



## **Rights and Quarantine During the SARS Global Health Crisis: Differentiated Legal Consciousness in Hong Kong, Shanghai, and Toronto**

**By Lesley A. Jacobs**

Interventions in public health crises inevitably give rise to concerns about infringements on legally entrenched individual rights and freedoms. As the social historian Peter Baldwin (2005:3) recently put it in his comprehensive study of the handling of AIDS in industrialized countries, “Attempts to curtail epidemics raise—in the guise of public health—the most enduring political dilemma: how to reconcile the individual’s claim to autonomy and liberty with the community’s concern with safety...How are individual rights and the public good pursued simultaneously? Public health thus allows a deeper plumbing of political instincts and attitudes than the surface foam of officially expressed ideology.” The 2003 SARS crisis provides an especially instructive window on how the balance between rights concerns and community health security might be handled.

Severe Acute Respiratory Syndrome (SARS) presented itself as the first genuinely global infectious disease of the new millennium, spreading quickly to numerous cities and countries around the world by international travelers. It initially emerged in November 2002 in Guangdong Province, China but was only identified internationally as a newly emerging infectious disease in March 2003. The World Health Organization (WHO) issued a global health alert about SARS on March 12, 2003, the first global alert it has ever issued. By the time the crisis ended in the summer of 2003, approximately 8,098 persons worldwide were diagnosed with probable SARS and there were 774 deaths (CDC 2003). There have been no reported new cases outside laboratories since June 2003 (Yardley 2005). SARS created a population health crisis because initially very little was known about its origins, symptoms, transmission, incubation, or long-term effects. Moreover, there was no test in place to confirm the disease and there still remains no vaccine.

During the SARS crisis, different jurisdictions struggled simultaneously with similar public health challenges posed by a previously unknown and deadly disease. Yet, instead of a convergence of strategies for meeting these challenges, especially with regard to the weighing of rights concerns and health security, different jurisdictions responded to the SARS crisis with measures that reflected considerable divergence about how to strike this balance. This divergence persisted despite the increased presence of global health organizations, especially the WHO during the crisis. What is surprising is not so much the divergence in the strategies





for weighing rights concern and health security, given how little was known initially about SARS, but rather the pattern of the divergence, specifically, rights concerns seem to have been marginalized in jurisdictions that have a “surface” reputation for taking rights seriously.

The varied use of quarantine in different cities during the SARS crisis makes the pattern of divergence in striking the balance between individual rights concerns and public health security especially evident because the racialized legacy of mass quarantine and its potential threat to individual rights is widely acknowledged. In a public health context, quarantine and isolation are carefully distinguished interventions (CDC 2004; Serradell 2005). Isolation is the separation of a patient known to have an infectious disease from otherwise healthy people. Quarantine is the confinement of individuals who have been exposed to an infectious disease but are asymptomatic. It involves an order by a public health official for a person to be separated from other people, restricted in his or her movement, and kept in a restricted area because there is a risk of him or her becoming infectious. In essence, quarantine orders are only applicable to persons exposed to an infectious disease but about whom it is not known if he or she is infected by it. Although quarantine was in the past a common measure for public health officials to utilize, in the past fifty years its use has almost disappeared, particularly in advanced industrial countries.

One of the unique features of the SARS crisis was the revived use of large scale quarantine in some countries.<sup>1</sup> The sheer numbers from a selection of cities at the center of the crisis are indicative of this usage. In Toronto, Canada, with a population of approximately 3 million, there were approximately 30,000 people quarantined (Naylor 2003; Rothstein et al. 2003).<sup>2</sup> In comparison, Hong Kong, with a population of approximately 7 million, the actual number of individuals subject to quarantine orders during the SARS crisis was surprisingly low, only 1282 individuals (SARS Expert Committee 2003:245). In China, initially, quarantine measures were not invoked at all (Liu 2005), but eventually, in April 2003, Shanghai and other major cities began to rely on quarantine. In Shanghai, with a population of about 18 million but few actual SARS cases, 4090 individuals were quarantined during the crisis (Shanghai Yearbook 2004). In all three cities, SARS ended at virtually the same time. Indeed, the Centers for Disease Control and Prevention lifted its travel alert on Hong Kong and other major Chinese cities before it lifted the alert on Toronto.<sup>3</sup>

The origins of this paper stem from the realization that Toronto’s use of quarantine was far more extensive than that of either Hong Kong or Shanghai, two jurisdictions with historically weak records regarding respect for fundamental rights and civil liberties. In fact, the quarantine numbers in Toronto were roughly the same as those in Beijing, a city of 18 million that faced an initial SARS outbreak at least five times as large as Toronto’s and was the site of about fifty percent of China’s total cases but likewise only quarantined 30,173 (Rothstein 2003; Ou, Li & Zeng 2003). The frequent use of quarantine by public health officials in Toronto in comparison to other jurisdictions seems, however, to have been virtually unnoticed.<sup>4</sup> Yet, it suggests perhaps





that in Toronto during the SARS crisis health security was weighed much more heavily than rights concerns by some public health officers whereas in Hong Kong and Shanghai there was much more of an even balance. Gostin, Bayer & Fairchild (2003:3231-3232) claim, “Coercive strategies [of public health interventions] reflect conceptions of individual rights, the legitimacy of state intrusions, and the appropriate balance between security and liberty. Measures tolerable in an authoritarian regime would not be tolerated in a liberal democratic state.” The implication is that a liberal democratic state would be less tolerant of interventions that infringe on individual rights and freedom.

This paper is designed to challenge that implication as overly simplistic. In any jurisdiction, there exist different and often competing perspectives on the balance between individual rights and community health security. In practice, this means how the balance is handled during a health crisis requires telling a complex story. In the case of the SARS crisis, instead of simply generalizing that in liberal democratic states the balance tips toward individual rights, the pattern of the divergence in the strategies for weighing rights concern and health security during the SARS crisis suggest that we need to delve into such a complex story. The pattern of the divergence is less surprising if one makes more visible the different perspectives on balancing rights and health security that exist not only in China and other developing Asian countries but even in a liberal democratic state such as Canada. Legal consciousness functions in this story as a lens for organizing and making visible these different perspectives. An examination of the complex SARS story offers the promise of insight into understanding why a particular perspective might prevail in a health crisis in one jurisdiction but a different one may prevail in another jurisdiction. Such insight may be useful as we prepare for the next global public health crisis, be it Avian Flu, a renewed strain of Legionnaires’ Disease, or something entirely new, aware that different jurisdictions will simultaneously be struggling with the difficult balancing of individual rights and the health security of the community.

### **The Current Study**

The current study investigates specifically how rights concerns were balanced against the uses of quarantine in Hong Kong, Shanghai, and Toronto over a four month period from early March to late June 2003. Hong Kong reported its first case in late February 2003. Over the course of the crisis, there were 1,755 confirmed cases leading to 300 deaths (SARS Expert Committee 2003). Although the vast majority of the world’s SARS cases and deaths were in mainland China, officially Shanghai was insulated from SARS. During the entire crisis, in Shanghai, there were only 11 suspected cases of SARS, 7 confirmed, and 2 deaths (Anti-SARS Taskforce 2003). Toronto was the city most affected by SARS outside Asia. All of the deaths and most of the reported cases in Canada were in the Greater Toronto Area. Its index patient





died on 5 March 5, 2003, after returning from Hong Kong on February 23, 2003. Between March and June 2003, there were 438 probable and suspect SARS cases in Canada, including 44 deaths in Toronto (Naylor 2003). These three cities were selected for this study because they are widely viewed to have been at the center of the SARS crisis and there exists reliable data about the extent of quarantine as a response to SARS in each of them. The focus could have been extended to numerous other cities affected by SARS but this would have entailed a much larger and more comprehensive study.<sup>5</sup>

For a socio-legal study, the SARS crisis is particularly promising because, as I explain in more detail below, decisions by public health officers were made largely informally. By this I mean that these officials exercised powers that relied on persuasion, invoking claims of legal authority and the threat of coercion for non-compliance, ordering individuals to quarantine themselves through oral instructions either in person or by telephone and without a formal letter. These decisions, because of the perceived urgency of the crisis and the pressure to respond quickly to fast moving events, were not subject to any formal judicial review with respect to their impact on individual rights. In the three cities—Hong Kong, Shanghai, Toronto—studied in this research project, formal legal actors—judges and lawyers—played only a minor role in the response to SARS. This means that investigating how the balances between legally entrenched individual rights and health security were struck in these three cities requires a focus principally on those public health officials making the decisions and the responses of the persons most affected by those decisions.

The subjects of this study are three distinct groups in each city. The first group is composed of the senior public health officials in each city responsible for directing the response to the SARS crisis. The second group is composed of frontline hospital workers, principally nurses, physicians and paramedics, who were responsible for providing care to probable and suspect SARS patients. The third group is composed of the close and distant contacts of probable SARS patients—families, associates, neighbors, fellow students, and co-workers—who were not frontline hospital workers.

These groups of subjects are presented in the research as offering distinct perspectives on the balancing of individual rights and community health security. Thus, rather than assuming that everyone in each of these cities shared the same perspective on the balancing of rights and quarantine, I have sought to emphasize different perspectives, reflecting where individuals were situated in the crisis. The rationale for comparing the perspectives of three different groups—senior public health officials, frontline hospital workers, contacts—in Hong Kong, Shanghai and Toronto is the assumption that the global character of the SARS crisis meant that although they lived in different cities, they faced similar circumstances with regard to the threat of an emerging infectious disease.

