] *Ibid* at Recommendation 12.
[40] *Ibid* at “Compliance Data”.
[41] *AODA*, *supra* note 35.

32) These low compliance rates relating to individual accommodation plans and workplace emergency response information for people with disabilities become especially concerning if one considers how the onset of the COVID-19 pandemic in early 2020 impacted the medical sector, with specific regard on hospitals. More specifically, this brings forth questions as to how the government and the medical system have responded to this global health crisis regarding the accessibility concerns for people with disabilities.

Accessibility Concerns Relating to Ontario's COVID-19 Triage Protocols

33) Before the onset of the pandemic, existing inequalities and access to health care was a significant accessibility challenge for vulnerable groups, such as people with disabilities: it has been stated these challenges have become much worse.[42] Implementing policy decisions such as physical distancing and recommending people to stay home create obvious barriers for people with disabilities, especially those who require personal assistance or live in long-term care or group homes.[43]

34) As COVID-19 is a highly contagious and airborne disease, the rapid growth of the pandemic created additional barriers for receiving aid and support. This created a significant roadblock in preventing infection, having access to testing, acquiring personal protective equipment (PPE), or in more severe cases, being provided a ventilator or other life-saving equipment.[44]

35) The COVID-19 triage protocols were drafted in March of 2020 by Ontario Health, based on concerns over the ability of the medical system to provide care in the event of staggering hospital admissions due to the virus. The protocols were to be implemented as a last resort to determine who should receive intensive care when the demand for critical care exceeds the supply It is important to note that these protocols were not publicly released but instead were drafted by the government in consultation with

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[42] Lemmens, Trudo and Mykitiuk, Roxanne, Disability Rights Concerns and Clinical Triage Protocol Development During the COVID-19 Pandemic (August 17, 2020) 1-14, online (PDF): <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3675742>.
[43] *Ibid* at 2.
[44] *Ibid* at 3.

Ontario Health.[45] The triage protocols became publicized through media coverage in newspapers such as the Toronto Star, leading to disability-advocacy groups such as ARCH, the AODA Alliance, and prominent disability advocates such as Trudo Lemmons and AODA Alliance Chair David Lepofsky that publicly oppose the protocols.[46]

36) The purpose of the triage protocols is to ensure that as many people as possible can access intensive care.[47] However, if hospital admissions reach overcapacity, doctors will be forced to decide who should or should have priority in receiving care.[48] The triage system aims to reduce mortality and morbidity for the overall population rather than individual risk.[49] As a result, a patient that a doctor clinically assesses to have a lower probability of surviving an acute illness would have a lower chance of receiving priority care.[50] Patients are assessed based on their Short Term Mortality Risk (STMR), as well as their score between 1 and 10 on a frailty scale to determine eligibility.[51] For example, under a level 1 triage scenario, individuals with severe baseline cognitive impairment, unable to perform certain activities independently, would be excluded.[52]

Ontario's Draft COVID-19 Triage Protocols Apply a Medical Model Approach to Disability

37) Upon consideration of how physicians assess patients and their relative risk of impending mortality, the triage protocols seem to be adhering to the medical model perspective of disability. Medical doctors use their subjective medical judgements, which in turn obstruct people with disabilities from having equitable access to health care.

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[45] Lattanzio, Robert. 2020. ARCH Letter on Clinical Triage Protocol. ARCH Disability Law Centre. Available: https://archdisabilitylaw.ca/resource/arch-letter-on-clinical-triage-protocol/#_ftnref7
[46] Onley and Lemmons, *supra*, notes 38 and 43.
[47] Clinical Triage Protocol for Major Surge in Covid Pandemic. 2020. Ontario Health, 1-19, online (PDF): <https://med.uottawa.ca/pathology/sites/med.uottawa.ca.pathology/files/clinical_triage_protocol_for_major_surge_in_covid_pandemic_-_march_28_20205.pdf>
[48] *Ibid* at 2.
[49] *Ibid* at 3.
[50] *Ibid* at 4.
[51] *Ibid* at 10.
[52] *Ibid* at 4.

