

January 18, 2021

To: The Hon. Christine Elliott, Minister of Health

Via email: [Christine.elliott@ontario.ca](mailto:Christine.elliott@ontario.ca)

Ministry of Health

5th Floor

777 Bay St.

Toronto, ON M7A 2J3

Dear Minister,

Re: Ontario Government's Protocol for Medical Triage of Life-Saving Critical Care in the Event Hospitals Cannot Handle All COVID-19 Cases

We urgently ask you to act *now*. *Please* prevent the serious and imminent risk that under your Government's written directions, Ontarians with disabilities risk being subjected to disability discrimination when they seek access to life-saving critical medical care during the COVID pandemic, if hospitals must ration or triage critical care. The time when triage may have to take place is getting close, according to Dr. James Downar, a member of the Government's external advisory Bioethics Table (speaking on [The Agenda with Steve Paikin](#) on January 13, 2021).

We attach a deeply troubling document we have received, dated January 13, 2021, entitled "Adult Critical Care Clinical Emergency Standard of Care for Major Surge". In this letter we call it the "Government's January 13, 2021 Triage Protocol". It appears to be your Government's most recent directions to Ontario hospitals on how to decide which patients, needing life-saving critical care, should be refused that care, if triage or rationing becomes necessary.

We understand that it was sent to Ontario hospitals on or about January 13, 2021. Your Government did not make it public then or after, nor did it acknowledge publicly that such a document was finalized or sent to hospitals. We only found out about it when a copy of it reached us. We are making it public, with this letter. Does the Government dispute that this is the document which was sent to Ontario hospitals on or about January 13, 2021, or any time this month, by or on behalf of the Ontario Government, Ontario Health, the Ontario Critical Care Command Centre, or any other such emanation connected to the Ontario Government?

Please immediately intervene to address the critical care triage issues we identify in this letter, and to keep your Government's unkept commitments

that during this pandemic, your Government will protect the most vulnerable, and be open and transparent in doing so. Right now, on this issue, your Government is being persistently secretive and is leaving the most vulnerable exposed as the most at risk of being denied life-saving critical care.

We have not had sufficient time to study in detail the January 13, 2021 triage protocol. However, given the subject's urgency, we alert you to very serious concerns that we have already identified. In summary, we are deeply concerned that the Ontario Government's approach to the impending possibility that life-saving critical medical care may soon have to be rationed or triaged, and that some patients will die as a result, is severely flawed. It risks unjustified discrimination based on disability. It risks victimizing people with disabilities who already bear COVID-19's worst hardships. It is not shown to be authorized by law. It does not provide fair due process to patients whose lives are at risk. It is the result of your Government dealing with this issue in secret, talking mainly or exclusively to doctors and bioethicists who have not shown themselves to have an appropriate understanding of the legal rights of people with disabilities.

We summarize our key points as follows:

1. The Government cannot direct which patients live or die by simply sending a memo to hospitals.
2. The new January 13, 2021 Triage Protocol wrongly directs triage doctors to use the disability-discriminatory Clinical Frailty Scale (CFS).
3. Setting a patient's 12 month likely survival as the triage criterion further risks disability discrimination.
4. References to respecting human rights in the January 13, 2021 triage protocol do not eliminate our documented serious concerns about its authorizing disability discrimination.
5. The January 13, 2021 triage protocol does not provide patients whose life is at stake with basic due process and procedural fairness.
6. The January 13, 2021 triage protocol is unclear on whether it is ever directing doctors to withdraw ongoing critical care from a patient already receiving it to make room for another patient.
7. The Ontario Government needs to announce and implement a clear and effective strategy to prevent the need for life-saving critical care services to ever have to be rationed or triaged.

8. The Ford Government's handling of the critical care triage issue from the start has been plagued with harmful secrecy, evasiveness and a lack of candor.
9. The Government must now rescind and fix the January 13, 2021 triage protocol, and directly consult the public on this issue.

