4. Stronger Health Protection Powers

The *Health Protection and Promotion Act*, which provides the legal machinery for our defence against infectious disease, needs to be stronger. Public health officials must be able to act quickly and decisively in the face of a public health risk. Quick action can stop an outbreak before it starts. Although emergency powers may be available after an outbreak gets out of control, it is the daily powers in the *Health Protection and Promotion Act*, powers of investigation, mitigation, and risk management, that prevent public health emergencies from developing. These daily powers require strengthening.

SARS demonstrated the importance of three key aspects of infectious disease prevention and management by public health officials: first, access to information about cases and situations in health care institutions and in the community that may pose risks to public health; second, the authority, resources and expertise to investigate such cases and situations to determine any risk to the public's health; and third, the authority, resources and expertise to intervene and take appropriate action necessary to protect the public's health. These three key functions have to be supported by adequate resources and legal powers.

The Commission has identified seven fields of public health activity that require additional authority under the *Health Protection and Promotion Act*:

- Authority of public health in relation to infectious diseases in hospitals;
- Authority of public health officials to acquire information necessary for them to protect the public from a health risk;
- Authority of public health officials to investigate health risks to the public;
- Authority and process by which the Chief Medical Officer of Health can establish an adjudication system to review, where appropriate, decisions of local medical officers of health in respect of case classification;
- Authority of the Chief Medical Officer of Health to issue directives to hospitals and other health care institutions;

- Authority as a last resort to detain noncompliant individuals who pose a health risk to the public, subject to an immediate court hearing; and

- Authority as a last resort to enter a private dwelling to execute an order made under the Act or in exigent circumstances to enter without a warrant, followed by a court hearing.

Health protection legislation requires a scaled response, with powers that increase as the risk increases. It is not good enough to act after a public health problem has erupted into the community. The authority is required to manage risk proactively to prevent a potential public health problem from becoming a public health emergency.

Dr. Basrur, in her submission to the Justice Policy Committee considering the issue of emergency legislation, referred to the need to strengthen the power for medical officers of health to deal with day to day risks to public health. She emphasized the need for public health's response to be ramped up depending on the level of risk, without having to declare a provincial emergency so as to have the legal authority to utilize those powers. She stated:

> You might, in the case of the health legislation, have a series of what I call "scalable" powers that are consistent with the day-to-day structure of the regulation of public health, not totally divorced from it, so that when you start with what seems like one case, two cases, four cases, and, "Gee, it's not just one institution, it's two institutions, and yes, there were workers who crossed over and we're not sure where a third one may have worked because we can't find that person," you want to be able to scale up but not have to invoke a new statute entirely in a non-provincial-emergency situation. You want to be able to scale up, scale back, scale up in particular geographic areas or on particular functional areas so that you've got a sensible response.
>
> Now, it is possible to have that kind of provision built into individual statutes – the Health Protection and Promotion Act, the Nursing Homes Act, the Homes for Special Care Act, the Charitable Institutions Act, all of the rest of them. You might have it in the Ministry of Health and Long-Term Care Act. Not being a lawyer, I'm not going to try to nuance what the differences would be. All I will say is that from a public health standpoint, I need the latitude, and I know the local medical officers of health need the latitude, to say: "These are our authorities. We know what we can do on a daily basis. We know if we have an urgent situation

> we can ramp up this quickly, but when we hit certain parameters, we've got to escalate it to the province, because this really goes beyond our borders; it goes beyond our competence," or, "It's multi-jurisdictional, and therefore a comprehensive response needs provincial coordination and control."[132]

The idea is to have a range of powers available daily to deal with any public health problem short of a provincial emergency. Once the problem rises to a level where emergency machinery and powers and the full resources of government are required, a bright line would be crossed and a provincial emergency would be declared. Once a provincial emergency is declared, the emergency powers kick in and there would be no more question of scalable powers. But the existence of a strong emergency management legislation does not negate the fact that public health officials must have their powers strengthened to allow them to deal with a public health problem short of it becoming an emergency.

To achieve this goal the *Health Protection and Promotion Act* must be strengthened. Medical officers of health must be involved in and aware of infection control issues as soon they arise in health care facilities. The powers and obligations set out in the *Health Protection and Promotion Act* must enable public health officials to become aware of unusual clusters of illness and reportable events both in health care facilities and in the community, they must empower them to direct epidemiological investigations where necessary, and they must authorize them to intervene and act, by making orders to individuals, groups, institutions and health care facilities for the protection of the public. Not all infectious disease outbreaks will require the declaration of a provincial emergency or resort to the broader emergency legislation. If the daily authority in the *Health Protection and Promotion Act* is strong enough, emergencies will be more preventable and the use of emergency powers will very seldom be necessary.

The Relationship Between Public Health and Hospitals

Faced with the risk of infectious disease outbreak, public health and hospitals need to work quickly and need to work together. There is no time for turf wars, procedural wrangling, jurisdictional disputes, or fine legal arguments. Deadly viruses do not stand still while hospitals and public health officials sort out their differences.

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132. Justice Policy Committee, Public Hearings, August 18, 2004, p. 141.

As noted in the Commission's first interim report, the sudden onslaught of SARS forced public health and hospitals to work together in a way and scale never previously encountered or even contemplated. This was no problem in some parts of the province because the local health unit and the local hospitals had good working relationships, including an active public health presence on hospital infection control committees. For other parts of the province, however, the opposite was true. It proved difficult in some cases for public health and hospitals to work together in a new and unfamiliar relationship driven by a crisis for which no one had planned. This uneasy and unplanned relationship detracted in some cases from the mutual fight against SARS.

A critical issue during SARS and now is the management of infection control concerns or outbreaks or potential outbreaks of infectious diseases in health care institutions and the role of public health. There are two distinct issues: first the role of public health when there is an infection control problem that poses a risk to the community, and second the role of public health in infection control programmes and standards in general. More will be said about the latter issue in the final report together with the story of what happened during SARS.

This report will focus in a preliminary way on the structures and relationships required between public health and hospitals to prevent, detect, investigate and manage infectious outbreaks in hospitals.

The Commission received many submissions on the relationship between public health and hospitals in respect of the prevention and management of infectious diseases within health care facilities. One common theme throughout the submissions, received from both the public health and health care communities, is the need for greater clarity in their respective roles and relationships in respect of infection control. Both sides want clarity. Both want to work together more effectively. Both sides realize that the working relationship, whatever it may become, must above all be transparent with clear role definitions and clear lines of authority and accountability.

As noted in the Commission's first interim report, public health authorities, at least in theory, have some role in hospital infection control. The Mandatory Guidelines under the *Health Protection and Promotion Act* provides as follows:

> The Board of Health shall ensure appropriate input to hospital infection control programs in the health unit. This shall include as a minimum:

a. representation of the Medical Officer of Health or designate on each hospital infection control committee;

b. reporting of designated communicable diseases from hospitals, including emergency rooms and out-patient clinics, to the Medical Officer of Health as required under the provisions of the *Health Protection and Promotion Act*;

c. consultation with the hospital infection control committee on the development and revision of infection control policies and procedures and an outbreak contingency plan;

d. providing advice when requested or when needed for the appropriate management of communicable diseases and infection control;

e. providing epidemiological information as needed regarding communicable diseases existing within the community and other institutions; and

f. collaboration or assistance in annual in-service education for hospital staff about communicable diseases.

The Guidelines provide for communication, advice and consultation between public health and hospitals in respect of infection control. But they give public health no authority and they require from hospitals no accountability. These Guidelines have not always been followed. Nor have they typically been enforced. Some hospitals had a minimal, if any, relationship with public health authorities around infection control. In those cases where some relationship existed, the relationship was sometimes poorly defined and poorly understood. As noted in the Commission's first interim report there is great confusion and uncertainty around the respective roles, responsibilities, authority and accountability of public health and hospitals in infection control and infectious outbreaks in hospitals.

