

Alberta Doctors' Digest

Increased litigation may be on its way

Of the numerous impacts that the COVID-19 pandemic has visited on Albertans, perhaps one of the most serious and overlooked is the effect COVID-19 treatments in over-crowded hospitals may have on non-emergent or elective medical care.

Alberta, like all provinces in Canada, has seen significant utilization of sometimes scarce hospital and ICU beds to deal with the waves of COVID-19 infections. The result of this is to delay the provision of formerly scheduled procedures including diagnostics and surgeries. In many cases, these delays last weeks or even months. One does not have to be a physician to appreciate the effects that such delays may have on diseases or other medical issues that are already progressive. Specifically, delays in surgeries intended to prevent the continued deterioration of conditions (such as progressive cancers) will undoubtedly result in less desirable results and, in some extreme cases, the outright cancellation of procedures that are no longer timely.

According to statistics recently published by the Canadian Institute of Health Information (CIHI), the COVID-19 pandemic has resulted in a widespread delay in many surgeries throughout Alberta, stating that Alberta hospitals have performed about 2,800 fewer surgeries per month during the first 16 months of the pandemic in comparison to previous years, with elective surgeries such as knee and hip replacements dropping by 81%.

While these delays and cancellations are in part due to government intervention through the issuance of public health directives, a question lingers as to whether such directives expose health care providers and physicians to legal action from patients who are victimized by the delays.

As discussed in our September/October 2021 article [*Sparking reactions and potential litigation from those impacted by the pandemic*](#), Alberta's *Covid-19 Related Measures Act* was passed as a pre-emptive response to this trend. The *Act* attempts to protect a broad range of health care providers and professionals from civil actions commenced by patients who were directly or indirectly infected with or exposed to the COVID-19 pandemic. This protection is retroactive to March 2020, when the pandemic first hit. What the *Act* fails to address, however, is where an action may be brought by a harmed patient against those same providers caused by delays in *non*-COVID-19 related care.

As is so often the case, to see how a trend in civil litigation will develop, one needs to look no further than to our neighbours south of the 49th parallel. It would appear that the US courts are just now starting to come to terms with the impact of delays in non-emergent or elective care arising from government-directed suspensions of surgical procedures.

In the case of *Adams & Boyle, PC v Slatery*, the United States Court of Appeal's Sixth Circuit was faced with the predicament of balancing the State of Tennessee's constitutional right to exercise its policing authority and the constitutional rights of a patient to obtain an abortion during the COVID-19 pandemic.

In April 2020, the Governor of Tennessee issued an Executive Order titled *EO-25*,” which required all health care facilities and professionals to stop providing elective and non-urgent surgeries for a period of roughly three weeks. However, the State made no public assurances that they would not extend that date.

The alleged goals of *EO-25* were twofold: first, the State sought to preserve the available personal protective equipment (PPE) for essential and emergency needs only. Secondly, the State wanted to prevent the spread of COVID-19 in the community. As a result, only surgeries or procedures that were seen as “life-sustaining,” “able to prevent death or risk of substantial impairment of a major bodily function,” or those that could “prevent rapid deterioration or serious adverse consequences to patients” were allowed.

Unfortunately, the Order provided no exemptions to medical professionals who reasonably believed that their procedures did not deplete hospitals of necessary equipment or room to fight the pandemic. The decision ultimately forced the Plaintiffs (various abortion centres in Tennessee) to cancel procedural abortions during the three-week period.

The Plaintiffs subsequently sought an injunction from the federal district court to prevent the State from enforcing *EO-25* against procedural abortions. The district court granted the injunction, resulting in an immediate appeal by the State to the United States Sixth Circuit.

In balancing the competing claims, the Sixth Circuit Court outlined the four-part test for injunctive relief:

1. Whether the Plaintiffs are likely to succeed on the merits of the claim;
2. That the Plaintiffs are likely to suffer irreparable harm in absence of preliminary relief;
3. That the balance of equities tips in the Plaintiffs’ favor; and
4. That the injunction was in the public interest.

In addressing the first point, the Court agreed with the Plaintiffs that no state held the authority to prevent a woman from terminating her pregnancy, subject to certain limitations, such as the viability of the child and so long as any state regulations about abortion did not impose an “undue burden” on the patient.

From the State’s perspective, however, was that notwithstanding this principle, the State did have the authority to impose necessary public health measures to protect the general population’s health and safety. The Appeal Court disagreed, concluding that *EO-25* clearly constituted a palpable invasion of a woman’s fundamental rights and therefore the Plaintiffs would likely succeed on the merits of their constitutional claim.

With regards to the irreparable harm, the court was presented with an outline of Tennessee’s abortion procedures. To summarize, the status of a woman’s pregnancy would dictate the type of abortive procedure legally available. The longer the patient waited, the more costly, invasive, dangerous, and time-consuming the procedure would become. Moreover, as most abortion patients in the United States are classified as poor or low-income, patients faced greater struggles the longer they waited for their procedure.

While the Court acknowledged the serious economic and social impact the pandemic put upon America and the State's desire to lessen this blow, the Court noted a lack of evidence by the State that any appreciable amount of PPE would be preserved if *EO-25* prevented procedural abortions. The Court also differentiated abortions from other elective procedures such as hip replacements or cataract removals, which were neither constitutionally protected nor as time sensitive. As such, the minimum three-week timeline imposed by *EO-25* had the potential to cause irreparable harm to patients, which far outweighed the State's goals.

Ultimately, the Appeal Court concluded that the preliminary injunction was properly granted by the district court. However, as injunctions are seen as extraordinary remedies, the Court reduced the injunction's scope to only allow patients who could not safely delay their procedural abortions to proceed, thereby avoiding the harm of a more invasive procedures.

This case provides a very interesting analysis of whether public health measures (such as the *EO-25* directive) do conflict with or override patients' legitimate interests in timely care.

In the Canadian context, while we have witnessed lawsuits and class actions launched in Canada (and specifically Alberta) relating to medical treatment (or non-treatment) arising from COVID-19 illnesses, we have not, to date, seen similar actions arise relating to delayed treatment of *non-COVID-19* illnesses. While perhaps the government may foresee such trends approaching and legislate appropriately, the case provides a potential back door to patients irreparably suffering from surgical delays by way of an injunction against the government.

While there are legal differences between Canada and the USA, as mentioned earlier, America's legal waves tend to spill over the northern border, and the case above only foreshadows a potential legal trend for patients who may detrimentally suffer from the surgical delays brought on by COVID-19.

Editor's note: The views, perspectives and opinions in this article are solely the author's and do not necessarily represent those of the AMA.

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