### **1. The Government Cannot Direct Which Patients Live or Die by Simply Sending a Memo to Hospitals**

It is not clear that your Government has authority to make such life and death decisions in secret, by a memo to hospitals. This concern has been reinforced by the Ontario Human Rights Commission, and at least to some extent, by the Government's own external advisory Bioethics Table.

The rule of law unremittably applies to the Ontario Government without exception, even during a pandemic. The Government cannot issue directions on which patients, needing life-saving critical care, are to be refused that care during rationing or triage, simply by sending a memo to hospitals, much less a secret memo written by unnamed people. There must be a proper legislative basis for any such direction. That legislation must comply with the Canadian Charter of Rights and Freedoms, the Ontario Human Rights Code, and the Criminal Code of Canada.

Any scholarly debate over what standard or rules should apply for conducting critical care triage is completely beside the point, if the triage directions are not legally authorized and mandated. Minister, what valid legislation gives the Government or its "Critical Care COVID-19 Command Centre" the authority to give such life and death directions, or to decide when they are to go into operation? The January 13, 2021 triage protocol simply says it was approved by the Ontario Critical Care COVID Command Centre.

Amplifying this concern, the January 13, 2021 triage protocol does not include the paramount requirement that any refusal of life-saving critical care to a patient needing it must be lawful. Where it lists principles to govern triage, the document makes some references to legal considerations, but fails to recognize legality as paramount.

### **2. New January 13, 2021 Triage Protocol Wrongly Directs Use of the Disability-Discriminatory Clinical Frailty Scale CFS**

We strongly object to the January 13, 2021 triage protocol because it uses, as part of critical care triage, the "Clinical Frailty Scale" (CFS). When used in such triage, the CFS demonstrably directs disability-based discrimination against some patients with disabilities.

We, the ARCH Disability Law Centre and others thoroughly warned The Government and its external advisory Bioethics Table of this months ago. The Ontario Human Rights Commission has also objected to the CFS being used in the triage protocol. Yet this discrimination has not been eliminated from the January 13, 2021 triage protocol. As explained further below, the January 31, 2021 protocol's various references to human rights do not counteract this impermissible discrimination.

In this letter, we address disability discrimination. Serious concerns about racial, Indigenous and other illegal discrimination have also been raised with the Government. That must also be effectively addressed. Moreover, where a patient has a disability and is also the member of another Human Rights Code-protected vulnerable minority, there is an increased risk of compounding impermissible discrimination.

People with disabilities have been disproportionately exposed to the risk of getting COVID-19 and suffering its most serious impacts. Disproportionately, those dying from COVID-19 in Ontario are people with disabilities. For example, those dying in our long term care homes are people with disabilities. Compounding this cruel reality, several reasons show that people with disabilities now risk being de-prioritized in access to life-saving critical care that they will disproportionately need if Ontario hospitals, now near the breaking point, cannot provide life-saving critical medical care to all patients needing it.

First, buried in the January 13, 2021 triage protocol amidst a blizzard of technical medical jargon is a mandate for doctors to use the "Clinical Frailty Scale" (CFS) as part of triage assessments of at least some patients who need critical care. The AODA Alliance and the ARCH Disability Law Centre demonstrated last summer to the external advisory Bioethics Table that the CFS is riddled with incurable disability discrimination. See e.g.:

1. The [August 30, 2020 AODA Alliance submission](#) to the Ford Government's Bioethics Table;
2. The captioned video of the AODA Alliance's [August 31, 2020 oral presentation](#) to the Bioethics Table on disability discrimination concerns in critical care triage; and
3. The [September 1, 2020 submission](#) and [July 20, 2020 submission](#) by the ARCH Disability Law Centre to the Bioethics Table.

The January 13, 2021 triage protocol permits two different ways to use the CFS, and includes a simplified tool for using it. The appendix to that protocol document entitled "Clinical Assessment Tools for Short Term Mortality Risk Assessment for Critical Illness" repeatedly authorizes a triage doctor to use the CFS, and also more generally states:

“Use Clinical Frailty Score as part of a holistic assessment for people aged 65 and over, without stable long-term disabilities (e.g. cerebral palsy), learning disabilities or autism. For any patient aged under 65, or a patient of any age with stable long-term disabilities (e.g. cerebral palsy), learning disabilities or autism, do not use the CFS as the degree of disability may not reflect STMR. Consider comorbidities and underlying health conditions in assessing their STMR.”