The present uncertainty makes it obvious that legislation is required to clarify these roles and responsibilities. But the most exquisite legislation will not solve the problem without an underlying framework of cooperation and an underlying attitude of respect between hospitals and public health authorities. While there will always be room for disagreement, it is essential to foster an atmosphere of mutual respect around the respective authority and accountability of hospitals and public health in respect of infection control. Some think this will be achieved if hospitals have clear

primary responsibility for managing outbreaks within an institution, subject to a greater role for public health in surveillance, investigation and, as a last resort, intervention.

As one submission to the Commission suggested:

> Authority for managing outbreaks of infection should be vested within the infection control officer of the hospital with the requirement that all outbreaks are reported immediately to the medical officer of health. The medical officer of health and the infection control officer of the hospital must work collaboratively to control infections in their respective jurisdictions and keep each other informed of infectious disease outbreaks.

While the goal of any professional relationship should be collaboration and cooperation, clear lines of authority are also required. The public interest requires that a health care facility's management of infection control problems, infectious disease outbreaks, or other public health risks be subject to investigation and, if necessary, intervention, by public health authorities. The medical officer of health and the Chief Medical Officer of Health require the authority and the resources to intervene whenever there is a risk to the public health, no matter where that risk is situated. The fact that a hospital may have an infection control programme does not negate the need for public health officials to intervene when an infection control problem or an outbreak present public risk. The ease with which a hospital based infection can spread to the community makes it essential that public health officials have the power to investigate, and if necessary, to require a hospital to take positive steps to prevent the spread of infection within the hospital and from the hospital to the community. As one submission received by the Commission observed:

> The *Health Protection and Promotion Act* should include more appropriate accountability mechanisms to ensure public health exercises control over all health care facilities, including hospitals, to ensure better oversight of infection control procedures.

Public health officials and experts can monitor a potential problem and act on it in time only if they know about it. Unless they are informed in its early stages, later investigation and intervention may come too late. It is too late to involve public health officials after a case is absolutely confirmed or an outbreak has clearly developed. The specific powers to enable public health officials to intervene and act to protect the public's health from infectious diseases are discussed below.

As a starting point it must be clear in the *Health Protection and Promotion Act* that public health has a role to play in infection control, whether in a hospital, a long-term care facility or a private clinic. The medical officer of health must have a legal duty, entrenched in the Act, to monitor, investigate and intervene where necessary in cases of infectious diseases, or where inadequate infection control standards or procedures pose a threat to public health. A curious gap in the Act is a positive duty to inspect and monitor community health hazards under s. 10 and environmental and occupational health hazards under s. 12, yet no concurrent duty to do the same in the case of communicable diseases. Part of the resistance to public health intervention may be addressed if it were made clear that this is their job and that they are legally required to be involved. The entrenching of these duties as a statutory requirement would also make it more difficult for municipalities to cut spending in the area of infectious disease prevention and management. Supported by the statutory duty, the local medical officers of health could point out that they are legally required to perform these functions.

The first step to strengthening the relationship between public health and hospitals is to reinforce the requirement that public health have a presence in the infection control committees of all hospitals in the province. To this end, the Commission recommends amending the *Health Protection and Promotion Act* to provide that each hospital infection control committee must have as a member the medical officer of health or his or her designate. While this simply puts into the Act what already exists in the Guidelines, it gives it the force of law, with a view to ensuring that it is a duty that cannot be overlooked or under-resourced.

It is further recommended that the Act be amended to impose a positive duty on public health officials to monitor, investigate, provide advice and intervene where necessary in the case of communicable diseases. The present language of the Mandatory Guidelines, which implies that the role of public health is optional, as if they are guests to be heard in hospitals only when invited, is unacceptable. Public health has a role in institutional infection control whenever there is a potential danger to the public's health.

Recommendations

The Commission therefore recommends that:

- **The role and authority of public health officials in relation to hospitals be clearly defined in the *Health Protection and Promotion Act* in accordance with the following principles:**

- **The requirement that each public health unit have a presence in hospital infection control committees should be entrenched in the Act; and**

- **The authority of the local medical officers of health and the Chief Medical Officer of Health in relation to institutional infectious disease surveillance and control should be enacted to include, without being limited to, the power to monitor, advise, investigate, require investigation by the hospital or an independent investigator, and intervene where necessary.**

Information

As noted earlier in this report, the ability of public health officials to intervene in the case of a health risk is dependent on them being informed. This can only be done where public health officials have access to current information about the existence or suspected existence of an infectious disease within a hospital or any other health care institution or facility. As one public health lawyer commented:

> We're really, quite frankly, waiting for the hospitals and practitioners to do the right thing and contact the local health unit if there's something that's getting out of hand. I think experience in the last two years has shown that that's not always satisfactory. If you give the medical officer of health a power to require compliance when an institution is engaging or stepping up its infection control procedures, then I think that you get over the hurdle of the hospital's lawyers saying, wait a second, you don't have any obligation to report this, let's just keep this in-house.

The reporting of infectious diseases information is dealt with in the following chapter of this report. It is critical that public health be informed of cases in hospitals and other health care settings immediately, so it can take steps to protect the public. Amending the specific sections of the Act to clarify and expand existing reporting obligations is only one part of the solution, however. Many public health professionals have suggested that it is not enough to simply be advised when there is a confirmed case of a reportable or communicable disease in a health care institution. By the time that determination is made the disease may have already spread to numerous people.

The *Health Protection and Promotion Act* does not deal with public health risks that fall outside the limited definitions within the statute. The local medical officer of health

has the power to act in the face of a "health hazard" as defined in the Act[133] or in relation to diseases that are defined as "communicable" under the Act. But public health risks may well arise that do not meet the limited definitions of "health hazard" but are not identified as a "communicable disease" under the Act.

There are two parts to this problem: first the ability of doctors and other health care professionals to inform public health voluntarily of any public health risk; second the ability of public health officials to compel the disclosure of information that does not fall within the categories requiring reporting under the *Health Protection and Promotion Act*. The latter problem, enabling public health officials to compel the disclosure of information outside of that clearly set out in the Act, will be dealt with in the following chapter on reporting.

The solution does not lie in amending the regulations each time a new illness or health hazard presents itself. Consider the example of SARS. Had a hospital in Ontario been confronted with one or more SARS cases before the mysterious new disease was identified, given a name, and classified as communicable, and taken the position that they would deal with the matter internally and not alert public health officials, there would have been no legal requirement for them to report details about the case or cases prior to March 25, 2003.[134]

It is essential that public health be aware of and be able to monitor, investigate and where necessary direct that action be taken in relation to health risks that do not meet the limited categories currently set out in the *Health Protection and Promotion Act*. Physicians who diagnose and treat patients must be able to report to public health a case of illness or an infection control issue, which may, if not addressed, represent a public risk. The principle is clear. The difficulty is to define the trigger for such an unspecified situation.

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133. "Health hazard" means, (a) a condition of a premises, (b) a substance, thing, plant or animal other than man, or (c) a solid, liquid, gas or combination of any of them. See s. 1(1) of the *Health Protection and Promotion Act.*

134. On March 25, 2003, amendments to Ont. Reg. 559/91 and Ont. Reg. 558/91 were filed as well as Ont. Reg. 95/103. The filing of these regulations designated SARS as a communicable, reportable and virulent disease. The regulations came into effect on March 25, 2003, the date they were filed but for purposes of enforcement did not come into effect until April 12, 2003, the date the regulations were printed in the *Ontario Gazette* unless actual notice of the regulation was given. For example, Toronto Public Health attached a copy of the regulations to orders served before April 12, 2003 to ensure notice was given. See ss. 3 and 5(3) of the *Regulations Act*, R.S.O. 1990, c. R-21.