Legal consciousness functions here in this study as a lens for organizing the different





perspectives on rights of these three groups. The concept of legal consciousness has been utilized in a myriad of ways, which reflect competing accounts of what precisely legal consciousness is making reference to. Here, I follow loosely those socio-legal scholars such as Silbey (2001:8624) who view legal consciousness as denoting “the ways in which individuals interpret and mobilize legal meanings and signs.” Evidence of legal consciousness, on this approach, comes not only from people’s statements about what their beliefs and attitudes are but also from what they do. It is best thought of as a form of cultural practice where beliefs and attitudes about legal rights affect practices and what people do, which in turn shape beliefs and attitudes. “In this theoretical framing of legal consciousness as participation in the construction of legality,” explain Ewick and Silbey (1998:46. Emphasis added), “consciousness is not an exclusively ideational, abstract, or decontextualized set of attitudes toward and about the law. Consciousness is not merely a state of mind. Legal consciousness is produced and revealed in what people do as well as what they say.”

Perspectives on the balancing of individual rights and community health security are treated here as expressions of legal consciousness. Below, in the three sections of the paper that immediately follow this one, I show how in different ways the practice of quarantine and rights-based concerns about it implicate law. The point is that whether someone is relying on quarantine as a form of public intervention or reacting to it, these different perspectives can be viewed as embodying legal consciousness. Evidence of this legal consciousness comes not only from people’s statements about what their beliefs and attitudes are but also from what they do. The primary sources for the research presented in this study are diverse: archival reviews of policy statements, legislation, directives and press releases; print media; semi-structured interviews with senior public health officials in 2004, 2005, and 2006 (some anonymous); original surveys conducted in 2005 in Toronto (200 respondents) and Shanghai (500 respondents); testimony before post-SARS public review commissions; reports by these commissions; and published accounts of personal experiences during the SARS crisis.

My analysis of legal consciousness during the SARS crisis focuses not on legal professionals such as judges or lawyers who were, as I noted above, largely marginal during the SARS crisis but rather on those who are not legal professionals such as nurses, physicians, public health officers, and contacts of probable SARS patients. However, instead of assuming a uniform legal consciousness in Toronto, Shanghai or Hong Kong among those who are not legal professionals, my approach has been to treat legal consciousness as varied among groups of individuals differently situated in the crisis. The promise of this differentiated approach to legal consciousness is that it enables me both to draw contrasts between perspectives of differently situated groups within the same city and to note commonalities between similarly situated groups in other cities.<sup>6</sup>

What my findings show is that the greatest differences in legal consciousness between







Hong Kong, Shanghai and Toronto were at the level of senior public health officials. Among front line health care workers and those persons subject to public health measures, there were remarkable similarities, which were reflected in frequent concerns that their rights were unjustly being infringed upon and that they were being treated unfairly. Yet, in Hong Kong and Shanghai, there was much more willingness to launch complaints in legal forums whereas in Toronto, individuals with similar complaints were inclined to “lump it”.

It is important to recognize that the idea of differentiated legal consciousness serves here as a heuristic device in this research, designed to draw out overlooked aspects of the debate around the balancing of community health security and legally enshrined individual rights during the SARS crisis, in particular, the diversity of perspectives on this balancing. The claim is not that differences in legal consciousness among senior public health officials in Hong Kong, Shanghai and Toronto caused different responses to the crisis with regard to issues such as the uses of quarantine. A causal explanation of the different responses would require a much more detailed examination of the public health institutions involved and their historical evolution as well as the broader legal system.<sup>7</sup> Differentiated legal consciousness provides instead a lens through which it is possible to identify in a systematic way the competing and diverse meanings and understandings about the tensions between community health security and individual rights during the crisis.

The discussion below is divided into six sections followed by a brief conclusion. The first section explains briefly what quarantine is and its legal status in Hong Kong, Shanghai and Toronto. The second section distinguishes three types of rights concerns that could potentially be raised by quarantine during the SARS crisis. The third section describes the informality of SARS quarantine decisions in Hong Kong, Shanghai and Toronto. The next three sections focus in turn on the different legal consciousness of public health officials, hospital workers, and contacts of probable SARS patients in the three cities.

### **Quarantine as a Public Health Intervention**

Reliance on quarantine as a public health intervention during an epidemic had diminished worldwide and virtually disappeared in developed countries in the past half century, until the advent of the SARS crisis. In the early part of the twentieth century, quarantine was a measure closely associated with the arbitrary and discriminatory uses of state force, targeting racial minorities and lower socio-economic classes. Moreover, in public health doctrine, the idea of targeting those who were demonstrably sick rather than those who had been merely exposed to an infectious disease prevailed as the most effective public health intervention in situations where a contagion was at work (Baldwin 1999). By 2003, when the SARS crisis took place, WHO, which took the lead role among international organizations in the containment of





infectious diseases, did not recommend the use of large scale stringent quarantine, although it did leave it at the discretion of local jurisdictions to use quarantine within certain limitations. (See Sapsin et al. 2004, Rothstein et al. 2003, and Gonzalez-Martin 2004).<sup>8</sup>

Despite the problematic status of quarantine in public health doctrine, from the perspective of international law, the use of quarantine is on secure grounds. As David Fidler (2003) explained during the SARS crisis, “International law on human rights has long recognized that governments may infringe on civil and political rights for public health purposes.” What international law requires, however, is that in order for this infringement to be justified, it must meet certain conditions, most notably, that the intervention prevent a significant risk to the public, that the intervention is the least invasive one available, and that it is narrowly tailored.<sup>9</sup> In practice, in most public health crises involving contagious diseases, there is no time for review of these conditions by those outside the public health decision-making community. As the Centers for Disease Control and Prevention (2004) noted recently, “The last litigated case involving the involuntary quarantine of a passenger arriving into the United States occurred in 1963.”

The legal status of quarantine decisions is further complicated by the nature of existing quarantine law in the relevant domestic legal systems. In most countries including Canada and China, there exist statutes that give the national government authority to quarantine individuals in the case of an infectious disease. In practice, however, in China and Canada decisions about quarantine are made at a municipal or provincial level by local public health officials. During the SARS crisis, officials representing the Federal Government of Canada did not request a single individual to be placed in quarantine (Njoo 2004; 2005). Instead, the practice in Canada is for federal officials to pass the responsibility even in individual cases to local public health officers (Njoo 2005). Nor is there any record of the national government in China doing so either. The general focus of the national laws in both countries is on the quarantining of passengers and travelers arriving in the country from other destinations. They reflected efforts by national government to conform to their international obligations stemming from the variety of international sanitary conventions that date originally to the late nineteenth century and were consolidated into the International Health Regulations by the World Health Organization, initially in its constitution in 1951 and then revised in 1983 (Fidler 1999). These regulations were designed to prevent the international spread of infectious diseases by requiring states to notify the international community of outbreaks of certain diseases and maintain public health facilities that can regulate international points of entry and exit so as to contain the spread of the disease.

The legal authority of local public health officers to implement quarantine measures do not however derive from these national quarantine laws but rather from more localized public health laws, which in Hong Kong, Shanghai, and Toronto all provide officers of public health with the discretion to use a wide range of interventions to combat infectious diseases. In China, during the SARS crisis, the national government enacted two new pieces of legislation, which both





took effect on May 12, 2003, and involved the delegation of primary responsibility for handling the crisis to municipal public health bureaus (Lui 2005). In Shanghai, the Shanghai Municipal Health Bureau worked cooperatively with the Shanghai Municipal Center for Disease Control and Prevention, which is responsible for surveillance and collecting health information in the city (Peng et al. 2003). In Toronto, although the authority to direct public health policy rested in the hands of the Chief Medical Officer of Health of Ontario, during the SARS crisis, the Chief Medical Officer had little role in making decisions about the actual intervention measures used nor did he succeed at coordinating interventions across the province (Campbell 2004). Instead, quarantine decisions were made by the municipal public health department, Toronto Public Health. In Hong Kong, which has its own infectious disease and public health legislation, the Special Regional Authority officials made decisions about how to handle the SARS crisis largely independently of China. In all three jurisdictions, existing infectious disease legislation was quickly amended to include SARS. These amendments provided public health officers with far reaching powers to investigate sources of the disease and to issue isolation and quarantine orders.

The real challenge for local public health officers was to look at what public health interventions were available in their toolkit when facing an emerging infectious disease like SARS. That toolkit did not include traditional quarantine, with its image of being a discriminatory intervention designed to control racial minorities and lower socio-economic classes, but it did include what is allegedly a more modern quarantine intervention. This modern form of quarantine is said to avoid the charge of being discriminatory by making “science-based interventions with attention to the medical, material, and mental health needs of quarantined persons” (Bell & WHO Working Group 2004: 2). Moreover, quarantine based on recent advances in science are said to be likely to be more targeted interventions for shorter periods of time, “thereby limiting the perpetual stigmatization of regions” (Awofeso 2004:707).

The SARS crisis was, as I noted at the outset of the paper, the first time that this modern form of quarantine was operationalized on any sort of large scale. Public health officials in Hong Kong, Shanghai and Toronto all made an effort to base their decisions about whom to quarantine on systematic tracings and other science-based criteria. It should be noted that the post-SARS assessments have in general questioned the effectiveness of quarantine as an intervention strategy for containing the disease. For example, in the WHO’s retrospective report on handling SARS, quarantine was not identified as a valuable public health measure for combating a SARS outbreak in the future (2003:12-13).