Applying this perspective fosters a terrible precedent that fails to appropriately consider persons with disabilities. Again, the *Health Care Consent Act* states that doctors are to ensure that the rights and autonomy of patients are protected.[53]

38) As suggested in paragraph 15, section 15(2) of the *Charter* ensures that any government action aimed to improve the accessibility conditions of disadvantaged groups, such as those with a disability, must not be discriminatory.[54] Neglecting people with disabilities who are dependent but otherwise healthy justifies a need for the government to require some form of analysis that considers these barriers and how to shatter them; drafting these triage protocols without consideration of these consequences have built more of them.

Analysis

Applying an Accessibility Lens in Review the COVID-19 Triage Protocols

39) As mentioned at paragraph 13, neither the provincial or federal levels of government have abided with or released an accessibility lens to be used in their policy decisions, despite promises to the contrary. Dr. Mary Ann McColl, who works with the Canadian Disability Policy Alliance (CDPA) and is a leading researcher and advocate for improving disability policy. Dr. McColl has drafted a lens that can be applied to policies and assist policymakers in determining the impact the policy has on people with disabilities. This framework titled the "Disability Policy Lens", lists seven considerations when drafting new policies and their implications towards people with disabilities: [55]

i. How and why did this policy come into effect? What are the suggested benefits and concerns of this policy?
ii. Does the policy specifically address people with disabilities? If so, does the policy consider how its implementation will affect them?
iii. How does the policy define disability versus being disabled, and are there eligibility requirements that include or exclude people?
iv. Does the policy focus on achieving goals of accessibility, support, or equity?

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[53] *Supra*, note 31.
[54] *Supra*, note 15.
[55] McColl, MA. (2017). *The Disability Policy Lens*. Canadian Disability Policy Alliance. 2nd Edition. Online (PDF): http://www.disabilitypolicyalliance.ca/wp-content/uploads/2018/02/dispollens-2017.pdf

v. Does the policy address people with disabilities as individuals of a vulnerable group or as a member of the entire population?
vi. How does the policy relate to other policies on both a provincial and/or national level?
vii. Does this policy impact the allocation of important resources, and if so, how does this affect people with disabilities and other subgroups in society?

40) To justify the government being mandated to use an accessibility lens, I will apply these seven considerations in accordance with the drafted COVID-19 triage protocols and whether the policy adequately considers the implications for people with disabilities.

i. How and why did this policy come into effect? What are the suggested benefits and concerns of this policy?

41) As previously mentioned in paragraph 33, Ontario Health recommended the triage protocols to the provincial government because of the growing levels of concern surrounding the COVID-19 pandemic. The increasing rates of exposure to the virus led to hospital capacities being overloaded with patients requiring support from COVID-19 infection.[56] Unfortunately, the pandemic and its devastating impact on people was not foreseen or expected, and the province of Ontario did not have emergency health measures in effect beforehand. Ontario Health drafted these protocols to recommend how the medical system can meet any overburdening intensive care requirements, such as with hospital beds, ventilators, or other essential resources.

42) The significant increase in COVID-19 cases brought forth concerns surrounding shortages in the distribution of these resources and hospitals being over their capacity limits. In short, this prevented many people from achieving the care they required, whether that be for COVID-19, major or minor surgeries, or any other reason to require hospital care.

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[56] *Supra,* note 48 at 2.

43) These escalating concerns brought the health care system into disrepute, forcing policymakers in the Ontario government to develop solutions to prevent a complete shutdown of the health care system. As a result, in March 2020, the government of Ontario drafted the COVID-19 triage protocols to be implemented if a significant surge in the COVID pandemic transpired.

44) The triage protocols seemingly do not have equal benefits for every Ontarian, as clinical triage forces physicians to make controversial decisions as to who will get the care they require and who may not. The triage protocols focus on utility, fairness, and proportionality as guiding principles, yet physicians cannot provide equitable care when hospitals are past capacity limits as a level 1, 2, or 3 triage scenario is in effect.

ii. Does the policy specifically address people with disabilities? If so, does the policy consider how its implementation will affect them?