135. R.S.Q. S-2.2.

A possible model for reporting public health risks generally can be found in Quebec's *Public Health Act*.[135] Under this Act, physicians and institutions have positive obligations to report certain specified diseases (as designated by the Minister) but also must report to the public health director,[136] situations where the health of the population is threatened. Section 93 of the Act provides:

> 93. Any physician who suspects the presence of a threat to the health of the population must notify the appropriate public health director.
>
> Possible Threat
>
> Health and social services institutions must report to the appropriate public health director any situation where they believe on reasonable grounds that there exists a threat to the health of the persons who are present in their facilities.[137]

Under the Quebce Act, "health threat" is defined in s. 2, as follows:

> A threat to the health of the population means the presence within the population of a biological, chemical or physical agent that may cause an epidemic if it is not controlled.

As attractive as this broad and expansive language is, it imposes a reporting duty which is vague and unspecified. As one public health official noted, it is one thing to allow a physician the discretion to report in such an unspecific event, but it is another to hold them potentially professionally liable or punishable under the Act for failure to report in that same situation:

> . . . it makes sense that a physician has the capacity to do it without reprimand but if they don't are they sued or liable, that would be very discouraging though . . . if the physician, he or she feels that there is some

136. Under s. 371 of the *Health and Social Services Act*, each region must appoint a public health director. The position of "public health director" is similar to the position of medical officer of health under the Ontario regime.

137. It is important to note that these reporting obligations have certain limitations. They do not include a requirement to report sexually transmitted diseases or to disclose personal or confidential health information unless the public health authority requires such information to exercise their powers under part XI of the Act, which sets out the powers public health may exercise in the event of a threat to the health of a population.

> concern, they could do so and not then be protected from reprimand on that, but at the same time, well were you not aware of something and how come you did not so therefore you are charged. It is very difficult. Right now we are working on seeking a voluntary mechanism to ask them to report proactively rather than saying well I better check with the CMPA [Canadian Medical Protective Association] and every legal obligation and cover all my P's and Q's before I report, it would be too late.

Another suggestion is to amend the Act to require the reporting of an unusual cluster of unexplained illness, or to establish some threshold criteria to capture an unusual and potentially dangerous event that has not yet been determined to be a reportable disease. As one public health lawyer told the Commission:

> . . . to change the wording of the regulation to broaden it, say that more things get reported to public health units and that when public health asks for it, then the hospitals are required to provide it. And that, I think, covers up some of the gaps. But it doesn't get at this initial problem that public health units are all, I think, saying when something, whatever that something is, is going on, we want you to report it. I think going to try and come up with some of those triggers, like sitting down with public health and saying, okay guys, sit down, what are the words that we can use, and we just didn't have time to do that. But they've got the triggers in s. 38 for the reportable events for the immunization. They've got triggers there for that kind of situation. I think we should come up with our own triggers, like the immunization situation, where it is an infection control situation, and here are the triggers that allow us to get the information that we need. And I think it will take some time, but I think we can do it.

Unlike the Quebec example, this reporting obligation would presumably be imposed on both physicians and health care institutions. This expansion of the duty makes sense, since what might seem like a single case of illness to one doctor may be a cluster of cases to the person in charge of infection control or the hospital administration who is aware of a number of similar cases of illness.

However, the language suggested above remains problematic in that, while it is somewhat more precise than "public health risk," it is still difficult to define. For example, what is a cluster? What is the meaning of "unusual" or "adverse", what is the meaning of a "dangerous event"? And with a penalty on one side for nondisclosure and the fear of penalty on the other side for violating privacy legislation, the reporting party is left to navigate these imprecise terms without concrete guidance.

The reality is that reporting in these instances will only work if there is cooperation from those on the front lines, those in infection control programmes in health care institutions, and health care administrators and leaders. A physician or hospital who does not want to report will find refuge in the vagueness of the terminology. It is only where there is a desire to report, combined with certainty in the legal authority to disclose the personal health information, that the problem of alerting public health of health risks, actual or potential, will be addressed.

The first requirement, creating a desire to report, will come only if there is a strong relationship between public health and those with reporting obligations. As noted above, public health must have a presence within all aspects of the health care system, from family clinics to hospitals, to nursing homes and long-term care facilities. There must be a mutual relationship of respect and understanding of the important roles each side occupy. This can only be achieved if public health and hospitals each have the time, resources and manpower to establish and maintain these relationships.

If the physician or the health care institution can be convinced of the importance of reporting anything that may pose a public health risk, regardless of whether it is defined as a reportable disease or whether it neatly meets the definition of health hazard, they must be able to do so without any question regarding their legal ability to do so and without fear of violating privacy legislation.[138] That being the case, it is important to add to the *Health Protection and Promotion Act* a broad and expansive reporting power for health care practitioners and institutions. One public health expert succinctly described the value of such a provision:

> … one of the things was that physicians out in the field [during SARS] felt disenfranchised with the [reporting] process. If a doctor felt there was something that needs to be reported, they would like to be able to pick up the phone on an informal basis, to call and report. If for that they were reprimanded, lost hospital privileges or whatever, they could seek protection and say, well by law I could and I had grounds to do so.

138. More will be said about the potential impact of privacy legislation on report in Chapter 7, Privacy and Disclosure.

Recommendations

The Commission therefore recommends that:

- **The Ministry of Health and Long-Term Care, in consultation with the Provincial Infectious Diseases Advisory Committee, and the wider health care and public health communities, define a broad reporting trigger that would require reporting to public health where there is an infection control problem or an unexplained illness or cluster of illness.**

- **Whether or not a workable trigger can be defined for compulsory reporting, a provision be added to the *Health Protection and Promotion Act*, to provide that a physician, infection control practitioner or hospital administrator may voluntarily report to public health officials the presence of any threat to the health of the population.**

Investigation

Once armed with information, public health officials require sufficient authority to investigate the problem that has arisen in a health care facility or institution, whether it has been reported formally or has come to their attention through some other means. It goes without saying that hospitals and other health care institutions will try to deal with problems in the way they think best. The problem is that what is best for a hospital is not necessarily best for the public interest in protecting the health of the wider community. A mechanism is required to ensure that the public interest is protected in any case where the hospital's approach to an infection control problem or a potential infection outbreak may not adequately protect the public interest.

Take, for example, a cluster of unexplained illness within a hospital, of which public health becomes aware. What powers does public health have to require the hospital to conduct an epidemiological investigation or to conduct surveillance on staff and other patients? Under Part IV, Communicable Diseases, s. 22 empowers a medical officer of health to make orders related to communicable diseases.[139] However, to make such an

139. Section 22 provides:

> Order by M.O.H. re: communicable disease

order, the medical officer of health must, on reasonable and probable grounds, believe:

- that a communicable disease exists or may exist or that there is an immediate risk of an outbreak of a communicable disease in the health unit served by the medical officer of health;

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(1) A medical officer of health, in the circumstances specified in s. (2), may give directions in accordance with s. (3) to the persons whose services are engaged by or to agents of the board of health of the health unit served by the medical officer of health.

Subsection 24(2) provides:

When M.O.H. may give directions

(2) A medical officer of health may give directions in accordance with subsection (3) where the medical officer of health is of the opinion, upon reasonable and probable grounds, that a communicable disease exists in the health unit and the person to whom an order is or would be directed under section 22,

(a) has refused to or is not complying with the order;

(b) is not likely to comply with the order promptly;

(c) cannot be readily identified or located and as a result the order would not be carried out promptly; or

(d) requests the assistance of the medical officer of health in eliminating or decreasing the risk to health presented by the communicable disease.

Contents of Directions

(3) Under this section, a medical officer of health may direct the persons whose services are engaged by or who are the agents of the board of health of the health unit served by the medical officer of health to take such action as is specified in the directions in respect of eliminating or decreasing the risk to health presented by the communicable disease.