Under the CFS as mandated here, in the case of a critical care patient with a progressive disease but who has more than six months to live, their likely mortality would be assessed in part by the number of activities of daily living that they can perform without assistance, having regard to each of these specific activities: dressing, bathing, eating, walking, getting in and out of bed, using the telephone, going shopping, preparing meals, doing housework, taking medication, or handling their own finances. The CFS is a clear illustration on its face of direct disability discrimination. As such, there is no need to resort to the additional fact that it also has clear discriminatory disproportionate impact on patients with disabilities.

It is a core feature of the CFS that it calls for an assessment of a patient’s ability to undertake certain activities of daily living independently or *without assistance*. Yet at the core of equality and human rights protections for people with disabilities is their right to disability accommodations where needed, and their right to have their abilities assessed with needed disability accommodations, not *with their* needed disability accommodations wrenched from them. The CFS thereby embodies a deeply entrenched, blistering violation of human rights on that basis alone.

For the triage protocol to invite doctors or other health care professionals to assess the abilities of a patient with disabilities to undertake certain activities of daily living independently or without assistance is to reinforce and build upon deeply injurious stereotypes about people with disabilities. To do so in a protocol that invokes bioethical commitments to “fairness” is especially indefensible.

It would be wrong to assess a doctor’s ability to practice medicine by first requiring them not to wear their eyeglasses. In a decision over life or death, it is all the more wrong to take that erroneous kind of approach to assessing a patient’s ability to undertake the CFS-listed activities of daily living without considering their needed disability accommodations.

Second, such an assessment by doctors or other health professionals of people with disabilities risks triggering a covert assessment of the social worth or “quality of life” of patients with disabilities. That deliberative process must be strictly and proactively prevented, and not directly or indirectly tolerated or encouraged. This serious problem is not eliminated by a reference elsewhere

in the January 13, 2021 triage protocol about not evaluating a patient's quality of life.

Third, Dr. James Downar, a prominent member of the advisory Bioethics Table, acknowledged during our virtual meetings last summer with that Table that there is subjectivity in a doctor's application of the CFS to a particular patient. From this we are concerned that two different doctors could well score the same patient differently. In other words, each doctor can become a law unto themselves.

I pointed that subjectivity out to Dr. Downar on the [January 13, 2021 panel on The Agenda with Steve Paikin](#) in which we both took part. Dr. Downar did not deny having said that.

Making this an even greater concern, the fact that a person has an MD does not mean they have expertise in assessing a patient's ability to undertake activities of daily living. During our meetings last summer with the Bioethics Table, we were told that most physicians are not trained in medical school on how to use the CFS. Some geriatricians have training or experience in its use. In contrast, we noted for the Bioethics Table that the health care professionals whose expertise more specifically focuses on a patient's ability to undertake activities of daily living (a central part of the CFS) are occupational therapists, not physicians.

Fourth, further increasing its arbitrariness and unfairness, the CFS's core focus on a patient's ability to perform certain activities of daily living can bias against patients based on their socio-economic status, or the timing of when they acquired their disability. Poor people with disabilities can have less access to rehabilitation training and supports compared to the more affluent. Someone who acquired their disability long ago may have had much more opportunities to learn to perform such activities of daily living, as compared to those who just got their disability more recently. When reviewing the CFS with some members of the Bioethics Table last summer, it was not disputed that the CFS measures can have such adverse affects depending on a patient's socio-economic status or when they acquired a disability.