45) The original protocols do not specifically reference individuals with disabilities, or how its implementation may impact them, except when emphasizing exclusion of care criteria, which will be addressed further in the next consideration of the analysis. However, in January of 2021, the Ontario Critical Care COVID Command Centre (OCCCCC) drafted the most recent version of COVID-19 triage protocols.[57] Similar to the drafted protocols by Ontario Health, the most recent protocols prioritizes individuals with the greatest likelihood of survival of their critical illness, at least 12 months after first getting sick.[58] As a result, if patients are unlikely to survive within 12 months have a lower priority in receiving ICU care.

46) As per section 6(f) and (g) of the *Accessible Canada Act*, people with disabilities are to be involved with the development of new laws, mandates, and policy decisions.[59]

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[57] Ontario Critical Care COVID Command Centre. (2021) "Adult Critical Care Clinical Emergency Standard of Care for Major Surge". online (PDF): *Hamilton Health Sciences.* <https://www.aodaalliance.org/wp-content/uploads/2021/01/Ontario-Adult-Critical-Care-EMERGENCY-STANDARD-OF-CARE-OCCCCC-20210113.pdf>

[58] *Ibid* at 4.

[59] *Supra,* note 23.

Despite the triage protocols suggesting consultation with disability advocates, the protocols continue to avoid recommendations that ensure vulnerable persons are not discriminated. Therefore, it can be argued that the triage protocols do not adequately consider how its implementation affects vulnerable persons, such as those with disabilities.

iii. How does the policy define disability versus being disabled, and are there eligibility requirements that include or exclude people?

47) The triage protocols prioritize treatment for those with the highest chance of survival, denying care to certain patients that have a lower likelihood of survival, referred to as their morbidity rates.[60] In addition, for fairness, the policy applies random allocation of support for patients who have a similar requirement of care.[61] Again, patients are assessed based on their predicted mortality risk within a year, used to determine eligibility of receiving critical care. This is referred to as their Short-Term Mortality Risk (STMR)[62] Doctors apply this utility-based approach through clinical assessment, where doctors will exercise their judgment about whether patients are near their end of life soon. Patients are placed into four different coloured groups, which are used to identify their predicted STMR. The four colours assigned are red, purple, yellow, and green.[63] Patients are assigned the colour red if they have between an 80-99% predicted STMR; purple for a 50-79% predicted STMR; yellow for a 30-49% STMR; and green for a 1-29% STMR.[64]

48) The triage protocols summarize eligibility requirements that include or explicitly exclude individuals, with specific exclusion considerations that disproportionally impact more dependent persons. The clinical assessment applies a scoring system, known as

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[60] Disability Rights Education and Defends Fund, Preventing discrimination in the Treatment of COVID-19 Patients: The Illegality of Medical Rationing on the Basis of Disability (25 March 2020), 1-32, online (PDF): <https://dredf.org/wpcontent/uploads/2020/03/DREDF-Policy-Statement-on-COVID-19-and-Medical-Rationing-3-25-2020.pdf>.
[61] *Supra,* note 47 at 4.
[62] *Supra* note 57 at 3.
[63] *Ibid* at 8.
[64] *Ibid.*

the Clinical Frailty Scale (CFS), that places patients on a score between 1 (very fit) and 9 (terminally ill).[65] Applying this scale helps clinicians determine the patient's chance of survival in proportion to how severe the shortage of medical care is available due to the intensive care admissions in hospitals. Markers of frailty include requiring assistance to walk, help with finances, or in more severe cases, requiring complete dependence for personal care.[66] These markers of frailty seem to be a way of referring to disability without explicitly stating frailty is measured by one's physical or mental difference.