### **Quarantine as a Rights Issue**

As I noted at the outset, quarantine is the confinement of individuals who have been exposed to an infectious disease but are asymptomatic. It involves an order by a public health







official for a person to be separated from other people, restricted in his or her movement, and kept in a restricted area because there is a risk of him or her becoming infectious. For the purposes of this paper, rights can be understood narrowly as special interests persons have that warrant holding other people to fulfill certain duties or requirements (Raz 1986; Waldron 1993). Quarantine raises three distinct types of potential rights concerns. One type concerns the historical legacy of quarantine as a discriminatory practice. The other two types of rights concerns are less commonly identified. They stem from, on the one hand, the confinement quarantine involves and, on the other hand, the degree to which the burdens quarantine imposes are unfair in their distribution. It must be emphasized that the rights issues raised by isolation—the confinement of a symptomatic person—as opposed to quarantine—the confinement of asymptomatic persons—are a different matter, well beyond the scope this paper.

The most common rights concern raised by quarantine is that it is discriminatory in character, in particular, that it discriminates against racial minorities and the poor. This concern stems from the discriminatory way in which public health officials in the past used quarantine as an intervention to regulate vulnerable groups in society. As I just noted above, however, modern forms of mass quarantine such as those used during SARS are said to be designed to avoid this charge of discrimination by relying on science-based decision making. The obvious complication in the case of SARS and indeed any emerging infectious disease is the absence of scientific evidence, for example, the incubation period of the virus, how it spreads, how much contact is required, and so on.

Many of the rights issues revolving around the confinement required by quarantine resemble those that arise in the more familiar case of the preventive detention of an accused awaiting a criminal trial (See also Sullivan & Field 1988). In most legal jurisdictions, the detention of a criminal suspect involves a risk assessment based on a combination of two principal factors: the threat the accused poses to the community and the risk that the accused might fail to appear at the trial. Decisions about preventive detention are ordinarily made by judges who are guided by regulations that require them to consider these two factors and sometimes other factors such as the nature of the crime and the concern that the accused might tamper with witnesses or impede the administration of justice in other ways. Why is the preventive detention of a criminal suspect taken so seriously? Why should anyone accused of a crime be freed from detention while awaiting trial? The answer of course is that the rights of the accused are at issue. Amar (1997) distinguishes between two rights or interests at stake when it comes to pretrial detention and restraints. One right revolves around “a physical liberty interest in avoiding prolonged pretrial detention” (89). The other right revolves around a mental interest in minimizing “reputation loss and anxiety caused by public accusation” (97). The point is that when judges make decisions about the preventive detention of a criminal suspect, their risk assessments are made with an eye to the rights at stake for the accused. In Canada and Hong Kong, there is a long tradition deriving





from English common law of acknowledging these rights. In China, likewise, pretrial detention of criminal suspects is recognized as raising similar rights issues and arbitrary detention of this sort is controversial and a focal point for criminal law reform.<sup>10</sup>

Parallel rights were at issue in the case of quarantine during the SARS crisis. A quarantined person has a physical liberty interest in avoiding such a detention. Evidence of the actual liberty costs of quarantine during SARS is largely anecdotal. However, the most transparent revolved around barriers to going to work and earning an income. Another cost was in terms of freedom of association. Quarantined persons in Toronto, for example, were instructed by the public health department “not to leave their homes or have visitors...wear masks when in the same room as other household members...and to sleep in separate rooms” (Toronto Public Health 2003 May 29). Access to caregivers and other family members for those who were quarantined in institutional settings was another dimension of the liberty costs. Many hospitalized children, for instance, were separated from their parents for weeks at a time during the SARS crisis, even though the children and parents were asymptomatic (Koller et al. 2006).

Quarantine during the SARS crisis not only raised concerns about rights to physical liberty but also interests revolving around mental anguish, reputation and social stigma, which in form are similar to those faced by criminal suspects. A study of residents of one neighborhood in Hong Kong where there was a community outbreak of SARS found that nearly 50% of those surveyed reported unfair or unpleasant experiences (Hong Kong Mood Disorders Center 2003). A survey in Toronto found that quarantine during the SARS crisis resulted in considerable psychological distress in the forms of posttraumatic distress disorder and depressive symptoms (Hawryluck et al. 2004). Anecdotal statements from health care workers and others subject to quarantine orders report social stigma and shunning for themselves and their family members, as we shall see in more detail below.

It is important, however, to recognize that distinct rights concerns can also stem from the fairness of the distribution of the burden imposed by a quarantine. Quarantines, explains Daniel Markovits (2005:323), “generate an egalitarian anxiety, which addresses the distribution of the burdens that quarantines impose and worries that this pattern of burden and benefit may be in itself unfair.” The point is that quarantines are measures designed to benefit a community as a whole whilst imposing costs on particular individuals. The fairness concern revolves around who should carry the burdens of those costs. The obvious remedy is for government compensation to individuals to help pay those costs. As the Government of Canada’s November 2003 report on SARS observes, “Applying the principle of reciprocity, society has a duty to provide support and other alternatives to those whose rights have been infringed under quarantine” (Naylor 2003:9f). Similarly, Gostin, Bayer, and Fairchild (2003:3234) reason, “When public health authorities requires people to forgo their freedom for the common good, equity requires that the financial burden be borne by the community as a whole.”





It follows from this analysis that the potential rights concerns raised by quarantine are of a three-fold nature. First, the discriminatory legacy of quarantine as a public health intervention stirs concerns about its potential as a vehicle for discrimination against racial minorities and other vulnerable groups. Second, with regard to confinement, the point of drawing the parallel between quarantine for exposed but asymptomatic individuals during the SARS crisis and pre-trial detention of criminal suspects as rights issues is to make explicit the respect in which many of the rights at issue during quarantine—liberty interests and mental interests—are familiar legal constructions recognizable not only among legal professionals such as judges and lawyers but also public health officials, health care workers, patients, their families, and their associates. Third, with regard to the distributive fairness concerns about quarantine, attention to compensation for those quarantined is a clear measure of how seriously the rights are being taken.

### **The Informality of Quarantine Decisions**

Decisions about the uses of quarantine by public health officers in Hong Kong, Shanghai and Toronto were made largely informally. By this I mean that these officials exercised powers that relied on persuasion, invoking claims of legal authority and the threat of coercion for non-compliance. Quarantine was mostly ordered orally by telephone or in person. Hence, unlike other areas of public health, these powers were exercised without careful attention to creating paper trails with an eye to process and procedure. This makes for a contrast to how, for example, child immunization records are maintained by public health officials in Hong Kong and Toronto and pre-marital medical examination records in Shanghai. Informal decision making of this sort relies on informal enforcement as opposed to formal enforcement through the “law”—enforcement through prosecution (Hawkins 2002). Quarantine decisions during the SARS crisis almost never relied upon the courts to back the exercise of those powers. Yet, as Hawkins (2002) has stressed, informal and formal enforcement decisions in a regulatory law field such as public health do not differ in kind but are on a continuum and reinforce each other. Despite the informality of quarantine decisions, they must be recognized as being steeped with understandings about law.

This is an important point because from the perspective of public health officials quarantine in Hong Kong, Shanghai and Toronto was largely “voluntary”. The claim is that when individuals were required to quarantine themselves, they willingly complied with the request. Voluntary quarantine contrasts to compelled or enforced quarantine, which involves the public health officials drawing upon legal resources, especially the police and the courts, to enforce the quarantine requirement (CDC 2004). During the SARS crisis, in all three cities, virtually all individuals who were subject to quarantine requirements were informed of these requirements orally, either in person or by telephone. The response to these requirements was





generally a willingness to comply. In Toronto, for example, only 29 persons were viewed as noncompliant and issued a legally enforceable written quarantine order (Rothstein et al. 2003; Svoboda et al. 2004). Chan et al. (2004) report a survey finding that law was not a major factor for most people who did comply in Toronto. DiGiovanni et al. (2004) found in Toronto that “the threat of enforcement had less effect on compliance than did the credibility of compliance-monitoring.” In Hong Kong, 26 individuals were sent compliance warning letters regarding mandatory home confinement, with all of them ultimately complying (Sapsin et al. 2004:171; Hong Kong SAR 2003). In China, imposing compulsory quarantine on an individual could be enforced principally through provisions in the criminal law (Liu 2005). However, there were only a handful of cases where these criminal provisions were appealed to and led to prosecution (Liu 2005; Lee 2006). Much of the criminal sanctions in China over the SARS crisis were directed not at private individuals for failing to comply with public health orders but rather at individuals accused of “spreading SARS rumors” (deLisle 2004:236), public health officials for failing to carry out their duties (Rothstein et al. 2003:69), and physicians who refused to provide care for probable SARS patients (Rothstein 2004:186).<sup>11</sup>

This fact of voluntary compliance may be interpreted as meaning that rights concerns were sidestepped in most instances during the SARS crisis because individuals permitted public health officers to transgress on their rights. Imagine, however, the space for negotiation between the public health officer and an individual being required to comply with a ten day quarantine when, in the shadow, is the threat of coercion if there is non-compliance. In what sense is voluntary quarantine genuinely voluntary in those circumstances? As Cava et al. (2005:344) note in reference to Toronto, “Although described as voluntary, anyone found to be violating a quarantine order faced a maximum fine of \$5,000.” Suppose by analogy that in China it was found that most people self-censored their critical comments regarding the government and human rights, in the shadow of facing serious penalties for not doing so. Presumably, most of us would (and do) regard this as nonetheless not avoiding the rights concerns that censorship of this sort raise. Likewise, it seems to me a mistake to exaggerate the significance of the voluntary dimension of quarantine during SARS, whether it occurred in Hong Kong, Shanghai or Toronto. The informality of enforcement of quarantine during the SARS crisis in all three cities does not diminish the fact that the threat of enforcement was there and indeed, when people did not respond to the informal enforcement, public health officials relied on formal measures.