Fifth, it does not reduce these concerns that the protocol directs a triage doctor to use a patient's CFS score as but one factor in a holistic triage assessment of the patient. This is because:

1. To the extent that a triage doctor uses the CFS at all for triage, it has all the serious problems that we and other disability advocates have repeatedly identified.
2. Under this new triage protocol, each triage doctor is given a sweeping discretion to weigh a patient's CFS score as a factor in their triage decision. There is no assured consistency in how much weight each

triage doctor gives that CFS score. Some will give it a lot of weight. Others could give it much less weight. Here again, each doctor will be a law unto themselves. The weight they decide to give the CFS score could well be a decisive factor on whether the patient is allowed to live or left to die.

3. For a triage doctor to be given a discretion to decide how much weight to give a patient's CFS score in making a triage decision is in effect to give that doctor or team a carte blanche to apply whatever triage criteria they wish. After using whatever triage criteria they wish, they could thereafter assign to the patient's CFS score that amount of weight that will support the outcome that the triage doctor otherwise preferred. Once again, each doctor becomes a law unto themselves.
4. This opens the door to covert or even unconscious disability discriminatory or stereotype-based decisions. It also opens the door to a triage doctor in effect making their decisions on the patient's perceived quality of life or social utility.

Even the Bioethics Table has in substance conceded that limits are needed to the CFS's use. The Government's earlier March 28, 2020 triage protocol (rescinded on October 29, 2020) directed the CFS's use for patients over age 18. The Bioethics Table subsequently recommended it not be used for those under 65, and recognized some limitations to it. The Bioethics Table in its September 11 Report in Appendix C stated the following:

"However, the Bioethics Table learned through its consultation with disability rights experts that the use of CFS in the context of critical care triage raises significant concerns that persons with disabilities, many of whom may need assistance with activities of daily living, would score higher on the CFS than an able-bodied person and that this could lead to the over-triaging of persons with disabilities."

The CFS was not created as or designed to be used as a triage tool. Limiting it to patients over 65 does not eliminate any of the foregoing concerns for those patients to whom it would be applied.

### **3. Setting a Patient's 12 Month Likely Survival as the Triage Criterion Further Risks Disability Discrimination**

The January 13, 2021 triage protocol sets as the triage criterion a patient's likelihood of surviving for at least 12 months. Like the Ontario Human Rights Commission, we object to this 12 month measure. We urge that it be substantially shortened.

It appears undisputed that doctors are not able to objectively predict if a patient, needing critical care, is likely to live for more than 12 months. No

objective tool exists for measuring this. The January 13, 2021 triage protocol, by offering a blizzard of medical jargon, may give the impression that this is all objective medical science. However, such an impression would be false.

The 12 month horizon would give doctors far too much latitude for subjective or unscientific assessments. This is yet another way in which triage doctors would become a law unto themselves.

Exacerbating this, last summer, during the Bioethics Table's virtual meetings in which we took part, I asked Dr James Downar (head of a hospital palliative care service) about how doctors evaluate a patient's 3 month likely mortality to qualify for admission to palliative care. He candidly said "We lie." For our part, we are concerned that if doctors lie for a 3 month mortality assessment, there is at least a risk that some doctors will do the same for a 12 month mortality assessment. Once more, doctors would each become a law unto themselves.

We do not understand Dr. Downar as saying that doctors lie maliciously or selfishly, in that context. We understood him to mean that they do so to help a patient get into palliative care.

Dr. Downar has taken strong exception to my making this point. An example of this was at the end of the January 13, 2021 panel on The Agenda with Steve Paikin. He argued that there is a difference between doctors doing so to get a patient into palliative care (i.e. to get them needed medical services). However, it is pivotal that Dr. Downar did not deny saying what he did regarding doctors' conduct. Moreover, to us, the cause for concern arising from his statement to us last summer is clear and present, despite Dr. Downar's argument to diminish it.

Beyond the foregoing, there is a practical risk that this triage protocol will not govern actual triage decisions, regardless of its contents. In a specific hospital, in the midst of a pandemic surge, there is a real risk that a triage doctor, called upon to make a critical care triage decision, will look at the four patients who need critical care and the two available critical care beds, and will size them up based on the doctor's own personal views of who is the most "deserving". Here again, the risk of stereotypes and of assessing perceived quality of life or social utility of each of the patients is palpable. The CFS's focus on a patient's ability to undertake certain activities of daily living independently or without assistance risks triggering such stereotype-based thinking.