49) To be admitted into an ICU bed, the patient must require either invasive ventilatory support, or have a concerningly low blood pressure level, medically referred to as hypotension.[67] The triage protocol has three levels, with each increasing level leading to a higher level of exclusion based on predicted mortality.[68] Level one aims to exclude people that have greater than 80% predicted mortality; level two excludes patients who have greater than 50% predicted mortality, and level three will exclude patients if their predicted mortality is more significant than 30%.[69]

50) If a major increase in COVID-19 cases force the implementation of level 3 triage, only those presumed with the lowest risk of death soon would be able to receive intensive care. In other words, more dependent patients, such as individuals diagnosed with ALS, would be less likely to receive critical care. As a result, one can conclude that the triage protocols seem to rely heavily on inclusion or exclusion criteria in determining who should receive care and who should be excluded.

iv. Does the policy focus on achieving goals of accessibility, support, or equity?

51) For this part of the analysis, I will briefly explain what accessibility, support, and equity goals refer to. The CDPA defines "access" as one's ability to participate.[70] As an example of a policy that focuses on a goal of access, the purpose of the *AODA* is to

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[65] *Supra,* note 48 at 10.
[66] *Ibid*.
[67] *Ibid* at 3.
[68] *Ibid* at 4; *supra*, note 58 at 8 under "Exclusion Criteria".
[69] *Ibid*.
[70] *Supra*, note 56.

promote an accessible Ontario, where Ontarians with disabilities have equal access and the ability to participate in society without significant barriers.[71]

52) A policy seeks to accomplish a goal of "support" when the policy provides resources to address special needs. As an example, the *Health Care Consent Act* was implemented with goals to ensure that individuals are provided protections regarding medical decisions if they lack the capacity to make decisions themselves.[72] Therefore, the Health Care Consent Act supports patients by ensuring they receive the medical care they require and that doctors are also legally responsible for making sure that patients understand what care they are obtaining, its benefits or risks, or if they cannot understand, to ensure an representative will.

53) Lastly, a policy seeks to achieve "equity" in three different forms: outcome equity refers to a goal of equal outcomes for those with disabilities compared to those without; vertical equity refers to the possibility to create equal opportunity for those with disabilities, and horizontal equity refers to policies aimed to promote equal treatment, where everyone is treated the same without any form of bias or discrimination.[73] As an example, section 15 of the *Charter of Rights and Freedoms* was enacted with aims to ensure that Canadians have equality rights where vulnerable individuals are not discriminated or subjected to any stigma, stereotyping, or other mistreatment.

54) The COVID-19 triage protocols seemingly aim to achieve goals in accessibility and support but disregard a goal of equity. Through the implementation of inclusion and exclusion criteria, determined both by the severity of the surge and a patient's level of mortality, this policy aims to ensure access to critical care for as many people as possible. This utility-based approach therefore prevents complete participation, as individuals who are at an increased risk of mortality are excluded in favour of others who are healthier.[74] Regarding people with disabilities, those who are assumed to be

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[71] *Supra*, note 36.
[72] *Supra*, note 31.
[73] *Ibid.*
[74] *Supra,* note 45.

highest on the frailty scale are most likely to be discriminated against through exclusion of care.

v. Does the policy address people with disabilities as individuals of a vulnerable group or as a member of the entire population?

55) The COVID-19 triage protocols refer to people with disabilities as individuals of a vulnerable group by stating that triage decisions based on STMR and degree of frailty should not be decided or influenced by demographic factors such as disability.[75] However, as previously mentioned, the guiding principles of the protocols are based on utility, proportionality, and fairness.[76] The purpose of the triage protocols seems to prioritize minimizing the mortality rates of the collective population rather than focusing on individual mortality.[77]

56) The medical decisions of exclusion should not discriminate against vulnerable persons, such as those with disabilities, yet the purpose of enacting this policy seems to contradict this. If a major increase in COVID-19 cases requires the protocols to be implemented, critical care should not wrongfully exclude individuals based on subjective presumptions as to who has a better likelihood of survival.

vi. How does the policy relate to other policies on both a provincial and/or national level?