### **The Legal Consciousness of Senior Public Health Officials**

As I noted earlier, legal consciousness functions here in this study as a lens for organizing the different perspectives on the balancing of individual rights and community health security during the SARS among three groups—senior public health officials, frontline hospital





workers, and contacts of probable SARS patients—in Shanghai, Hong Kong and Toronto. The promise of this differentiated approach to legal consciousness is that it enables me both to draw contrasts between perspectives of differently situated groups within the same city and to note commonalities between similarly situated groups in other cities.

In all three cities, senior public health officials instituted maximum health surveillance measures, most notably quarantine, to prevent the further spread of SARS. Consider first how quarantine was handled in Shanghai by senior public health officials. The most notable feature is how long it took for public health officials there to embrace quarantine as an option. Eventually, as I pointed out earlier, 4060 individuals were quarantined in Shanghai. Initially, in April 2003, Premier Wen Jiabao promised not to implement extreme quarantine measures. In a joint announcement by the Communist Party of China, Central Committee, Ministry of Justice and Ministry of Health in early May 2003, the law on epidemic prevention and treatment was highlighted as “of great significance in protecting people’s health and in ensuring the prevention and treatment of severe acute respiratory syndrome (SARS)” and it urged “the whole country to keep up the fight against SARS in line with the law.” Throughout the SARS crisis, however, the Chinese government stressed not only isolation and quarantine but also travel restrictions, temperature screening at airports, health declarations, and other less intrusive means such as the wearing of masks in public.

On May 6, 2003, the Shanghai Municipal Government announced that it was expanding its monitoring network from 110 hospitals to all 588 local medical facilities and clinics and requiring that anyone returning from an area “hard-hit” by SARS must stay at home for at least several days. One director of a health center in Shanghai reported at the time, “Our center covers 51 neighborhood communities and 180,000 residents. Now, there are 51 people undergoing observation at home. If anyone refuses to stay home for observation, we can force them to do so with the help of the police” ([www.chinaelections.org](http://www.chinaelections.org), 6 May 2003). The invocation of legal authority here to support quarantine measures is clear. Moreover, there is no explicit decree to balance public health goals and individual rights. Yet, in practice, as one American journalist observed at the time, “Shanghai’s quarantine policy has not been rigorously enforced, as dozens of visitors from Beijing and Hong Kong continue to disperse into the city with a trace” (Beech 2003b).

The largest targeted group for quarantine was migrant workers in Shanghai’s booming construction industry. (There are estimated to be 3 million migrant workers in Shanghai.) These workers live predominantly in company bunkhouses and return home to their families in rural China when ever possible. The Shanghai Municipal Government (2003) announced, “Effective May 8, 2003, construction sites and other work units which operate staff dormitories are obliged to provide daily reports on personnel from outside Shanghai to the local supervisory authority. Persons who report actual SARS cases are eligible for a reward from the authorities.” When







it became clear that the incubation period for SARS was about ten days, all returning migrant construction workers were ordered to be quarantined in their bunk houses for a two week period.

From a rights perspective, it is significant that the Municipal Government put in place two policies that appear to show sensitivity to the importance of compensating quarantined workers for the infringement on their rights. The first was a provision that guaranteed to returning migrant construction workers subject to quarantine that they would not be fired by their company. The second was a directive from the Shanghai Municipal Government (2003) stating, “an employer must pay full compensation to employees for the quarantine” as well as continue to provide him or her with room and board. This order that construction companies pay quarantined workers their regular wages meant that the financial cost of quarantine to the migrant construction workers was minimal. This emphasis on compensation addresses in particular the sort of concern about distributional fairness in terms of who carried the burden of securing public health during the crisis. The important upshot is that looking at what senior public health officials in the Municipal Government of Shanghai government said and did suggests a genuine effort to balance the pursuit of public health goals and individual rights, even though the national law did not require this degree of compensation for individuals who were quarantined.

The provisions protecting quarantined migrant construction workers put in place by Shanghai’s municipal government placed the burden of the costs on individual construction companies. These companies were required to pay the costs of housing the quarantined workers as well as their wages. Despite the invocation of the law by public health officials, there is little evidence that compliance by construction companies in Shanghai was determined by the threat of legal action. There were few prosecutions by the municipal government for non-compliance, even though many individual workers complained of non-compliance, especially regarding dismissals and non-payment of wages. Instead, compliance by individual construction companies was influenced by two major factors. The first was a sort of shaming ritual in the local media. As is well known, the initial reaction of China’s government was to cover-up the SARS epidemic. However, the firing of the Minister of Health, the mayor of Beijing, and more than 100 health officials for covering up and under-reporting SARS infection rates established new standards of public accountability (Human Rights Watch 2003:7). In the shadow of these new standards, the media in Shanghai vigorously held companies accountable for how they treated their workers affected by the SARS quarantine measures. The second factor was how much value the construction company placed on being regarded as a “model” firm by the municipal government. Model firms are treated more favorably in processes such as contract tendering and permit applications. In effect, model firms complied voluntarily with the orders to not fire quarantined workers, to continue to pay their salaries during the quarantine, and to pay the costs of their room and board during the quarantine.

It must be recognized, however, that underlying these measures may not have been rights





concerns but rather concerns about implementing effective interventions. One anonymous (2006) senior public health official in Shanghai emphasized to me that he doubted that Shanghai had the public health resources to implement a quarantine on the scale that Toronto had. An interesting related problem that arose in China in general was the controversy of where in fact quarantined individuals should be housed. In rural villages, for instance, violent protests and riots involving 1000s of peasants and farmers occurred when public health officials proposed quarantining some asymptomatic persons in local facilities (Beech 2003a). Compensation can also be seen in this light, as it took away one compelling reason for individuals to not comply with a quarantine order—the financial costs—and did so in a manner that did not deplete public resources but instead shifted the burden on to employers. But, in doing so, and in order to avoid huge protests from employers, the number of individuals quarantined had to be reasonable.

Let me make one final point about the link between compensation and implementing effective interventions. By legislating compensation early on in the crisis, the Shanghai municipality created an environment where people could respond to quarantine orders with a clear sense of the consequences for themselves of complying. In a public health crisis such as SARS, as Burris (2005: 73) notes, “laws that allow people to act quickly are needed.”<sup>12</sup> Moreover, by establishing a legislated compensation scheme, Shanghai sidestepped the prospect of numerous Tort cases being filed by quarantined individuals; instead, complaints against employers were a matter of administrative and labor law.

It is also noteworthy that senior public health officials in Shanghai used quarantine sparingly even though the general public seems to have been supportive of a much more far reaching intervention. In response to a survey question about the use of quarantine during a crisis like SARS by more than 500 Shanghai residents in early 2005, conducted in collaboration with the Shanghai Academy of the Social Sciences as part of the Asia Pacific Dispute Resolution Project (APDR 2005), I found that 58% of respondents gave the highest importance to the government having the right to do whatever it judges necessary to prevent the spread of the disease and 19% gave it very high importance. (There is a sharp contrast to how residents responded in Toronto to the same question, which I note below.) My point is that 80% of Shanghai residents would seem to have been very sympathetic to much wider use of quarantine. It is also significant to note that although municipal public health officials in Shanghai made compensation for lost income mandatory for everyone quarantined, the Chinese government’s own published survey of what citizens think about SARS, only 21% said that “the government should help and reimburse SARS patients, especially poor people” ([www.chinaelections.org](http://www.chinaelections.org) May 29, 2003).

The evidence from Hong Kong suggests that compulsory quarantines were not readily used by senior public health officials. The Director of Health reported to Hong Kong’s SARS Expert Committee, “Draconian measures such as compulsory quarantine were deliberately





avoided at the outset because of concern about driving SARS patients into hiding. There were also concerns about issues of civil liberty and public acceptability” (SARS Expert Committee 2003:4.27). Instead, in Hong Kong isolation and quarantine measures were gradually introduced. Ultimately, as I noted at the outset, the actual number of individuals subject to quarantine orders confining them to their homes in Hong Kong during the SARS crisis was surprisingly low, only 1282 individuals (SARS Expert Commission 2003:245).

It is significant, I believe, that the office of the Director of Health consulted Hong Kong’s Equal Opportunities Commission (EOC) on a number of occasions in order to seek advice about the implications of proposed policies for basic rights that fell within the mandate of the EOC (Wu 2005). This sort of consultation by senior public health officials in Hong Kong too makes for a marked contrast to both Toronto and Shanghai. For example, the EOC was consulted before the closure of all schools in Hong Kong was ordered. Although the Director of Health was considering school closures only in particular areas of Hong Kong, the EOC advised that although Hong Kong’s anti-discrimination ordinance allowed for school closings based on infectious diseases, these closures should be applied across the territory and not be targeted at particular areas within the territory.