This is made more evident since, during the December 17, 2020 roundtable on this issue held by the external Bioethics Table and the Ontario Human Rights Commission, Dr. Andrew Baker, a member of the Government's Critical Care Command Table, made it clear that in his view, the way to address triage now would be life years saved. That would fly in the face of the bioethics Table's September 11, 2020 report, the Government's January 13, 2021 direction to

hospitals, and the Ontario Human Rights Code and Canadian Charter of Rights and Freedoms. He thereby further illustrated the risk of a doctor becoming a law unto themselves.

#### **4. References to Respecting Human Rights in the January 13, 2021 triage protocol Do Not Eliminate Serious Concerns about Its Authorizing Disability Discrimination**

Despite its several references to human rights, the January 13, 2021 triage protocol takes a fundamentally wrong approach to the Ontario Human Rights Code. That law cannot be overridden by a Government memo, a hospital administrator or a front-line doctor. It is a quasi-constitutional law. It can only be overridden, if at all, where another valid piece of legislation includes an override provision. Yet contradicting this, the January 13, 2021 triage protocol erroneously directs hospitals and doctors in effect that there may be some room to act contrary to the Ontario Human Rights Code during the pandemic. It states:

“This standard of care is intended to align with the Ontario Human Rights Code (Appendix A) to the extent permitted in the context of a major surge.”

Making this worse, the protocol then purports to explain what the Ontario Human Rights Code requires. It does so in a dangerously incomplete way, from the prospective of patients with disabilities. It does not explain that no assessment tool can be used which, though neutral among patients, and medically-sincere in its application, has a disproportionate discriminatory impact on people with disabilities, unless a compelling defence can be made out that accords with human rights standards. As explained earlier in this letter, the Clinical Frailty Scale which the document later explicitly permits is just such a disability discriminatory tool. Any such requirement can only be used if the organization using it can show that it is impossible to accommodate people with disabilities in relation to the service in question without undue hardship. The burden of proof to justify it is on those using the discriminatory tool, not on the patient with a disability who would be its victim.

#### **5. The January 13, 2021 Triage Protocol Does Not Provide Patients Whose Life is at Stake with Basic Due Process and Procedural Fairness**

The January 13, 2021 triage protocol says that fairness and fair procedures are valued principles that are to apply. Yet it does not provide due process to a patient whose life is in jeopardy due to possible critical care triage. This flies in the face of the Canadian Charter of Rights and Freedoms, our submissions to the Bioethics Table last summer, and the Bioethics Table’s September 11, 2020 report to the Government.

Under this protocol, the patient whose life is at stake is in effect treated as a passive body lying on a gurney, over whom doctors will deliberate, make

decisions, and then communicate the good or bad news (offering emotional support if the news is bad). There is no opportunity for the patient or their supporters to have input into the assessment.

For example, under this protocol, a doctor, who has never before hospital admission met the patient, may use the disability-discriminatory Clinical Frailty Scale to help rate the patient's likely 12 month mortality, in part by assessing if the patient can without assistance undertake 11 activities of daily living, such as getting out of bed, dressing, eating or doing their finances. Due process entitles the patient to have fair notice and a chance to be heard by the persons making a life-or-death decision about their access to life-saving critical care (e.g. by showing why they can do those activities).

As well, there is no right of appeal. The Bioethics Table recommended an internal appeal within the health care system. We support that but have urged that there also needs to be an external swift appeal to a court or tribunal, given that lives are at stake. From what we have received, it appears that the Government may have included an internal appeal within the health care system in its secret November 13, 2020 draft protocol (never made public or shared with us). It also appears that the January 13, 2021 triage protocol has eliminated even that partial element of due process for patients. No explanation for this has been given.