57) The OCCCCC claim that the triage protocols adhere to the *Ontario Human Rights Code* as they emphasize the protocols avoid considerations such as a patient's quality of life, cost of future health care, or patients need for accommodations or general assistance.[78] However, the mandates of the OHRC seems to conflict with the primary reason for implementing triage protocols, as physicians base their assessment of a

[75] *Ibid,* at 2.
[76] *Ibid.*
[77] *Ibid.*
[78] *Ibid* at 5.

patients through indicators such as their quality of life in determining a patient's level of frailty and chance of survival.

58) Doctors claim that these assessments rely on objectivity, however it is unlikely that physicians can successfully determine a patient's chances of survival without applying subjective, ableist biases. A patient's short-term mortality risk is an estimation applied by physicians, which can become disproportionate towards vulnerable persons such as those who have disabilities.[79] These estimates seemingly create ableist biases which adhere to the medical model of disability and reaffirm continued acts of discrimination and mistreatment towards people with disabilities.

59) Other provinces such as Alberta and Quebec have drafted triage protocol frameworks with a similar approach focusing on equity and providing care for the greatest number of people.[80] More specifically, Alberta's framework suggests a similarity to Ontario's protocols, based on randomization of care where patients have an equal likelihood of survival, as well as on the exclusion process based on level of mortality. It is important to note that these protocols have not been put into effect by the government of Alberta. Overall, this suggests provinces are taking a similar stance across the country that prioritizes a utility-based approach of providing critical care to the detriment of those most at risk of short-term mortality.

vii. Does this policy impact the allocation of important resources, and if so, how does this affect people with disabilities and other subgroups in society?

60) As stated by the *Ontario Human Rights Commission* in their statement of COVID-19 recovery planning, the most vulnerable groups, such as people with disabilities, have been disproportionately affected.[81] In addition, the designing and

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[79] Osgoode Hall Law School. Disability Discrimination in Ontario Critical Care Triage Protocol. May 3, 2021. Available: https://www.youtube.com/watch?v=Ju8cyH7TbQo

[80] Alberta Health Services. 2020. Critical Care Triage during Pandemic or Disaster – A Framework for Alberta. 1-52, online (PDF): https://www.albertahealthservices.ca/assets/about/scn/ahs-scn-cc-critical-care-triage-framework.pdf

[81] Ontario Human Rights Commission. 2021. "OHRC Policy statement on human rights in COVID-19 recovery planning", online:

delivery of policies relating to the pandemic has not adequately involved consultation with people who experience barriers in accessing health care, and the government seemingly cannot determine solutions without their input.[82]

61) The primary objectives of implementing triage protocols are to ensure that people can get critical care when needed. The government must help equip the medical system to be prepared to handle the worst possible scenarios regarding the pandemic. Medical care is a fundamental resource claimed to be a guarantee for everyone, despite any form of physical or mental difference. Canada promises a universal health care system, and a right to life is the most important resource to protect.

62) The current triage protocols seemingly do not guarantee the required medical assistance that patients may need, especially if ICU build up leads to initiating higher triage levels. This utility-based approach seems to disproportionally impact vulnerable groups such as those with disabilities that require additional care and who seemingly score higher on the clinical frailty scale.

I will now provide an analysis of the COVID-19 triage protocols in accordance with the *Charter*, as well as both Ontario and federal law.

The Ontario Draft COVID-19 Triage Protocols Infringe the Charter

63) As determined in *Canadian Doctors for Refugee Care v Canada (Attorney General)*, 2014 FC 651, all protocols relating to health care that the government implements must be in accordance with the *Charter*.[83] The courts have previously declared that physicians have a responsibility to their patients which must take precedence over the physician's duty to the medical system when the patient is at risk of harm.[84]

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https://www.ohrc.on.ca/en/news_centre/ohrc-policy-statement-human-rights-covid-19-recovery-planning#_ftnref16

[82] *Ibid*.