Idem

(4) Directions under this section may include, but are not limited to,

(a) authorizing and requiring the placarding of premises specified in the directions to give notice of the existence of a communicable disease or of an order made under this Act, or both;

(b) requiring the cleaning or disinfecting, or both, of any thing or any premises specified in the directions;

(c) requiring the destruction of any thing specified in the directions.

- that the communicable disease presents a risk to the health of persons in the health unit served by the medical officer of health; and

- that the requirements specified in the order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease.[140]

The powers in s. 22 can be exercised only on a high standard of proof, the criminal standard of reasonable and probable grounds. In the above fact scenario, the medical officer of health may not yet have sufficient knowledge to form an opinion on reasonable and probable grounds. Moreover, the disease may be too new or too little understood to be listed by regulation as a communicable disease and may therefore be outside the scope of this section of the *Health Protection and Promotion Act*. The new disease might not even have a name, as was the case in the early days of SARS.

The powers in s. 22 do not give public health the necessary power to become involved with a hospital disease outbreak at the earliest stage, the crucial stage where there may still be time to stop its spread.

This is not to suggest that hospitals or other health care institutions would necessarily alert public health in the future should an unidentified disease enter its facility. In many jurisdictions public health has an ongoing relationship with the health care providers in their jurisdiction and there is a vital exchange of information that occurs on a continuous basis. But that is not the case with all institutions and with all public health units. And there is always the risk that fear of bad publicity, concern over panicking patients and visitors, or fear of civil litigation might cause a health care institution to report a risk to the public later rather than sooner. Or, they might attempt to handle the matter internally without involving public health officials. Add to this the fact that individuals and institutions now have to consider their potential legal liability and question the legal authority before they disclose personal health information to public health officials. Absent a clear legal authority to do so, many health care providers will likely have concerns about providing personal health information to public health and may opt to err on the side of nondisclosure rather than risk violating privacy laws. Public health must have the power to enter and investigate where there is a risk to the public, not just in those cases where the disease is communicable or where, in the hospital's own opinion, it determines it is necessary. The power must be set out in explicit statutory language to ensure that health care

140. See s. 22(2).

providers can be confident of their ability to cooperate in an investigation and to ensure that public health officials have the clear authority to compel cooperation from a dubious or reluctant institution.

An example of the type of power that is needed can be found in Part XI of Quebec's *Public Health Act*. Under that part, public health authorities have a number of powers to enable them to respond to a threat to the health of the population. Among those powers is the power to conduct an epidemiological investigation. Section 96 provides:

> 96. A public health director may conduct an epidemiological investigation in any situation where the public health director believes on reasonable grounds that the health of the population is or could be threatened and, in particular,
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> 1) where the director receives a report of an unusual clinical manifestation following a vaccination under section 69;
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> 2) where the director receives a report of an intoxication, infection or disease to which Chapter VIII applies;
>
> 3) where the director receives a notice under Chapter IX to the effect that a person is refusing, omitting or neglecting to be examined or treated or to comply with compulsory prophylactic measures;
>
> 4) where the director receives a report under Chapter X.

The relationship under this Quebec regime between public health and hospitals is two-way. Where an investigation reveals that a health threat had origins in a health care institution, or in a deficient practice, public health must notify the director of professional services or the executive director.[141] The section also requires that the

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141. Section 99 provides:

> Health threat in health facility
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> A public health director who becomes aware during an epidemiological investigation that a threat to the health of the population appears to have its origin in a facility maintained by a health or social services institution or in a deficient practice within such an institution must notify the director of professional services or, if there is no such director, the executive director.

institution must take all measures required as soon as possible to inspect its facilities and review its practices and, if necessary, correct the situation. The measures taken must be communicated without delay to public health authorities.

Section 100 of Quebc's *Public Health Act* sets out the powers of the public health investigator[142] and s. 106 sets out the powers of the public health director where, following the investigation, a "threat to the health of the population" is found to

142. Section 100 provides:

> Powers of public health investigator
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> Subject to s. 98, a public health director may, where required within the scope of an epidemiological investigation,
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> 1) require that every substance, plant, animal or other thing in a person's possession be presented for examination;
>
> 2) require that a thing in a person's possession be dismantled or that any container under lock and key be opened;
>
> 3) carry out or cause to be carried out any excavation necessary in any premises;
>
> 4) have access to any premises and inspect them at any reasonable time;
>
> 5) take or require a person to take samples of air or of any substance, plant, animal or other thing;
>
> 6) require that samples in a person's possession be transmitted for analysis to the Institut national de santé publique du Québec or to another laboratory;
>
> 7) require any director of a laboratory or of a private or public medical biology department to transmit any sample or culture the public health director considers necessary for the purposes of an investigation to the Institut national de santé publique du Québec or to another laboratory;
>
> 8) order any person, any government department or any body to immediately communicate to the public health director or give the public health director immediate access to any document or any information in their possession, even if the information is personal information or the document or information is confidential;
>
> 9) require a person to submit to a medical examination or to furnish a blood sample or a sample of any other bodily substance, if the public health director believes on reasonable grounds that the person is infected with a communicable biological agent.

exist.[143] Section 104 makes it clear that cooperation must be given to the public health director to enable him or her to conduct an epidemiological investigation:

> 104. Every owner or possessor of a thing or occupant of premises must, at the request of a public health director, provide all reasonable assistance and furnish all information necessary to enable the director to conduct an epidemiological investigation.

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143. Section 106 provides:

> Powers of public health director
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> Where, during an investigation, a public health director is of the opinion that there exists a real threat to the health of the population, the director may
>
> 1) order the closing of premises or give access thereto only to certain persons or subject to certain conditions, and cause a notice to be posted to that effect;
>
> 2) order the evacuation of a building;
>
> 3) order the disinfection, decontamination or cleaning of premises or of certain things and give clear instructions to that effect;
>
> 4) order the destruction of an animal, plant or other thing in the manner the director indicates, or order that certain animals or plants be treated;
>
> 5) order the cessation of an activity or the taking of special security measures if the activity presents a threat for the health of the population;
>
> 6) order a person to refrain from being present for the time indicated by the public health director in an educational institution, work environment or other place of assembly if the person has not been immunized against a contagious disease an outbreak of which has been detected in that place;
>
> 7) order the isolation of a person, for a period not exceeding 72 hours indicated by the public health director, if the person refuses to receive the treatment necessary to prevent contagion or if isolation is the only means to prevent the communication of a biological agent medically recognized as capable of seriously endangering the health of the population;
>
> 8) order a person to comply with specific directives to prevent contagion or contamination;
>
> 9) order any other measure the public health director considers necessary to prevent a threat to the health of the population from worsening or to decrease the effects of or eliminate such a threat.

The Quebec legislation allows for a scaled response: inform, investigate and then act if required. A similar model of response is required for Ontario.[144]

Some question whether our public health system has the capacity to enter and provide infection control direction to health care institutions, particularly well-known teaching hospitals with renowned staff experts in infection control. One public health official questioned whether public health has the necessary technical expertise:

> I'm concerned, if we're given the statutory authority to demand actions on the part of hospitals where we consider that there's an issue, a problem, a substandard approach to an infection control issue, whether we have at this point in time the full skill set related to infection control, especially with the myriad of complexities in some of our larger acute care institutions … To give us the authority to demand action without the skill and resource base to do that may be a recipe for credibility issues, for a less fulsome success as could be the case. And I'm wondering if there isn't a parallel but separate mechanism like the Provincial Infectious Diseases Advisory Committee to increasingly establish what are the standards of practice, the expectations, the evidence based practice dimensions of an increasingly comprehensive approach to infection control; and then the resources, the human resources, the skills, the protocols the audits, monitoring capabilities and then the sanctions, the requirements to comply with these increasingly comprehensive and specific infection control standards of practice. This puts less of the onus on us. I'm impressed and humbled by the complexity of that terrain [infection control] and in

144. The Commission is recommending that powers similar to those found in Quebec's *Public Health Act* be added to the *Health Protection and Promotion Act*. There are, however, portions of the *Public Health Act* that the Commission would not support. For example, s. 107 provides:

> 107. Notwithstanding the provisions of s. 106, a public health director may not use a power provided for in that section to prevent a threat to the health of the population from worsening or to decrease the effects of or eliminate such a threat if a government department, a local municipality or a body has the same power and is able to exercise it.