#### **6. The January 13, 2021 Triage Protocol is Unclear on Whether it is Ever Directing Doctors to Withdraw Ongoing Critical Care from a Patient Already Receiving it to Make Room for Another Patient**

The January 13, 2021 triage protocol is unclear at points on whether it only gives directions on refusing to admit a new patient to critical care who needs it, or whether it could also include evicting an existing patient, already receiving critical care, from a hospital's critical care service. Some points in the protocol make it sound like it only speaks to restrictions on which new patients can get into a critical care ward. Other parts could leave open the possibility of evicting an existing critical care patient from continuing to receive their critical care, without their consent, even though they still need critical care.

For a hospital or doctor to evict a critical care patient over their objection from receiving further critical care they need, risks extremely serious issues, including those that must be considered under the Criminal Code. I raised this once again during the [January 13, 2021 panel on The Agenda with Steve Paikin](#). Here again, we do not see how this can take place, much less how a Government memo has legal authority to permit this. The protocol's lack of clarity on this point is deeply troubling.

## **7. The Ontario Government Needs to Announce and Implement a Clear and Effective Strategy to Prevent the Need for Life-Saving Critical Care Services to Ever Have to Be Rationed or Triage**

There would be no need for rationing or triage of critical medical care if the Government had implemented an effective plan to ensure that Ontario had enough critical care beds, equipment and doctors to accommodate the COVID-19 surge. The Government knew last February, 11 months ago, that it needed to be ready. It cannot now excuse its failure to be ready on some unexpected surprise.

On the Agenda with Steve Paikin's January 13, 2021 panel, Dr. James Downar stated that the risk is not a shortage of hospital space or equipment. There is a risk of a shortage of doctors to deliver critical care. Of course, the Government could not have trained a whole new class of doctors in the past eleven months. However, the Government could have implemented a strategy to train doctors to be redeployed to meet this surge need, who are practicing in related areas, to the extent possible. That would seem preferable to turning away patients altogether from needed life-saving critical care, due to staffing shortages. Because the Health Ministry has refused to talk to us about this entire issue, we have had no chance to discuss this.

Just two months ago, despite warnings from professionals about the anticipated winter COVID-19 surge, the Government was in public denial of the situation's severity. On November 5, 2020, answering an opposition question about this triage issue in the Legislature's Question Period, Robin Martin MPP, your Parliamentary Assistant denied the likelihood that a triage protocol would have to be invoked. She said:

"We don't anticipate getting anywhere near having to use such a protocol..."

Making this worse, we do not know what the Government has done to ensure that there is a swift, efficient, centralized system in place to transport critical care patients from overloaded regions to those not yet overloaded. The January 13, 2021 triage protocol ambiguously states:

"In the context of a major surge, it is expected that hospitals and regions will collaborate to coordinate the allocation of critical care resources to save the most lives possible, and cooperate with provincial directions provided by the Ontario Critical Care COVID Command Centre."

For this to operate effectively, it should be centrally planned and operated on a province-wide basis, administered and monitored, with public accountability. It cannot simply be an "expectation" or hope that hospitals will do this in the midst of a pandemic crisis, each being left to re-invent the wheel.

## **8. The Ford Government's Handling of the Critical Care Issue from the Start Has Been Plagued with Harmful Secrecy, Evasiveness and a Lack of Candor**

We respectfully take exception to how your Government has dealt with this issue over the past eleven months. As a troubling start, last winter and spring, your Government developed the March 28, 2020 critical care triage protocol in secret. You did not alert the public that you were developing a protocol for this issue. You sought no input from the public including the disability community. It seems you only obtained input from the medical and bioethics community. Yet they have no expertise in the law, the Constitution, human rights or disability rights, as the past months have amply shown.

Once that secret March 28, 2020 triage protocol was leaked, your Government claimed that it was only a draft. Yet it was never marked draft. Your Government has still never made it public.