[83] *Canadian Doctors for Refugee Care v Canada (Attorney General)*, 2014 FC 651 at para 506

[84] *Law Estate* v. *Simice* (1994), 21 CCLT (2d) 228 (BCSC), aff'd (1995), 27 CCLT (2d) 127, 17 BCLR (3d) 1, [1996] 4 WWR 672, 67 BCAC 89, 111 WAC 89 (BC CA).

64) It is therefore resoundingly clear that placing a greater emphasis on utility rather than on the individual is a breach of an individual's right to life, liberty, and security of the person, as per s.7 of the *Charter.*[85] Denying access to care infringes the security of the person, as it prevents patients from being able to receive treatment they require.

65) The COVID-19 draft protocols infringe people with disabilities section 15 *Charter* rights, which guarantees a right of equal treatment. As mentioned at paragraph 18, the two-part *Kapp* test is used to determine an infringement of an individual's s.15(1) *Charter* rights.

66) The first prong of the test is to determine whether a protected individual or group is being differentially treated. It can be argued that vulnerable persons, such as people with disabilities, are being provided differential treatment in their medical care, compared to individuals who are considered healthier. More specifically, individuals with a high level of frailty are being systematically excluded from receiving critical care treatment based on their higher risk of death soon. People with mental or physical disability are specifically identified under s.15(1) as a protected ground, to ensure that all individuals have the right to equal protection and benefit of the law. Therefore, this passes the first stage of a section 15(1) analysis.

67) To meet the second part of the *Kapp* test, one must determine that a protected ground, such as an individual having a disability, is facing significant amounts of discrimination through arbitrary, prejudicial disadvantage or stereotyping.[86] Regarding the draft protocols, it is evident that physicians make medical decisions on who should or should not receive care based on their subjective opinions of the patient's potential risk of death in the near future. This is determined based on a patient's level of frailty, and their Short-Term Mortality Risk (STMR), ss referenced on paragraph 46. Determining a patient's level of frailty by factors such as their dependency on others for

[85] *Canadian Charter of Rights and Freedoms*, s 7, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11 [Charter]
[86] *Supra*, note 22

assistance, their capabilities in doing everyday tasks such as handling their finances, or the relative severity of their current physical disability.

68) It is resoundingly clear that people with disabilities have a higher chance of scoring high on the frailty scale in comparison to people without disabilities. People with disabilities have a higher likelihood of a higher score when considering their tendency to have lower activity levels and a greater dependency on others for care. This creates a structural distinction between both groups that is formulated and reliant on subjective medical opinions.[87] Labelling individuals with disabilities into groups instead of considering their individual needs is a means of discrimination and reinforcing stereotypes on people with disabilities. In other words, the triage protocols reinforce a medical model approach to defining disability as it allows for subjective value judgements rather than objective and individual assessment[88]. It is clear this successfully meets the second component of a s.15(1) analysis, passing the *Kapp* test.

69) Therefore, in applying the *Kapp* test, one can easily conclude that Ontario's COVID-19 triage protocols are discriminatory towards persons with disabilities and are consequently a blatant infringement of the sections 7 and 15 *Charter* rights for people with disabilities.

I will now briefly conclude about the Ontario COVID-19 triage protocols and their compliance with Provincial legislation.

The Draft Ontario COVID-19 Triage Protocols Do Not Act in Accordance with Federal and Ontario Law

70) The draft Ontario COVID-19 triage protocols contrast with federally mandated statutes such as the *Accessible Canada Act (Bill C-81*) and the *Canadian Human Rights Act.* Similarly, the protocols also conflict with the *OHRC*, *AODA*, and the *Health Care Consent* Act.

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[87] Lattanzio*, supra*, note 46.
[88] *Ibid.*

71) The overall objective of enacting these statutes is to ensure that vulnerable groups, such as people with disabilities, have equitable access to society and are not subject to further discrimination. The COVID-19 triage protocols do not adhere to these standards. People with disabilities are more likely to be denied critical care based on a flawed, subjective system of frailty, which create further obstacles to receiving equitable health care. Worst of all, enacting these protocols would disproportionately exclude people with disabilities from receiving critical care treatment.