It is difficult to understand the rationale behind this section. The Chief Medical Officer of Health, with her political independence and obligation to speak and act on behalf of the health of the public of Ontario, and local medical officers of health who have similar obligations, are best positioned to determine when and where to act. The fact that another politician or official may have similar powers should not detract from the power available to public health officials.

> my training, most if not all of our training, we just don't get the exposure to a sufficient level of detail nor the opportunity and the resources to maintain a currency with development in the evidence related to infection control that we would need to be truly credible and competent directors, requirers of action if we feel that something is not up to snuff.

This is a legitimate point. Public health must invest in the scientific and professional capacity necessary both locally and provincially to provide meaningful expertise and advice to health care facilities and institutions. For long-term issues, protocols, policies and directives, the province has a tremendous resource in the Provincial Infection Diseases Advisory Committee (PIDAC),[145] with its multi-disciplinary approach and

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145. PIDAC's Main Committee consists of the following members:

Co-Chairs

Dr. David Williams	Medical Officer of Health – Thunder Bay District Health Unit
Dr. Dick Zoutman	Director of the Joint Infection Control Service Chief of the Joint Microbiology Services Attending Physician, Infectious Diseases Service Kingston General, Hotel Dieu, and St. Mary's of the Lake Hospitals and the South Eastern Ontario Health Sciences Center

Members

Anne Bialachowski	Infection Control Practitioner Hamilton Health Services Centre, Hamilton General Hospital
Dr. Maureen Cividino	Occupational Health Physician St. Joseph's Hospital, Hamilton
Dr. Gary Garber	Head of Infectious Diseases Ottawa Hospital
Dr. Ian Gemmill	Medical Officer of Health Kingston, Frontenac and Lennox and Addington Health Unit
Dr. Colin Lee	Associate Medical Officer of Public Health Simcoe County District Health Unit Staff Emergency Physician, Royal Victoria Hospital of Barrie
Dr. Anne Matlow	Director, Infection Prevention and Control The Hospital for Sick Children, Toronto

Dr. Chris O'Callaghan	Project Coordinator, NCIC Clinical Trials Group Assistant Professor, Queen's University
Dr. Mary Vearncombe	Medical Director, Infection Prevention and Control Sunnybrook and Women's College Health Sciences Centre

Ex Officio

Dianne Alexander	Manager, Policy Planning and Coordination Community Health and Acute Services Divisions Ministry of Health and Long-Term Care
Dr. Karim Kurji	Associate Chief Medical Officer of Health Ministry of Health and Long-Term Care
Dr. Frances Jamieson	Medical Microbiologist Clinical and Environmental Microbiology Department Ministry of Health and Long-Term Care
Dr. Sandy Nuttall	Manager (A) Hospital Policy and Funding Unit Hospitals Branch, Ministry of Health and Long-Term Care
Allison J. Stuart	Director, Emergency Management Unit Ministry of Health and Long-Term Care

Terms of Reference – PIDAC

Mandate

The Provincial Infectious Diseases Advisory Committee (PIDAC) advises Ontario's Chief Medical Officer of Health with respect to the prevention, surveillance and control measures necessary to protect the people of Ontario from infectious diseases. PIDAC provides expert advice relevant to both ongoing and emerging infectious disease issues.

Activities

Activities of PIDAC include the following:

- Reviewing and recommending the revision of provincial standards and guidelines for infection control, including but not limited to comprehensive infection control programs, human resource requirements, infection control training and education, and specific infection control protocols and procedures.

- Preparing advisory statements and bulletins for health care providers, to address new infection control developments or infectious disease issues of provincial significance, as they arise.

- Collaborating with appropriate academic, research and professional bodies in the development of such things as core indicators, audit tools, model infection control protocols or

wide spectrum of expertise, to play the role of advisor and expert. But no advisory committee can supply the operational resources required to respond to immediate problems in the field that require speedy investigation and intervention. As another public health official noted:

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programs, and any other product, tool or document at the request of the Chief Medical Officer of Health.

- Reviewing and advising upon:
  - specific areas of infectious disease control, including surveillance;
  - infection control and infectious disease research priorities;
  - educational programmes about infectious diseases for both health professionals and the public;
  - proposed changes to existing provincial legislation and regulations related to infectious diseases;
  - infectious disease protocols and guidelines;
  - immunization issues;
  - emergency preparedness issues, including emergency response protocols or contingency plans, as the need arises.
- Advising upon relevant infection control and infectious disease policy, at the request of the Chief Medical Officer of Health.
- Reviewing regularly the regulations under the Health Protection and Promotion Act which designate Communicable, Virulent and Reportable Diseases.
- Reviewing regularly communicable disease surveillance protocols published jointly by the Ontario Hospital Association and the Ontario Medical Association, pursuant to subsection 4(2) of Regulation 965 under the Public Hospitals Act.

Membership

Membership of PIDAC includes individuals chosen for their expertise in the areas of epidemiology, public health, infection control, medical microbiology, adult infectious disease, paediatric infectious disease, occupational health and safety, zoonotic disease and primary care, as well as Ministry of Health and Long-Term Care representatives (ex officio).

Members are appointed to PIDAC in writing for a three-year term by the Chief Medical Officer of Health. Sitting members may be reappointed for additional terms of three years each. After ceasing to be a PIDAC member, an individual may serve as a member of a subcommittee or on a working group as requested.

> … certainly within public health there is a level of expertise and we may not know all the ins and outs of infection control within the [different hospital] units, but we know if there's a problem. We can then ensure the protection of the patients that are also entering [a hospital] who will then subsequently be discharged in 48 hours out back into the community.

Another health expert, asked how to deal with major teaching hospitals whose level of infectious disease expertise may surpass that of public health, said:

> My response to that would be work towards the majority. We have five or six major centres in this province where they probably have an infection control person who is world renowned and knows a hell of a lot more than just about any other person. But we also have, if you want to include all the long-term care facilities that these guys have to deal with, hundreds of facilities out there, most of which have someone who has got sixteen hours out of grad school under their belt and they have been thrown into an infection control management position and quite honestly if the academic centres want to complain about having a two or three years out of grad school person come in and point fingers, let them complain. They might not be happy to hear me say that but you have to work towards what is out there and the majority of the situations are really poor or lacking or needing direction in the kind of programmes going on and I think we need to look at the larger population needs as opposed to the academic science centres.

SARS demonstrated that hospitals and other health care facilities are not isolated institutions operating on their own. Events that occur in one hospital may have implications for the broader public health. In those cases, public health must have the knowledge and power to monitor and, where necessary, intervene to ensure that the protection of the public is paramount.

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to include powers similar to those set out in Quebec's *Public Health Act*, to allow for early intervention and investigation of situations, not limited to reportable or communicable diseases, that may pose a threat to the health of the public.**

Case Classification

During SARS, the classification of cases as suspect or probable was the responsibility of local medical officers of health. Since SARS was a reportable disease under the *Health Protection and Promotion Act*, physicians and hospitals were legally required to report new cases to the local medical officer of health.[146] The local medical officer of health, in turn, had a corresponding duty under the Act to report new cases to the province,[147] as either a probable or suspect case of SARS. This was a heavy burden because of the impact of a mistake. Missing a case could lead to further spread of the disease. A false-positive diagnosis, on the other hand, could unnecessarily close hospitals, schools, public buildings and other workplaces and quarantine large numbers of people. It could also have consequences on the world stage where the World Health Organization was closely monitoring the situation in Ontario.