Last April, that secret March 28, 2020 triage protocol was widely condemned as discriminatory against some patients with disabilities. Yet your Government left it festering in place at Ontario hospitals for six months. Only after the disability community, the Ontario Human Rights Commission and even your own Bioethics Table called for it to be rescinded, did your Government rescind it, though only after weeks of further delay. That too was done in secret on October 29, 2020. We only learned of its cancellation on November 5, 2020 when your Government was pressed on this triage issue by the opposition in Question Period.

For the entire pandemic, you and your Ministry have refused to meet or talk with us about our input and concerns on this triage issue. You have not answered any of the six earlier letters that we sent you since September. For the past eleven months, your Government has been hiding behind its external advisory Bioethics Table, using them in effect as human shields. We know from decades of disability advocacy that on such important issues, it is essential to speak directly to those inside government who are making the decisions.

Too often, we only find out about steps taken on this issue when the opposition ask questions in Question Period in the Legislature, or when a reporter asks a question at the Premier's news conference, or when documents are leaked. Written questions to the Government from the media too often go unanswered or get evasive answers.

There are still more illustrations of the Government's secrecy on this issue. The January 13, 2021 triage protocol reveals that on January 12, 2021, the Government-appointed external advisory Bioethics Table revised its September 11, 2021 report to the Government, and issued a new report dated January 12, 2021. That revised report has not been disclosed to us and the public. We ask

that you immediately make it public and provide it to us in an accessible format.

The January 13, 2021 triage protocol states that it is “informed by extensive Ontario-based research into public views on pandemic triage and resource allocation”. We have never been shown any such research, nor has it been discussed with us. As far as we can tell, no such information was made public. Most troubling, your Government has held no public discussion or direct Government public consultation on this issue since the pandemic began.

The January 13, 2021 triage protocol was approved by the Ontario Critical Care COVID Command Centre, to which authority is given over part of the triage process. Its mandate and membership should be made public, along with its key decisions. On December 15, 2020, we wrote you to ask for that Centre’s mandate and membership. Here again, you have not answered.

Your Government apparently sent an earlier draft protocol to hospitals on November 13, 2020, not shared with us or the public. We gather from other documents we have received that it did include some kind of patient appeal rights. These evidently have been removed from the January 13, 2021 document which we are addressing in this letter. No explanation has been offered for the removal of any patient right of appeal.

In the past two months, your Government twice made important public statements, when pressed on this issue, which turn out to be inaccurate. On November 5, 2020, the opposition asked the Government about this topic. As quoted in part earlier, your Parliamentary Assistant Robin Martin stated:

“A revised framework may be shared in the future and distributed, should pandemic conditions deteriorate significantly in the province....We don’t anticipate getting anywhere near having to use such a protocol—”

A short eight days later, on November 13, 2020, your Government secretly sent a draft new triage protocol to hospitals – one which the Government has not made public or admitted publicly to having sent. You did not send any such materials to us, though we keep asking for such materials. Ms. Martin’s answer is contradicted by your Government’s action eight days after she spoke.

Similarly, on December 3, 2020, at the Premier’s news conference, you were asked by Global News about this triage issue. You made it sound like your Government is having discussions with the Ontario Human Rights Commission on together writing a new triage protocol. On December 7, 2020, the Chief Commissioner of the Ontario Human Rights Commission wrote you. Her letter in effect makes it clear that there were no such discussions between the Ministry and the Human Rights Commission.

Last Wednesday, January 13, 2021, Dr. James Downar, a member of the Bioethics Table and obviously a key player on this issue, stated during the [panel on The Agenda with Steve Paikin](#) that consultations on this issue are ongoing, speaking in the present tense. He strongly opposed suggestions that your Government has not been open and consultative on this issue.

We learned subsequently from the January 13, 2021 triage protocol that the Bioethics Table had secretly delivered a revised report to your Government the day before that panel, January 12, 2021 – one which we had not heard of or seen. We also now know from the January 13, 2021 triage protocol that by then, the Government's Ontario Critical Care COVID Command Centre in charge of this issue had a week earlier approved a series of specific checklists for critical care triage – including tools we reference above as seriously discriminatory against people with disabilities.