These consultations allowed the EOC in Hong Kong to articulate the view that SARS raised issues of disability rights. Specifically, the EOC advised that Hong Kong’s disability discrimination ordinance allowed for a broad definition of disability that includes disease and protects from discrimination not only individuals who had SARS but also those imputed to have had SARS and all of their families, neighbors, colleagues, and associates (Papadopoulos 2005). This view shaped how, for instance, public health officials dealt with public school examinations during the SARS crisis (Wu 2005). These examinations for students are viewed as an extremely important event in Hong Kong’s school system. All candidates for these exams had their body temperatures monitored. However, if their temperature was over 38 degrees, the candidates were not denied access to the exam—this would have constituted disability discrimination according to the advice of the EOC—but merely required to write the exam in another room nearby.

The Director of Health also consulted the EOC about the precise wording of bulletins for employers (Wu 2005). The main thrust of these bulletins was to ensure that those imputed with SARS and their families and associates received sick pay for any time away from work, were not sacked, and were not required to take unpaid leaves from work (Hong Kong Special Administrative Region 31 March 2003b). The government also offered compensation to firms facing these expenses as well as establishing a low-interest loan scheme for companies in certain industries. The loans had to be used to pay staff salaries (Hong Kong Special Administrative Region 30 April 2003). Moreover, the Social Welfare Department offered very early on in the crisis emergency financial assistance to anyone affected by a quarantine order who did not have a regular income from a full-time job (Hong Kong Special Administrative Region 31 March





2003a). Furthermore, all individuals in quarantine were provided with food and other provisions by public health officials for the length of their confinement. In effect, these various schemes functioned to limit the financial burden placed on quarantined individuals.

Unlike Shanghai where the costs were largely shifted from individuals to firms, in Hong Kong it was the government that took on the financial burden of quarantine. How senior public health officials handled quarantine for residents of Amoy Gardens, a residential housing block that was the site of Hong Kong's biggest community outbreak of SARS illustrates the point. Although residents of Amoy Gardens reported wide spread stigma and discriminatory treatment in the broader Hong Kong community, they overwhelmingly reported fair treatment by public health officials. In their efforts to contain the breakout in one block of flats at Amoy Gardens, public health officials placed residents in quarantine. However, because at the time there was a concern that SARS was spreading in the building through the water system or some other environmental structure, the public health officials moved 247 individuals to holiday resorts for the duration of their quarantine, providing them with both housing and provisions (SARS Expert Committee 2003:50). The SARS Expert Committee noted, "once the nature of the environmental threat became clear, bold and decisive action was taken to evacuate, isolate, and quarantine Block E residents, bearing in mind that such draconian control measures had not been used for decades...The purpose of the evacuation was to protect of the health of Block E residents themselves" (SARS Expert Committee 2003:76).

Financial compensation by the Hong Kong government for quarantined individuals constitutes a significant effort to address the distributive unfairness of quarantine. But it is also notable that in Hong Kong and Shanghai, public health officials did not rely principally on quarantine measures but tried to distribute the burden of containment measures widely among the general population rather than concentrate the costs for one small subgroup, those who were infected or had contact with them. Dr. Py Leung, who directed the overall response of the public health department in Hong Kong to SARS, has stated to me "equal emphasis has been placed on the infected/exposed and the general public in averting the SARS crisis" (Leung 2005).

Encouraging the use of masks in Hong and Shanghai, as contrasted to Toronto, seems to illustrate this. It must be acknowledged that the wearing of face masks in public as a way to contain viruses such as the common cold was common place throughout Asia prior to the SARS crisis and hence not considered much of a burden whereas in North America the wearing of face masks in public is unusual and is perceived as an extraordinary measure. Among Hong Kong residents, 82% perceived wearing a mask as an effective way to contain SARS (Lau et al. 2003). More than ninety percent of residents of Hong Kong were found to have used preventive measures, most notably, wearing masks (Lau et al. 2004. See also Serradell 2005.) In this regard, the burden of containing SARS was distributed widely among the population. The image of these two Asian cities in the international media as ones where residents were wearing masks





in public contrasted to Toronto, where the media portrayed the burden of containing SARS being the responsibility principally of hospital workers and those who had contact with probable SARS patients from certain ethnic groups, most notably Chinese and Filipino Canadians (Leung & Guan 2004). One American newspaper explicitly noted at the time the contrast, “Shutdowns and quarantines aside, Toronto is less a city in hysterics than it is simply on edge. For the most part, masks aren’t flying off the shelves in drugstores and virtually no one wears them while walking down the street. Nobody seems to be equipping themselves with protective gloves or baby wipes, as has become common in Hong Kong” (Niedowski 2003). For Canadian public health officers, projecting the image of wide spread use of masks in Toronto and the idea that all residents had a responsibility to contribute to the containment of SARS by wearing masks in public was a scary one suggesting that the disease was out of control (Njoo 2005). The point I am trying to make is that from the perspective of distributive fairness, the wide spread use of masks in Hong Kong and Shanghai had the effect of reinforcing the belief that the responsibility for securing public health falls on everyone, not just those who had a traced contact with a probable SARS patient and could be quarantined.

Many more people were quarantined by public health officers in Toronto than either Hong Kong or Shanghai during the SARS crisis. In contrast to the findings from Shanghai reported above, I found that only 19% of respondents in Toronto gave the highest importance to the government having the right to do whatever it judges necessary to prevent the spread of the disease and 27% gave it very high importance (APDR 2005). Unlike in Hong Kong and Shanghai, however, senior public health officials in Toronto did not express publicly a commitment early on in the crisis about not relying heavily on quarantine measures. In fact, Toronto moved to begin large scale quarantine almost immediately after the crisis led to a hospital closure in late March 2003. Indeed, Dr. Colin D’Cunha, Ontario’s Chief Medical Officer of Health, stated in mid April 2003, “I believe and I feel firmly: We can control this outbreak. Every time you find a case, you throw the ring [around it]—and tight. The science is clear about infection control” (Niedowski 2003). Yet, there is no evidence that senior public health officials consulted widely either among infectious disease specialists nor civil rights advocates about this strategy (Schabas 2006). However, in response to some of the comparisons I have made about quarantine use in Toronto and other cities, Barbara Yaffe, who is director of communicable disease control for Toronto Public Health, insisted, “We agonized over [whether to quarantine people]. We always take human rights into consideration... We did quarantine people, but people understood it was necessary” (Gerson 2005).

One of the striking features of how Toronto handled the SARS crisis is the unknown number of individuals who were actually subject to quarantine. Reports for the Government of Canada (Naylor 2003) and the Centers for Disease Control in Atlanta (Rothstein et al. 2003) both put the numbers at about 30,000. Toronto Public Health, however, identified 23,103 individuals as requiring quarantine because of their direct contact with SARS, but were successful at







contacting only 13,291 (Svoboda et al. 2004). These numbers do not include, however, the collective quarantine requests made by public health officials. For example, more than 1500 students and staff at one Toronto high school were placed in quarantine because one student had SARS symptoms (Gostin, Bayer, & Fairchild 2003:3231). Similarly, they do not include many of the collective quarantines at some hospitals. For example, at one community hospital, on March 28, 2003, 5000 people were quarantined including 1800 staff, 225 physicians, 170 high school students who use the hospital cafeteria, and hundreds of visitors and volunteers (Dwosh et al. 2003). Hence, Dr. Colin D'Cunha (2003), Ontario's Chief Medical Officer of Health, estimated that at least 20,000 were quarantined. Dr. Barbara Yaffe (2004) from Toronto Public Health claims that at any one time in Toronto, up to 6,995 people were in quarantine.

The picture, however, that emerges about quarantine decisions in Ontario is one of arbitrariness and little due process. There is no public record of senior public health officials consulting with either the Ontario Human Rights Commission nor the Ontario Privacy Commissioner about rights setting boundaries on the nature of imposing quarantine orders nor in interviews that I conducted in Toronto does anyone recollect any such consultations (Njoo 2005; Schabas 2006, Go 2006). This contrasts with Hong Kong, where as I noted above the EOC had a key role advising senior public health officials about their response to the SARS crisis.

Moreover, the record is one of disregard of such concerns about the use of quarantines, even when those concerns were raised by other medical officers outside the public health field. The use of quarantine in the town of Perry Sound north of Toronto nicely illustrates the point. Dr. Larry Erlick (2003), President of the Ontario Medical Association at the time was critical of how the quarantine was imposed, observing, "a quarantine recommendation was made without adequate understanding of quarantine protocols. This led to the unnecessary quarantine of nearly 10 percent of the town's population. This resulted in a disruption of people's lives, their jobs, the productivity of the area and created a huge strain on an already struggling region." Richard Schabas, who had been Ontario's Chief Medical Officer of Health for ten years before D'Cunha and was Chief of Staff of one of Toronto's hospitals during the crisis, reported to me a similar experience, where in effect his skepticism about quarantine decisions were dismissed out-of-hand by Toronto's senior public health officials (Schabas 2006).

Paralleling the large number of quarantine requests in Toronto was the minimal regard for the question of rights-based compensation, which is, as I noted above, at the center of any serious consideration of the distributive fairness of quarantine. The Canadian federal government announced on April 4, 2003 that the two week waiting period for unemployment benefits would be waived for individuals quarantined because of SARS. "This measure was taken so that persons who are quarantined would receive an income and would not have to chose between respecting the quarantine by staying home from work or risking the spread of an infectious disease" (Canada Employment Insurance Commission 2005:40). However, given the





low number of individuals eligible for employment insurance in Canada generally, especially low wage workers, this measure by design did not benefit very many individuals. In total, 771 SARS-related claims were expedited by the waiver of the two week waiting period, many of them not involving quarantined asymptomatic individuals but rather SARS symptomatic individuals. (Canada Employment Insurance Commission 2005:40). The point is of course that the number compensated here constituted a small fraction of the total number of individuals quarantined because of SARS. The average weekly benefit for these 771 claims was \$289, meaning that in total the federal government's employment insurance scheme paid at most \$400,000 in compensation to those quarantined.