Conclusions

1. The Social Model Appropriately Defines Disability, whereas the Medical Model is Inappropriate and Ableist

72) The first issue raised in this memorandum is which of a medical or social model is more appropriate when defining disability. It is strikingly clear that applying a social model definition of disability better adheres to the standards set in both provincial and federal governmental jurisprudence, and for ensuring people with disabilities can be successful members of society.

73) Applying a medical model of disability wrongfully discriminates people with disabilities by allowing physicians to rely on ableist biases and subjective opinions to mislabel patients with disabilities. Medicine is not an exact science, and much of what doctors conclude is based on their subjective opinions and experiences instead of any scientific method. Unfortunately, neither the science of medicine nor the doctor's expertise can definitively conclude what the quality of life is for a person with a disability.

74) The medical model only considers the individual implications of disability, without consideration of the societal, political, and cultural factors that influence how people with disabilities are perceived. The COVID-19 triage protocols rely on a medical model application, which prevents equitable medical treatment and care: having access to it must be equally available, regardless of any physical or mental difference.

75) The social model of disability, in contrast, recognizes the restraints that societal misconceptions cause on people with disabilities and the medical differences that

people may have. In addition, the social model appropriately considers disability as a difference and not a deficiency. When considering accessibility restraints, it is restrictive to claim that the only solution is to cure a person with a deficit medically. The social model addresses the root cause of systemic discrimination towards people with disabilities: labelling people with disabilities as inferior and requiring a cure builds societal barriers rather than destroying them. Simply put, society must change, not the individual.

76) The social model mirrors provincial and federal enactments (explained in paragraphs 15-30) implemented to make society more accessible and prevent discrimination towards people with disabilities. For example, federal statutes, such as the *Accessible Canada Act*, and Ontario legislation, such as the *AODA* and *Human Rights Code*, was drafted to combat accessibility restraints and systemic discrimination towards people with disabilities. The social model aligns with these provincial and federal governmental mandates. Therefore, the social model applies an appropriate way in defining disability, whereas the medical model is discriminatory, ableist, and misguided.

2. An Accessibility Lens Would Benefit the Review of the Draft Ontario COVID-19 Triage Protocols

77) The second issue in this memorandum is whether utilizing an accessibility lens would benefit a review of Ontario's draft COVID-19 triage protocols. As determined above (paragraphs 63-69), the draft protocols implemented by the Ontario government violate the *Charter*, as well as federal and provincially enacted jurisprudence.

78) The COVID-19 triage protocols clearly oppose the *Charter*, as well as the purpose of the aforementioned Ontario and federal laws. The government of Ontario clearly realized the controversial nature of the draft protocols, especially when considering the public concern and refusal to officially release them to the public. The COVID-19 pandemic clearly caused a serious strain on hospital capacities and the

medical system as a whole, yet this does not justify discriminating towards certain vulnerable groups.

79) Applying Dr. McColl's Disability Policy Lens is an example of an effective application of an accessibility lens in review of a drafted policy. Policymakers must consider similar questions outlined in that framework when drafting legislation that indirectly and/or directly impacts people with disabilities. This is especially clear when reviewing the COVID-19 draft triage protocols with an accessibility lens perspective. Drafted legislation cannot conflict with the fundamental rights and freedoms of people with disabilities.

An Accessibility Lens Must Be Mandated in Front of Everything the Government Does

80) The third issue of this memorandum questions whether an accessibility lens must be mandated in front of every decision a government makes. Based on the analysis conducted, a legal case reaffirms a need for mandating an accessibility lens in front of every decision the government does. Despite the enaction of both provincial and federal laws that seemingly aim to combat accessibility concerns for people with disabilities, barriers continue to be built that further exclude and discriminate. In addition, it is evident that the medical model of disability is still relied upon in the medical field, and the government, despite jurisprudence requiring the contrary. The government willfully avoided releasing these COVID-19 protocols, clearly suggesting a need for enforcing accountability.