It took three months of pressure to get the Government to release the Bioethics Table's September 11, 2020 report and recommendations. After the Government's three months of stalling, we were then given just a few days to take part in a roundtable, with insufficient time to properly review it. Even then, the Government held back from us a key document, sent to hospitals on November 13, 2020, on which we should have been able to comment. Even then, participants from the disability, racialized and Indigenous communities all voiced serious human rights concerns about the Bioethics Table's September 11, 2020 report. We asked in advance of that roundtable for specific illustrations of how that report's approach to triage would work in individual cases. None was given, then or afterwards.

The January 13, 2021 triage protocol speaks about the importance of accountability in the triage process. Yet it provides no public accountability. Your Government's approach to this issue lacks proper public accountability.

We sympathize very much with the plight of front-line medical staff and health workers dealing with the COVID-19 pandemic. We don't expect that they want the responsibility that the Government is foisting upon them through the January 13, 2021 triage protocol, or that they would want to be party to disability discrimination.

## **9. The Government Must Now Rescind and Fix the January 13, 2021 triage protocol**

We therefore ask you to do the following:

1. Please immediately advise if your Government disputes the accuracy of the attached as the January 13, 2021 triage protocol that your Government has had sent to Ontario hospitals to deal with critical care triage. Please now make public any and all documents that have been

so sent, and the earlier November 13, 2020 draft, as well as the Bioethics Table's January 12, 2021 report to the Government.

2. Immediately rescind the January 13, 2021 direction to hospitals.
3. Immediately make public the names of all those in decision-making or senior advisory roles on this issue within the Government, including within your Ministry and Ontario Health. That includes the membership and mandate of the Ontario Critical Care COVID-19 Command Centre.
4. Immediately hold urgent public consultations on this issue, before finalizing any policy on it.
5. Ensure that there is a proper legislative foundation for any policy on this issue. If, as we fear, there is none, then introduce legislation on this, and ensure that the public can present to the Legislature on it. Do not invoke closure to preclude such public input.
6. Ensure that any policy or law in this area includes:
  1. If a short term mortality criterion is to be used, something far shorter than 12 months.
  2. No use of the Clinical Frailty Scale.
  3. No use of any other assessment tool until and unless it is publicly explained, and shown to be free of unlawful discrimination.
7. Ensure the provision of proper procedural fairness and due process for patients at risk of critical care triage, including an appeal to court or the Consent and Capacity Board.
8. Make public the Government's plan for ensuring that critical care patients can be effectively and quickly transported to other parts of the province if needed, and that doctors can be effectively deployed to preclude the need for any critical care triage.

We remain eager to help. Please answer us. It is a matter of life and death.

Stay safe.

Sincerely,

David Lepofsky CM, O. Ont

Chair, Accessibility for Ontarians with Disabilities Act Alliance

cc:

Premier Doug Ford [premier@ontario.ca](mailto:premier@ontario.ca)

Helen Angus, Deputy Minister of Health [helen.angus@ontario.ca](mailto:helen.angus@ontario.ca)

Raymond Cho, Minister of Seniors and Accessibility [Raymond.cho@ontario.ca](mailto:Raymond.cho@ontario.ca)

Denise Cole, Deputy Minister for Seniors and Accessibility  
[Denise.Cole@ontario.ca](mailto:Denise.Cole@ontario.ca)

Mary Bartolomucci, Assistant Deputy Minister for the Accessibility Directorate,  
[Mary.Bartolomucci@ontario.ca](mailto:Mary.Bartolomucci@ontario.ca)

Todd Smith, Minister of Children, Community and Social Services  
[todd.smithco@pc.ola.org](mailto:todd.smithco@pc.ola.org)

Janet Menard, Deputy Minister, Ministry of Children, Community and Social  
Services [Janet.Menard@ontario.ca](mailto:Janet.Menard@ontario.ca)

Ena Chadha, Chief Commissioner of the Ontario Human Rights Commission  
[cco@ohrc.on.ca](mailto:cco@ohrc.on.ca)