In May 2003, the federal government of Canada and the Government of Ontario did establish income compensation schemes for health care workers adversely affected by SARS, including the effects of quarantine. The federal government committed \$2 million to a compensation scheme for health care workers who were not covered by its employment insurance system (Government of Canada, May 2, 2003). On May 28, 2006, the Government of Ontario announced two extensive compensation schemes for health care workers and physicians who had lost income during the SARS crisis. One was directed principally at hospitals and entailed \$330 million being expended on health care workers for lost wages. The other scheme, called the SARS Income Stabilization Program for Physicians, involved the provision of \$700 million to fee-for-service physicians for lost income during the crisis, almost none of it because of quarantine.<sup>13</sup> The important point is that although the provincial government provided in these two schemes more than \$1.1 billion of compensation for lost income during the SARS crisis, none of it was directed towards quarantined individuals who were not health care workers.

At a more local level, unlike in both Shanghai and Hong Kong, public health officials did not put immediately in place general measures that mitigated for the costs of quarantine such as orders that employers continue to pay the wages of quarantined individuals. The Ontario Government did enact new legislation on April 30, 2003, the SARS Assistance and Recovery Strategy Act, which guaranteed that individuals could not be fired because of compliance with a quarantine order and required employers to give such individuals a leave of absence without pay. That legislation did not, however, include any sort of compensation scheme, even though the premier of Ontario had said the week before that there would be compensation (Campbell 2005:255). Eventually, after the SARS crisis had ended, on 13 June, 2003, the provincial government announced a compensation allowance for non-health care workers—SARS Compassionate Assistance Program --who had missed work and were not paid because of quarantine (Government of Ontario 2003c). This program, although said to be comparable to the ones for health care workers and physicians noted above, involved an initial budget of only \$10 million, as compared to \$1.1 billion. In other words, the government's intention was to spend only about 1% of the total income relief on those working outside the health care sector,





even though these workers constituted the vast majority who were quarantined. Given the timing of the program—months after most people had been quarantined—and its come-and-get-it structure, there is no evidence that very many eligible individuals knew about or applied for the compensation under the SARS Compassionate Assistance Program. And no indicator in subsequent financial statements that the government provided anything close to the \$10 million allocated to this program.

### **The Legal Consciousness of Frontline Hospital Workers**

In all three cities, frontline hospital workers were among those most affected by the SARS crisis. In Hong Kong, 386 health care workers were infected with SARS and eight died. In Toronto, health care workers accounted for over 40% of SARS infections and three died. In Shanghai, fewer hospital workers were infected with SARS, which is partially a reflection of the small number of SARS cases reported in the city. The issues for hospital workers in Shanghai revolved around the risks these workers took, the extra amount of work they did, and their liability for the treatment of patients who did contract SARS. One senior hospital official in Shanghai reported to me in September 2004, “The nurses and doctors who treated SARS patients have a right to special entitlements or extra wages. All of these persons got enough extra wages and some persons even got a short-term holiday after SARS. However it is hospital not government [who pays] for most hospitals” (Anonymous Xinhua Hospital, Shanghai 2004). This idea that hospital workers should receive extra pay for the work they did should be distinguished from the common view in China that the risks hospital workers took of being infected with SARS is part of their job and, should they have been infected with SARS, they should not receive any extra compensation. The same senior hospital official in Shanghai said, “In my opinion, government should pay for the treatment of the nurses and doctors who contracted SARS. However, I don’t think those nurses and doctors who contracted SARS should have the right to sue government for compensation” (Anonymous 2004).

In Toronto, many of the senior public health officials were also hospital-based staff physicians and for this reason several of them became infected with SARS. Seventy-two percent of the total number of SARS cases were health care related and forty-four percent of the total cases were health care workers (McDonald et al. 2004). Three health care workers died of SARS—the report on SARS by the Chinese-Canadian National Council has emphasized that all three were members of Chinese or Filipino Canadian communities (Leung & Guan 2004). In the local media, the initial pattern of reporting during March and April, 2003, was one critical of frontline health care workers followed in May, 2003 with much greater emphasis on the heroics of these frontline workers (Drache, Feldman, & Clifton 2003).

One of the most immediate questions that arose for frontline hospital workers in Toronto





revolved around their rights to a safe workplace and protecting their families from infection.<sup>14</sup> Large numbers of hospital workers were mandated to 10-day quarantines by Toronto Public Health when SARS exposure was suspected. At Sunnybrook hospital, which treated the most SARS patients in Toronto, 297 staff were quarantined. This included 185 nurses who were subject to what was coined “home-work” quarantine. “For approximately two months, many of these nurses were isolated in their home environments, prohibited to have physical contact with family members, required to drive alone to work, and attend work only on the SARS unit on which they were assigned” (*Ontario Nurses Assn. v. Sunnybrook and Women’s College Health Sciences Centre* 2004). The Federal Government’s SARS report observed, “Hundreds of health care workers isolated themselves from their families during the outbreak, wearing masks at home, sleeping in the basement, taking meals alone, and waiting to see if they would develop tell-tale symptoms” (Naylor 2003: 42). One study by Hawryluck et al. (2004) of the psychological effects of quarantine in Toronto that focused predominantly on health care workers who had been subject to work quarantine found that many of them reported stigma and anxiety, which corresponds to the rights concern that revolves around a mental interest in minimizing “reputation loss and anxiety caused by public accusation” that I identified above in the parallel between quarantine and pre-trial detention.

The concerns raised by health care workers also included how effective this practice of ‘work quarantine’ was at safeguarding their families and what sort of financial compensation they deserved. Four hundred paramedics in Toronto were subject to work quarantine. Bruce Farr (2003), who was Chief General Director for the Toronto Emergency Medical Services, which provides paramedic and ambulatory services, expressed well this concern,

“I’m sick, I have a cold, I have sniffles. Do I have SARS? I’m a paramedic, should I come to work? Should I not come to work?...If I have SARS, how am I going to get paid? If I have SARS, am I going to infect my family? Sick versus WSIB [Ontario’s workman’s compensation fund]. People who got SARS clearly were paid for WSIB but if you went home on quarantine or you had the sniffles...does WSIB pay? Makes a disincentive to come to work if I’m going to lose money...We have to make sure that staff get paid while they’re on quarantine, and this doesn’t just apply to healthcare staff but for the general public.”

Similarly, Jan Kasperski from the Ontario College of Family Physicians commented, “Physicians were reassured that they would receive adequate workman’s compensation and disability pension benefits, if they became sick on the job. The protection they were offered was never put in writing and was later withdrawn without notification while they were working the SARS community clinic, worrying about themselves, worrying about their families, and their reassurance was removed!” The point of these two examples is to show that frontline health care workers in Toronto were concerned about the distributive fairness of quarantine; it just seems





that it was senior public health officials in Toronto who were not responsive to those concerns.

Ultimately, as I have emphasized above, when the governments did on May 28, 2003 announce a compensation package for health care workers, it was not designed to address those in particular who were subject to work quarantine or risked exposing themselves or their families to infection, but rather was a broad package that compensated all health care workers who had suffered income losses or had worked overtime. For example, although the Ontario provided additional funds to hospitals to pay for extra wages, the largest expenditure went toward the SARS Income Stabilization Program for Physicians. This program was “intended to minimize financial loss in physicians’ OHIP professional fee-for-service billing income resulting from the SARS emergency” (Government of Ontario 2003b). What this meant is that the province paid physicians 80% of their average billings during the crisis, regardless of how many services the physicians actually provided. (The sense at the time was that family physicians’ offices were empty except for emergencies.) This, of course, did not compensate frontline health care workers subject to work quarantines in Toronto hospitals where the SARS epidemic really existed.

Significantly, when individual hospitals did try to compensate in some way frontline workers affected by SARS, the efforts raised different sorts of objections. For nurses, the nature of the compensation ranged widely from gift certificates donated by local business to several educational leave days to free on-site parking to a week of paid holiday including a hotel voucher and expense allowance. In practice, however, most hospitals in the Toronto area did not offer any special compensation package for nurses. Moreover, at the hospitals that did, some nurses received several packages whereas other nurses with similar experiences with work quarantine during the SARS crisis did not receive any at all. Not a single hospital in Toronto sought to include the nurses’ union in the decision making about providing such compensation packages. In the only completed labor litigation surrounding the SARS crisis, *Ontario Nurses Assn. v. Sunnybrook and Women’s College Health Sciences Centre* (2004), the Ontario Nurses Association (ONA) successfully challenged before the Ontario Labour Relations Board the arbitrary way in which these compensation packages were put in place at Toronto hospitals. The ONA argued that they should have been included in the negotiations regarding any such packages and that any such packages should have been provided to all nurses at the relevant hospital. The OLRB accepted the first claim and ordered the hospitals to enter into negotiations with the ONA but held that the second claim should be among the subjects of such negotiations.