Because SARS was such a difficult disease to diagnose, because there were no reliable lab tests, and because knowledge about the disease was rapidly evolving on a daily basis, there were disagreements from time to time between the reporting institution and public health officials as to whether a particular case was a case of SARS. It was critical that each SARS case be recognized and reported. It was equally vital that every non-SARS respiratory infection not be classified as SARS simply as a precaution.

In May 2003, a central "adjudication" system under the apparent authority of the Chief Medical Officer of Health sprang up in an attempt to resolve disputes over classification of cases. The Commission described the adjudication system and the concerns surrounding it, in the Commission's first interim report, under the heading "Lack of Transparency:"

> There clearly was a need to ensure accuracy and consistency of classification and reporting of cases. Having regard for the challenges of making a correct diagnosis, it made sense to set up a case review system to assist local medical officers of health by giving them access to SARS experts. Although well meaning, the adjudication system lacked clear lines of accountability and in particular it lacked transparency.

146. Pursuant to s. 25(1) and 27(1) of the *Health Protection and Promotion Act*.
147. Pursuant to s. 31(1) of the *Health Protection and Promotion Act*.

First, the adjudication system appeared to supplant the decision-making of the local medical officers of health. There was no explanation why, well over a month into the outbreak, the adjudication process was suddenly imposed.

Second, the adjudication system was not clearly defined or explained. A May 2nd memorandum from Dr. D'Cunha, the Chief Medical Officer of Health, to all medical officers of health and associate medical officers of health simply stated:

> Effective immediately, all new, potential "probable cases" of SARS require adjudication by the POC.
>
> If a potential probable case is identified in your jurisdiction or circumstances would indicate reclassification of an existing suspect case to a probable case, you are to contact [name and number of contact person] to make arrangements for a chart review.
>
> Please be prepared to forward by courier the copies of all relevant information, including clinical information and copy/s of x-ray/s to the infectious disease consultant on call that day.
>
> Thank you for your cooperation.

It was unclear in the memo how the adjudicators were chosen, or why they were best qualified to make decisions. While the name and telephone number of a contact person were provided in the memo, many medical officers of health did not know the person and were unfamiliar with their qualifications, position, role, and authority. Moreover, they did not know who would receive any confidential personal health information about a possible SARS case, where this information would go, how many people would have access to it and whether they had a right to it. The local medical officer of health did not know what would happen if they did not accept the advice of the adjudicator or who had the final call. The local medical officer of health did not know who would be accountable and bear the ultimate legal responsibility if they changed their initial classification of a case based on advice given through the adjudication process.

How the adjudication system was to be implemented was unclear. Was it

to be voluntary in that the medical officer of health could resort to it for advice but was not required to do so? Or was it mandatory in the sense that all new SARS diagnoses had to be screened through this process? The use of the word "adjudicate"[148] and the wording of the May 2nd memo suggests that it was to be mandatory. If this was the case, wondered many local medical officers of health, what was the legal authority for the adjudication process?

One medical officer of health described it as follows:

> An adjudication process was introduced that was designed that any listing of a new probable case had to go through a case review by the provincially selected infectious disease specialist. They were to gather all the chart information from the hospital. They would not have the epi information that was in the public health charts on whether this was a case or not – a probable or suspect case, and submit a report in writing to the POC or SOC, it was never described who they would report it to, and then we were supposed to accept this benignly.

The concerns of medical officers of health sometimes rose to serious levels of mistrust. Many were troubled by the fact that the adjudication process was imposed two days after the WHO travel advisory had been lifted. More will be said about the adjudication process and the classification of cases in the final report. Suffice it to say that the lack of transparency in the adjudication system led to confusion over roles and responsibilities and created the perception among some that local medical officers of health were being muzzled by the province.

In a widespread public health system with 37 different local medical officers of health, it makes sense during an infectious disease outbreak to have some central system to ensure as much as possible the accuracy and consistency of local decisions to designate a case as a reportable disease. The difficulty with the adjudication system during SARS comes down again to lack of planning and preparedness. There was no time to plan or consult before imposing a system that inevitably, because it sprang up overnight, attracted all the problems associated with lack of prior consultation and lack of transparency.

148. The Canadian Oxford Dictionary defines adjudicate as: "Act as judge in competition, court, tribunal, etc."

> To avoid this problem in the future the Commission recommends that the respective roles of the Chief Medical Officer of Health and the medical officer of health, in deciding whether a particular case should be designated as a reportable disease, should be clarified and regularized in a transparent system authorized by law.[149]

For many local medical officers of health, the system was suspect, coming months into the SARS outbreak, shortly after the imposition and subsequent lifting of the travel advisory, with little explanation or rationale for the system itself and without transparency in the process or the identity of those who would make the decisions. For example, what expertise did the adjudicator have that made their classification more reliable than that of the local medical officer of health? How the adjudication system was to be implemented was unclear. Was it to be voluntary in that the medical officer of health could resort to it for advice but was not required to do so? Or was it mandatory in the sense that that all new SARS diagnoses had to be screened through this process? If it were mandatory, did the overriding party assume and bear all accountability in the event their decision was wrong? It was unclear under what authority in the *Health Protection and Promotion Act* the Chief Medical Officer of Health could override the discretion of the local medical officer of health? The only answer appears to lie in ss. 86(1) and (2) which provide:

> 86(1) If the Minister is of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, he or she may investigate the situation and take such action as he or she considers appropriate to prevent, eliminate or decrease the risk.
>
> (2) For the purpose of subsection (1), the Minister,
>
> (a) may exercise anywhere in Ontario any of the powers of a board of health and any of the powers of a medical officer of health; and
>
> (b) may direct a person whose services are engaged by a board of health to do, anywhere in Ontario (whether within or outside the health unit served by the board of health), any act,
>
> (i) that the person has power to do under this Act, or

149. The Commission's first interim report, pp. 49-51.

> (ii) that the medical officer of health for the health unit served by the board of health has authority to direct the person to do within the health unit.

But this is an awfully blunt tool. In a widespread public health system with 36 different local medical officers of health, it makes sense during an infectious disease outbreak to have some central system that ensures as much as possible the accuracy and consistency of local decisions to designate a case as a reportable disease. Furthermore, not all medical officers of health may feel that they have sufficient expertise about a particular disease to classify a case. Consider the case of SARS. During March, April, May and June of 2003, there were a number of brave and dedicated physicians in the greater Toronto area had been involved in the diagnosis and care of many SARS patients. Had SARS spread to a smaller community outside the greater Toronto area, the physicians in that community, including the local medical officer of health, could undoubtedly have benefited from the depth of their colleagues' experience and knowledge. In such a case one might expect that the Chief Medical Officer of Health would intervene and assist or ensure that the local medical officer of health had the benefit of the expertise available from outside their jurisdiction.

But the process by which this would occur must be clearly established in advance and it must be clear how it may be initiated. The respective roles of the Chief Medical Officer of Health and the medical officer of health, in deciding whether a particular case should be designated as a reportable disease, should be clarified and regularized in a transparent system authorized by law. As one submission to the Commission stated:

> There needs to be clarity with respect to who has authority to designate cases of infectious disease in an outbreak situation; what lines of authority are in such instances; and who has the responsibility for making the final determination.

It is unlikely that the power and process by which cases are classified will become an issue on a day to day basis. However, should an outbreak of an infectious disease occur, the same issues that arose during SARS regarding the classification of cases will undoubtedly surface again. Now, in the aftermath of the outbreak, is the time to address the issue and implement a clear process should the need arise to adjudicate the classification of cases in the future.

Recommendation

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to clarify and regularize in a transparent system authorized by law, the respective roles of the Chief Medical Officer of Health and the medical officer of health, in deciding how a particular case should be classified.**

Directives

During SARS, directives were issued to hospitals and other health care providers under the signature of the Chief Medical Officer of Health, Dr. D'Cunha, and the Commissioner of Public Safety and Security, Dr. Young.[150] They differed from orders under s. 22 of the *Health Protection and Promotion Act* in that they were issued across the province, broadly targeting hospitals and other health care providers. They were not issued based on individual criteria and circumstances, but rather they were general directives to health care providers that required particular procedures and precautions in the management of SARS cases and the prevention of its spread.