81) An accessibility perspective must consider important factors beyond simply how the proposed policy implicates people with disabilities. For example, the lens questions how the policy defines disability and whether the policy regards people with disabilities as individuals or holistically as members of society. In addition, the lens questions how the policy compares to other national or provincial jurisdictions.

82) Applying an accessibility perspective provides guidance for policymakers who do not understand the living circumstances of others: mandatory implementation of an accessibility lens, like the one drafted by Dr. McColl, would ensure that a proposed policy adheres to the standards of Canadian jurisprudence such as the *Charter, AODA, Accessible Canada Act,* and the *OHRC*, among others. Using this lens in review of the draft COVID-19 triage protocols emphasizes the need to mandate the government apply an accessibility lens in every decision they make.

I will now briefly outline three recommendations for consideration that would ensure an accessibility lens can be mandated for all governmental decisions.

Recommendation One: The Government Must Consult with People Who Have Disabilities When Drafting Policies That Affect Them Directly or Indirectly

83) To put it bluntly, governmental employees do not understand the hardships that people with disabilities endure. In addition, neither do medical doctors. The only individuals who understand the barriers that people with disabilities face daily are people with disabilities. If the government wishes to ensure the country is more accessible for people with disabilities, they must collaborate with them. This should not solely be a legal obligation, but also a moral one.

Recommendation Two: Judicial Enforcement of an Accessibility Lens

84) The courts must help enforce the application of an accessibility lens. The COVID-19 triage protocols are policy decisions and therefore, directly conflict with precedent that is set by the *Charter*, the *AODA*, the Human Rights Code*,* among others. As the judicial system is independent of the government, the courts can ensure enforcement of an accessibility perspective and hold the government constitutionally accountable for protecting their vulnerable groups, such as people with disabilities.

Recommendation Three: Enforcement Through an Independent Advisory Committee

85) In addition, I recommend that enforcement of an accessibility lens be designated to an independent advisory committee that can oversee the government and hold them accountable. As an example, the Accessibility Directorate of Ontario (ADO) oversees enforcement of the *AODA*. Evidently, concerns have arisen regarding the ADO and their relative success in ensuring compliance with the *AODA*, as has been stated by the Honourable David Onley in his report on the *AODA* (see paragraphs 29-31).[89] However, despite these shortcomings, the ADO has been somewhat successful, as stated in reiterates why an independent advisory committee would better ensure that disproportionate policy decisions towards vulnerable populations are not wrongfully implemented, as has been seen with the draft COVID-19 triage protocols.

86) A further example is seen in *Bill C-81*, the *Accessible Canada Act,* which tasks the Canadian Accessibility Standards Development Organization (CASDO), an independent agent of the Governor in Council, to collaborate and consult with people with disabilities and the public. The CASDO holds this position to help the Minister of the Queen's Privy Council of Canada draft an independent review of accessibility standards.[90]

87) Through collaboration with the judicial system, a designated independent advisory group, and adequate consultation with people with disabilities and other vulnerable groups would ensure that the government will be held accountable for ensuring any policy decisions consider the implications towards people with disabilities.

Concluding Remarks

88) It is resoundingly clear that the government cannot be relied on to adhere to the required accessibility standards for people with disabilities by themselves. As per my recommendations, the government require mandatory advisement to ensure people with disabilities and their needs are met. As stated by Canada's top medical doctor,

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[89] *Ibid*, note 37.
[90] *Supra*, note 24, s.11.

Theresa Tam, the country has failed its vulnerable populations in their COVID-19 response.[91] The draft COVID-19 triage protocols restate this clear failure, and how it must be required to mandate usage of an accessibility lens in front of every decision a government creates to ensure this systemic failure of people with disabilities does not continue any longer.

Notes

[91] Rachel Aiello. 2021. "'We failed the most vulnerable': Dr. Tam's biggest takeaway after a year of COVID-19". CTV News. Available: www.ctvnews.ca/health/coronavirus/we-failed-the-most-vulnerable-dr-tam-s-biggest-takeaway-after-a-year-of-covid-19-1.5345393.