In March 2004, the Ontario Nurses Association (2004) on behalf of 30 nurses who were infected with SARS launched a lawsuit against the Ontario government on the grounds that it instituted “workplace safety precautions that were inadequate and did not properly protect the nurses from SARS” and that the government “breached their Charter of Rights and Freedom rights to ‘life, liberty and security of the person’ because of the harm to their health.” These nurses complained that the SARS had devastating effects on their long term health and well-







being, and that these effects were not recognized in the government's compensation packages. In August 2005, the Superior Court allowed the case to proceed, enabling the plaintiffs to sue the government for negligence. By April 2006, 52 nurses as well as the family of one nurse who died had joined the litigation (Ontario Nurses Association 2006). This litigation, which remains before the courts, was only one of two initiated in Ontario by health care workers and their families regarding SARS.

The picture that again emerges from Hong Kong is quite different. Like in Toronto and Shanghai, hospital workers readily offered care to suspected and probable SARS patients. Indeed, among the approximately 53,000 staff employed by the Hong Kong Hospital Authority, only one is on record for having resisted an assignment (Rossiter 2005).<sup>15</sup> The Equal Opportunities Commission also received one complaint regarding quarantine but it was resolved with the EOC's intervention (Chok 2005). Although initially the Hospital Authority gave individual hospital administrations latitude in their policies, decision making during the SARS crisis was soon centralized in a senior management team who met daily to review policies. Significantly, that team included past heads of the physician union as well as the current head of the hospital support staff union. According to David Rossiter (2005), Director of Human Resources, staff rights were given currency at these meetings. Communications to staff were likewise centralized and directed by the team. Only in one instance was the media relied on to convey significant information to hospital staff.

The decisions of the Hong Kong Hospital Authority were surprisingly attentive to the rights of hospital workers, although perhaps sometimes in a paternalistic manner. For example, pregnant women on staff were offered positions outside of hospitals (Rossiter 2005). This policy anticipated the subsequent recommendation by the Equal Opportunities Commission that special provisions be made for pregnant employees including home-based work, which was viewed as very innovative for Hong Kong where accommodation for home demands are rare (Wu 2005). Similarly, extensive provisions were made to minimize the risks to the families of employees. In contrast to the image of hospital workers in Toronto isolating themselves in their basements in compliance with work quarantine, the Hospital Authority made available free of charge 1200 furnished apartments in a new housing block for employees (SARS Expert Commission 2003). At the peak of crisis, more than 2000 employees were staying in the apartments, which also were stocked with food and other provisions (Rossiter 2005). The Hospital Authority also provided employees with mobile and video phone to facilitate family contact. Likewise, the Hospital Authority organized in a systematic manner support for families of employees in terms of services such as baby-sitting and grocery shopping. (Like in Toronto, many of these families had both caregivers employed by hospitals.) The significant point is this. In Hong Kong, frontline hospital workers were not subject to broad quarantine orders involving work quarantine or other such measures that affected thousands of their counterparts in Toronto. Instead, the Hospital





Authority provided resources and supporting infrastructure that gave these workers the choice of going home after work or living instead in free accommodations and thus reducing the risk of exposing their families and other possible contacts to SARS. But ultimately it was at the discretion of these hospital workers what to do.

The compensation packages for its employees the Hospital Authority did provide were offered uniformly and openly. Individual hospitals did not create them nor were they allocated in an arbitrary fashion. The Hospital Authority provided initially, for instance, a \$50,000 HK Recuperation Grant to all infected employees and applied the same formula for compensating the families of those employees who died, each of whom received financial assistance of about \$3 million HK (See Hong Kong SAR 29 June 2003).

There has been no litigation by Hong Kong hospital workers regarding the SARS crisis. The fact that Hong Kong workers in other industries readily launched complaints with the Equal Opportunities Commission, as I note below, suggests that frontline hospital workers themselves perceived the measures taken by the Hospital Authority to be quite fair.

### **The Legal Consciousness of Close and Distant Contacts**

The picture of legal consciousness among the close and distant contacts of probable SARS patients—families, associates, neighbors, fellow students, and co-workers—in Hong Kong, Shanghai and Toronto is a much more complex one. In all three cities, these contacts experienced a considerable degree of stigma and discrimination by other residents of the cities. In Hong Kong, the Equal Opportunities Commission was viewed as the point of first contact for people concerned about rights issues during the SARS crisis (Papadopoulos 2005). The commission received 100s of complaints and quickly developed a rapid response process. This process emphasized a rights-based approach to resolving disputes and concerns about how SARS issues were being handled (Wu 2005). Ultimately, the Commission received 37 cases for investigation and conciliation (Chok 2005). These were resolved without litigation in all but one case. All of these complaints dealt with employment, provision of services including education, or the exercise of public power. The one case that led to litigation involved a woman who allegedly that she had been fired because her mother had SARS ([www.chinadaily.com](http://www.chinadaily.com) 25 September 2004). Thirty-six complaints were handled with follow-up by the EOC but did not require conciliation (Chok 2005). It is interesting to note that there is no evidence that the Officer of the Privacy Commissioner for Personal Data, Hong Kong (2004) received any complaints.

Perhaps the most interesting examples in Hong Kong revolve around the residents of the Amoy Gardens housing estate. Residents of Amoy Gardens accounted for almost a quarter of Hong Kong's SARS cases and constituted its principal community outbreak. These residents





claimed that they suffered discrimination that reflected the idea that they were marginalized and avoided. In an effort to contain the community outbreak at Amoy Gardens, Hong Kong's Director of Health ordered the isolation of one building (Block E) and evacuated the residents to various facilities. As I noted earlier, however, this measure was recognized at the time in Hong Kong by senior public health officials as draconian and was carried out with careful consultation with the Equal Opportunities Commission (Wu 2005). The EOC also followed up with attention to the long term effects of this measure.

Although many residents of Amoy Gardens believed that their rights had been violated, these concerns were not directed at the quarantine measures per se. A significant number of these residents complained to the EOC about unfair treatment, especially with regard to access to alternative private market housing and services (other than those offered by the department of health) as well as treatment by employers. Nearly fifty percent of those surveyed in a study of the psychosocial difficulties after the SARS outbreak reported unfair or unpleasant experiences (Hong Kong Mood Disorders Center 2003). The measures designed to remedy for such unfair treatment were not well received by the residents of Amoy Gardens. Few of them believed that the legal institutions held much promise and most believed that healthcare workers were the ones who received most of the attention. And there is some anecdotal evidence to support this belief. For example, in one legal case in Hong Kong's District Court, *Wing v. Xiong* (2003), which involved a tenant who moved out of his Amoy Gardens flat and forfeiting two months rent, the judge held that the tenant was still responsible to compensate the landlord for the additional rent he lost while the flat was vacant. There are compelling reasons to think that this legal consciousness contributed to the significant psychosocial impact of SARS in Hong Kong (Hong Kong Mood Disorders Center 2003; Tsang et al. 2004). Yet, in my own interviews and discussions, many of those living elsewhere in Hong Kong expressed sympathy for how the residents of Amoy Gardens felt, noting that they had analogous experiences in the sense that all residents of Hong Kong felt ostracized in the broader world. Surveys after the SARS outbreak began support this expression of unity within the Hong Kong community ([www.china.org](http://www.china.org) 13 May 2003).

Unlike Hong Kong, Shanghai did not have a major community outbreak of SARS. Instead, SARS cases were largely confined to hospital settings. Those who suffered discrimination and perceived it as wrong were largely rural migrant workers. However, although the Chinese government (PRC Information Office 2004:VII) does profess a commitment to encouraging the disabled "to participate in social life on an equal footing", Shanghai does not have any sort of human rights law comparable to the Hong Kong's EOC disability discrimination ordinance and thus there is no ready access to the legal system for such complaints about discrimination. The more revealing issues of legal consciousness revolve around the failure of employers to pay these workers during the SARS crisis. This fits into a more general pattern of employers not paying migrant workers the wages they are owed. Indeed, the Chinese





government identifies this as a fundamental human rights cause and claims that after SARS real progress was made. In the three month period from November 2003 to February 2004, it reports that 24 billion yuan of overdue wages were paid to rural migrant workers (Information Office PRC 2004:IV).

In Shanghai, migrant workers brought complaints about unpaid wages during and after the SARS crisis to legal aid clinics, looking to the courts for remedies. The Shanghai Justice Bureau operates with the financial support of international NGOs these legal aid centers, most notably, the Legal Aid Center for Migrant Workers (now known as the Shanghai Legal Services Center for Workers). This legal aid center has played a major role in making migrant workers in Shanghai more aware of their rights, reaching more than a half-million migrant workers in the past five years (CIDA 2006). In 2003, the Center provided free lawyers in about 4000 cases that went before Shanghai's courts, many of them involving migrant workers seeking to obtain unpaid wages (Shanghai Daily News 2005). Although the precise number of how many of these cases arose from quarantine cannot be discerned with any precision, the fact that numerous court cases exist differentiates Shanghai from both Hong Kong, where complaints were largely handled by the EOC, and Toronto, where such complaints did not reach the courts, the labor relations board, or the provincial human rights commission at all.

In Toronto, similarly, there was not a major community outbreak of SARS. However, large numbers of residents were subject to quarantine and appeared in the eyes of the broader community as possible carriers of SARS. Information about those who were subject to quarantine as well as those who were infected was widely circulated in the city. Indeed, the assistant commissioner from Ontario Information and Privacy Commission has conceded in the only major appellate ruling on privacy in the SARS crisis, a case that involved a journalist requesting information from Toronto Public Health under the freedom of information legislation, that the media and a large number of SARS-related internet sites identified individuals who were infected with SARS (Information and Privacy Commissioner/Ontario 2004a). Yet, nobody launched a complaint with the Information and Privacy Commissioner. Nor does the Commissioner acknowledge any consultation with Toronto Public Health or any other official regarding SARS (Information and Privacy Commissioner/Ontario 2004b).