While many privately questioned the authority of either group to make blanket orders to hospitals and other health care facilities, regardless of whether they met the criteria for an order under s. 22 of the Act, for the most part health care facilities and hospitals complied, leaving aside legal uncertainty in the spirit of cooperation. Post-SARS, directives have continued to be issued directing health care facilities on issues ranging from infection control to surveillance and case management.

Even now that SARS is over, the question remains: under what legal authority were these directives issued and under what authority are they continued and replaced by new directives?[151] Many directives were issued across the board to all hospitals

150. For example: Directive 03-01, Directives to all Ontario Acute Care Hospitals, April 1, 2003; Directive L03-03, Directives to all Ontario Non-Acute Care Facilities for Admissions and Transfers from Hospitals of Non-SARS Patients, April 11, 2003.

151. For example: Directive PHCO03-01, Directives to all Pre-Hospital Care Providers and Ambulance Communications Centres Regarding Management of Patients with Possible Communicable Diseases Including SARS under Outbreak Conditions, December 7, 2003; Directive HR04-13, Directive to all Ontario Health Care Facilities/Settings for High-Risk-Aerosol-Generating Procedures Under Outbreak Conditions, April 15, 2004.

whether they had SARS cases or were even within the greater Toronto area. How would those hospitals without SARS cases, remote from the greater Toronto area, fit the requirement under s. 22 that a "communicable disease exists or there is an immediate risk of an outbreak of a communicable disease in the health unit"? Legal arguments can be made for and against the authority of the Chief Medical Officer of Health to issue such directives under s. 86 of the *Health Protection and Promotion Act*. It may be that a generous reading of the *Health Protection and Promotion Act* could support the legal authority for the directives issued to hospitals during and after SARS.

There is too much at stake to leave this vital issue to a debate between lawyers about strict and generous interpretations of the *Health Protection and Promotion Act*. The law must be clear. The Chief Medical Officer of Health must have the clear power to issue directives to health care facilities and institutions on issues related to the prevention and control of infectious diseases to ensure a uniform and adequate standard of public health protection within the health care field as a whole. One undetected or unreported case of an infectious disease may have disastrous consequences for the public's health. One health care facility with substandard procedures or poor infection control could be the site where the index patient of a new disease seeks treatment and spreads the deadly virus. The province, through the Chief Medical Officer of Health after appropriate consultation with the appropriate experts and health care communities, must have the authority to direct and ensure an appropriate level of institutional protection against infectious disease.

The Chief Medical Officer of Health must be able to issue directives on a broad range of issues in respect of the prevention and control of infectious diseases, applicable across the province or directed at specific types of institutions or specific areas of the province. One public health official noted the importance of this power:

> … there have been instances from time to time when a piece of contaminated equipment has been identified or a manufacturer's malfunction has been identified and it can't be properly sterilized and that's only discovered after the fact. And it would be really helpful to have clear authority from the Chief Medical Officer of Health in those instances to issue directives, rather than the present way of working through the bureaucracy in a way that is not efficient.

It is imperative that hospitals and other health care institutions, both private and public, have clear direction as to the legal authority of the directives and the potential consequences of noncompliance. As one hospital wrote the Commission:

> Under the *Public Hospitals Act*, a hospital must be governed by a board of directors, who have certain enumerated responsibilities and duties, in addition to the broad common law duty to govern in the best interest of the hospital corporation. Given this model of hospital governance, it may be expected that hospital board members would query directives emanating from a central body, particularly where such directives require the hospital to implement new services, discontinue existing services, or completely reorganize the delivery of such services. Therefore, any special health emergency legislation that provides for a centralized authority, external to hospitals, with the power to issue directives, must also make clear the legal force of such directives and the consequences to members of the health care sector for departing from them.

Accountability requires that all directives be issued under one single authority. As one hospital said:

> During a declared Provincial Emergency, a single authority should be designated for the purpose of issuing guidance to health care organizations. Each action communicated to health care organizations by this authority should be clearly labelled as to whether the action is mandatory, recommended or discretionary.

The Commission recommends that all directives be issued under the signature of the Chief Medical Officer of Health. The independence and medical expertise associated with that office make it the best single source of directives. The directives of the Chief Medical Officer of Health would of course be informed by the best advice of other health care professionals and medical experts. But at the end of the day the directives come under the signature of the Chief Medical Officer of Health alone and the holder of that office bears full accountability.

The power to issue directives is distinct from the power to issue orders under s. 22 of the Act. The power to issue directives should provide explicitly that it does not derogate from the existing power under s. 22.

To support this enormous responsibility it is essential that the Chief Medical Officer of Health have the scientific support and resources to administer a timely system of directives. These directives must reflect the best scientific advice and the best operational advice on how they should be organized and expressed to make them understandable and practical in the field. The directive system used during SARS was hampered by the fact that it was thrown together quickly without the time or

resources necessary to ensure that the directives made immediate sense to those administering them in the emergency rooms, hospital wards and medical floors of the hospitals. It would be unfair and dangerous to assign this task to the Chief Medical Officer of Health without the resources to carry it out. Should this occur, the Commission would expect that the only recourse available to the Chief Medical Officer of Health would be to exercise her independence and speak out publicly to alert the public and health care providers of the situation and the clear risk that such an event would pose to the public's health.

As noted above it is vital to ensure that the directives are not only medically sound but that they are also capable of being followed in a practical manner. The Commission has heard repeatedly from various members that the directives sent during SARS and post-SARS are lengthy and unwieldy for practitioners. As Dr. Larry Erlick of the Ontario Medical Association said in the Commission's Public Hearings:

> The directives that were produced by the provincial operations center or POC during the height of the emergency, suffered immeasurably from a lack of simple practicality. These directives did not work from a hands-on clinical perspective. The disparity between what will function academically and practically during an emergency became obvious in these directives.[152]

One physician provided a stark example to the Commission of a directive that spanned over many pages, which the chief of staff at his hospital had to reduce to one page, so that emergency room physicians could review and absorb the main message in a timely fashion. As he described it to the Commission:

> Here are current directives for respiratory illness during emergency [holds up thick document]. And here's what our Chief of Emerge did when trying to sort out what to do [holds up one sheet of paper]. When we get a directive from the MOHLTC it is pages and pages of stuff and buried in there is what is important. Practicing physicians cannot cope with this. It is too much. These are final ones, dated March/04, not the kinds we were getting in March and April 03 which where changing all the time. I cannot read that in less than one hour and make sure I've got it straight. When there is a central body that wants to give directives that central body, whatever it is, whoever makes directives, there has to be a

152. SARS Commission, Public Hearings, September 29, 2003.

> receiving person for all the different types of professionals, a receiving nurse or receiving community based physician, who is responsible for rewriting them in the language of receivers. This one page document from the Chief of Emerge works for me. It speaks my language. But to a public health nurse it won't mean anything. I don't know who can read the directives well. I can do it if I take an afternoon off and have no distractions. But it is nuts for every single practicing physician in the community to have to do that. What a waste of resources. It is appropriate to have various receiving leaders for whom the directive is designed, area experts to rewrite directives in the receivers' language because we all use different language, then show it to the decision makers and say is this what that says, and then use it.

Another hospital wrote:

> If directives are to be the mechanism for the centralized authority to direct the activities of the health care sector during an emergency, such directives should be written in clear and unambiguous language so that the recipients are equally clear as to the measures that are to be taken, and whether the directives are permissive or mandatory.

It was an incredible waste of time and energy during SARS that each institution had to take the directives and translate them individually into accurate messages that their staff could quickly learn and retain.