In the community, SARS in Toronto was associated with certain racialized immigrant communities, most obviously the Chinese community, but also for example the Filipino community. Some individuals within these communities certainly felt discriminated against. According to Dr. Ming-Tat Cheung (2003), who led the Community Coalition Concerned With SARS in Toronto,

“Members of the Asian community experienced numerous instances of stigmatization. It was commonplace for passengers to change seats or move away from Asians in public transit, or to wait for the next elevator to avoid riding with someone of Asian descent.





Parents warned their school children to avoid Chinese students... We feel that much of the stereotyping that did occur, could have been avoided, if a high ranking government official, or public health officer, had stepped forward at an early stage of the outbreak, to make an unequivocal statement condemning such discrimination.”

The Chinese Canadian National Council documented in a narrative fashion a range of these experiences, concluding that in Toronto the SARS crisis was heavily racialized, with blame for the spread of the disease falling on the Asian Canadian community. One example is a statement by a Filipino respondent, “some employers started to think that just because the workers are Filipino, then no, they cannot come and work... Do 10 day quarantine... After the 10 days, you know what happens? They are given 2 weeks notice that their services are not needed anymore. So to prove what I am saying is that I know these people who were terminated because of that” (Leung & Guan 2004:27).

Yet, these rights concerns did not lead to formal complaints with human rights organizations nor lawsuits. The Metro Chinese and Southeast Asian Canadian Legal Aid Clinic did receive a number of telephone inquiries regarding discrimination, but certainly not hundreds like the EOC did in Hong Kong (Go 2006). One example was someone who was ordered into home quarantine but denied access to her apartment. Others were ones such as those reported above by the CNCC regarding the loss on one’s job after quarantine. However, the Clinic was not asked to press forward with any of these concerns.<sup>16</sup> Avvy Go, Director of the Clinic, believes that people in Toronto were simply willing to accept a certain amount of unfair treatment without complaint. This is puzzling because in both Hong Kong and Shanghai persons with similar types of complaints readily turned to legal forums, be it the Equal Opportunities Commission in Hong Kong or the district courts in Shanghai.

## **Conclusion**

At the outset, I noted that balancing concerns about individual rights and concerns about a community’s health security are inevitably at the center of public health crises. By focusing on how the balance between rights and quarantine was handled from three different perspectives in three different cities during the SARS crisis, I have sought to show how different this balance can be struck and how those differences are reflected in the legal consciousness of differentially situated groups in the crisis with a view to better understanding the pattern of divergence that subsequently emerged in 2003.

The surprising upshot of contrasting Toronto to Hong Kong and Shanghai in terms of differentiated legal consciousness is that it was the legal consciousness of senior public health officials in Toronto that differed the most not only from the legal consciousness of their counterparts in Hong Kong and Shanghai but also from that of frontline hospital workers and the







contacts of probable SARS patients in Toronto. It has been suggested to me by Njoo (2005) that perhaps in Toronto the belief that the decisions about SARS by senior public officials, provided that they had a legal basis, would be made fairly is so deeply ingrained among the public that there was little need to question or scrutinize those decisions. Yet, I have tried to show that from the perspective of those most affected by quarantine decisions, there was dissent. But, rather than legally mobilizing that dissent, for the most part these dissenters simply lumped it, choosing not to utilize the courts or human rights bodies to press their concerns about rights violations, which undermines claims that there exists in Toronto a strong belief that those legal venues are forums for fairly adjudicating disputes in situations where the health security of the community is at stake.

A similar point about complexity can be made about rights in Hong Kong and Shanghai. Eric Feldman (2000) in his work on legal consciousness and rights in Japan has tried to show how rights concerns can play an important role in Japanese public health policy making, even though the legal status of those rights may be unclear or dubious. Randal Peerenboom (2005, 2006) has made a similar general claim about human rights in China. Likewise, rights concerns about quarantine were mobilized in Hong Kong and Shanghai both in the decisions about the handling of SARS and in the responses by those most affected by quarantine, despite the shaky legal foundations of those concerns.

As we anticipate that another global public health crisis might be just around the corner, be it Avian Flu, a renewed strain of Legionnaires' Disease, or something entirely new, it seems likely too that different jurisdictions will simultaneously be struggling with the difficult balancing of individual rights and the health security of the community. The responses to SARS and indeed to AIDS (Baldwin 2005) reveal that it is improbable that any sort of convergence on how this balance will be struck. Nor will leadership by an international organization such as the WHO eliminate divergence at a local level; international rules and norms will inevitably be selectively adapted at a local level (Nelken 2006; Jacobs & Potter 2006; Potter 2004; Nelken & Feest 2001). What I suspect the next couple of global public health crises offer, like SARS and AIDS already have, is the opportunity for "experiments in living" characterized by different perspectives on how to balance rights concerns and community health security. Instead of assuming that the pattern will be one where liberal democratic states tilt the balance in favor of individual rights, making more visible the different perspectives on balancing rights and health security that exist in all jurisdictions will likely yield a clearer picture of what is happening where.

## **Endnotes**

- 1 The Centers for Disease Control and Prevention (CDC) did not compel anyone in the United States to be isolated or quarantined during the 2003 SARS crisis. Some local jurisdictions did. For example, New York





- City public health officials involuntarily quarantined one individual. See Rothstein et al. 2003: 40.
- 2 There is in fact little consensus about the precise number of individuals quarantined in Toronto. See the discussion below.
  - 3 See for example the timeline set out in WebMD Medical News (2003).
  - 4 Three exceptions are a comment in passing in the report on quarantine and isolation prepared for the Centers for Disease Control and Prevention by Rothstein et al. (2003: 54), an observation by Ries (2004) about the contrast between Toronto and Beijing, and a brief critical commentary on Canadian quarantines by Schabas (2004).
  - 5 A brief snapshot of how quarantine was used in a many different jurisdictions during SARS can be found in Rothstein et al. 2003.
  - 6 This idea of differentiated legal consciousness within a particular context is similar to Nielson's (2000) study of public harassment speech but differs in the way that individuals are classified in terms of situating legal consciousness. Nielson (2000) classifies individuals principally along the lines of race and gender whereas this study classifies individuals functionally according to their place in public health interventions.
  - 7 It may well be the case that in such an account, neo-institutionalist claims about path dependency and policy legacies are compelling. and could be modeled on Baldwin's (2005) argument in the AIDS context. For an example of a path dependency explanation for the development of Canada's public health care system, see Jacobs (2005). I know of no sophisticated path dependency explanations that have been applied to Hong Kong or mainland China's health care policy.
  - 8 The new International Health Regulations adopted by WHO in May 2005 continue to allow for discretionary use of quarantine by state parties. See Fidler & Gostin 2006.
  - 9 These conditions derive from the Siracusa Principles on the limitations on international human rights. See Davis & Kumar 2003.
  - 10 See Lubman (1999) as well as personal correspondence with Sarah Bidulph (University of Melbourne Law Centre).
  - 11 A common misperception is that China threatened to impose the death penalty for non-compliance. Rothstein et al. (2003: 71) explain: "The controversial portion of Article 9, authorizing the death penalty in some instances, must be understood in the context of the statute. Under Article 9, individuals who engage in "beating, smashing, or looting" while measures to prevent and control the spread of an emerging infectious disease such as SARS are in place are subject to penalties increasing in severity with the seriousness of the offense. The ring leaders of such "rioting" could be subject to the death penalty if their behavior otherwise constituted "capital murder" under the criminal code. In other words, a person instigating a riot on a train quarantined during an epidemic might be sentenced to death if that person had destroyed property and used a gun to rob and kill someone during the disturbance."
  - 12 Shanghai can be contrasted to Beijing. Kaufman (2006) claims that during the period in April 2003 when the municipal government in Beijing did not provide clear guidelines for quarantine, millions of migrant workers fled Beijing out of fear of being detained and quarantined.
  - 13 These first two figures come from the budget estimates projected at the time by the Government of Ontario (2003a). The estimated cost of the Income Stabilization Program is based on the total fee-for-service physician billings for 2003 in Ontario of \$6,689.6 billion. It is estimated that quieter private practices and cancelled elective surgeries reduced average physicians billings to the Ontario Health Insurance Plan by about 35% during the SARS crisis in Ontario. The Program topped up payments to all physicians to 80% of their billings in the previous quarter, which is in effect about 10% of the total billings for 2003. See Government of Ontario 2003b. The federal government eventually transferred \$330 million to the province to help cover these two programs. See Ontario Ministry of Finance 2004.
  - 14 The Ontario Ministry of Labour, which is responsible for workplace safety, was sidelined during the SARS crisis and has no record of investigating any complaints involving workplace quarantines. See Campbell





2007:836.

- 15 This complaint is also the only one by a hospital worker on record with the Equal Opportunities Commission among its more than 500 complaints and enquires received.
- 16 The one formal complaint the Metro Chinese and Southeast Asian Legal Aid Clinic did make was to the Chair of the Canadian Refugee Board because members of tribunals in Toronto were wearing masks only while reviewing refugee applications from China and other Asian countries. This complaint lead to a meeting with the Toronto Chair of the Refugee Board but involved no follow up (Go 2006).

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