The Commission recommends the appointment of a working group comprised of health care professionals from various institutions who are tasked, and paid, to translate the directives into a form that can be understood and applied by staff, without altering the content of the message. The Commission recommends further the development of an educational programme to ensure that everyone affected by the directives knows how they work, what they mean and how they should be applied. There is often room for different interpretations of medical directives and it is essential that they be applied consistently to ensure that the hospitals throughout Ontario take the same message and apply it in the same way. This group would be tasked with the additional responsibility of overseeing the education of health care professionals about the directives, to ensure that regardless where the health care institution was situated, the directives were being applied consistently.

It is not enough to ensure that the directives are medically sound and are vetted to make them understandable and workable in the field. Understanding and workabil-

ity require active feedback machinery. Even the most exquisitely crafted directives require a regular reality check to ensure they are properly understood and practically workable in the field and that they are in fact clear and manageable. The enormous experience and wisdom of the nurses and doctors and other health care workers in the field will be wasted if not incorporated into a simple feedback system driven by those whose job it is to make the directives work in practice.

As Dr. Larry Erlick of the Ontario Medical Association told the Commission:

> Another area of deep concern was that POC was established with little or no capacity to hear feedback or suggestions from affected stake-holders. On some occasions, only when we refused to distribute confusing or incorrect directives, were we finally able to get a hearing to our concerns and make suggestions for improvement.[153]

On a cautionary note, it must be understood that the directives are addressed to specific public health concerns and expressed in a general way that applies to health care facilities across the province or, in the case of a limited direction, a substantial number of facilities. The directives represent the minimum that needs to be done to protect public health. The directives do not in any way diminish the standard of care ordinarily required by the circumstances that prevail in any particular institution. The directives represent the floor, not the ceiling, of medical precaution. They do not relieve any institution of the obligation to take further precautions where medically indicated. As one hospital wrote to the Commission:

> Recommendations from the Minister should represent the minimum standards in an evolving situation when it is not always clear what the minimum should be. For example, it is now known that SARS is airborne as well as droplet and contact mode of transmission. Therefore institutions should be required to meet the recommendations of the Provincial Medical Officer of Health, but free to implement additional precautions as deemed necessary in such situations, for example use of two gowns versus one gown, a hood versus a head covering etc.

Another cautionary note is that for the directives to be effective there must be some machinery of enforcement. Any enforcement mechanism to be workable requires consultation with, and input from, health care facilities and private clinics, as well as a

153. *Ibid.*

means by which the Public Health Division can audit those to whom the directives are targeted to ensure compliance. The Commission therefore recommends that the Ministry of Health and Long-Term Care consult the affected health care communities with a view to developing effective machinery to enforce directives.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health to issue directives to hospitals, medical clinics, long-term care facilities, and all other health care providers, private or public, in respect of precautions and procedures necessary to protect the public's health. All directives should be issued under the signature of the Chief Medical Officer of Health alone.**

- **The Ministry of Health and Long-Term Care appoint a working group of health care professionals from various institutions who are tasked, and paid, to translate the directives into a form that can be understood and applied by staff, without altering the content of the message. The Commission recommends further the development of an educational programme to ensure that everyone affected by the directives knows how they work, what they mean and how they should be applied.**

- **The Ministry of Health and Long-Term Care, in consultation with the affected health care communities, develop feedback machinery driven by health care workers in the field, to ensure the directives are clear and manageable from a practical point of view in the field.**

- **The *Health Protection and Promotion Act* and the directives provide explicitly that they in no way diminish the procedures and precautions required by the circumstances that prevail in any particular institution, that they represent the floor, not the ceiling, of medical precaution, and do not relieve any institution of the obligation to take further precautions where medically indicated.**

Power to Detain

Freedom from arbitrary detention is a social value of superordinate importance. Detention must be clearly authorized by law and accompanied by safeguards. It has proved necessary to grant, sparingly, powers of detention and arrest in cases clearly required by the public interest, such detention to be followed by an early opportunity to challenge the detention in a court of law. The realities of the risk posed by a virulent disease require a narrow zone of power to detain individuals who present a clear danger to the public's health. While such power must be protected with legal safeguards, the community cannot shirk its obligation to detain, however briefly it may be necessary, those who threaten the safety of the entire community. The power to detain necessarily carries with it the power to arrest. The power to detain temporarily an infectious person, unless ultimately backed up by the power to arrest in those rare cases where the detainee refuses to cooperate, has no practical force.

The issue of detention arises in a number of possible scenarios:

- Brief detention for the purpose of identification;
- Detention for the purpose of decontamination; and
- Detention for the purpose of examination, treatment, isolation or to prevent the spread of disease.

Currently, the *Health Protection and Promotion Act* only deals with the third scenario, detention for the purposes of treatment or isolation in respect of a virulent disease. Under s. 35(3) of the Act, a judge may order a person who fails to comply with an order of a medical officer of health detained:

> 35(3) In an order under this section, the judge may order that the person who has failed to comply with the order of the medical officer of health,
>
> (a) be taken into custody and be admitted to and detained in a hospital or other appropriate facility named in the order;
>
> (b) be examined by a physician to ascertain whether or not the person is infected with an agent of a virulent disease; and
>
> (c) if found on examination to be infected with an agent of a virulent

> disease, be treated for the disease.

An order under s. 35(3) can be made only for noncompliance with an order made under s. 35(2) in relation to a communicable disease that is virulent. Subsection 35(2) provides:

> An order may be made under subsection (3) where a person has failed to comply with an order by a medical officer of health in respect of a communicable disease that is a virulent disease,
>
> (a) that the person isolate himself or herself and remain in isolation from other persons;
>
> (b) that the person submit to an examination by a physician;
>
> (c) that the person place himself or herself under the care and treatment of a physician; or
>
> (c) that the person conduct himself or herself in such a manner as not to expose another person to infection.

One gap in the law is the lack of machinery for the rare situation where public health authorities need urgently to take the name and address of someone who may have come into contact with an infectious disease. Take for instance the closing of a hospital because an infectious disease outbreak within the hospital appears to be running out of control. It is necessary to identify all those leaving the hospital when it is closed. Otherwise there is no way to ensure that they have not become carriers into the community of a deadly disease. Most people leaving a hospital in these circumstances will cooperate and provide to public health authorities their name and address and telephone number. But for those few who refuse to cooperate, those who decline to stop on their way out, and decline to give their name and address for the purpose of contact tracing, clear authority is required to enforce cooperation. There is now no authority to stop and require identification from people leaving places of infection.

Without this authority it may be impossible to ensure the appropriate follow-up of those who may spread a deadly infection to the community, and indeed to their own families.

It would better protect the public if public health authorities have the power to detain briefly and to require identification from anyone leaving a place of infection or

suspected infection. One observer described the importance of this temporary power of detention which would have to be backed up with the possibility of arrest and police assistance in cases of non-cooperation:

> The idea is not so much to detain them as to make sure you know who was there at any point in time. If they all walk out and scatter and run home you inadvertently expose all their families when we have nothing sorted out in terms of who was there. It takes sixteen times as long to sort out who was there, if they don't identify themselves before they leave.

The Commission therefore recommends that the *Health Protection and Promotion Act* be amended to provide authority to public health officials to detain temporarily for the purpose of identification anyone who refuses to provide their name and address and telephone contact information when required to do so for the purpose of identifying those who are leaving or have been in a place of infection, this power to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.

The next legal gap to consider is the lack of any authority to detain for the purpose of decontamination.

Dr. Henry, testifying before the Justice Policy Committee, described the need for this power in relation to an anthrax threat. She stated:

> I think we need to look at some authorities that we may need to have. One of the issues we ran into when we were dealing with suspicious packages – and you may notice that we haven't actually evacuated Queen's Park for quite some time because we put together a very coordinated response to this. But the questions arise. Somebody receives a threat in an office, a credible threat with a powder in it; they're covered in white powder and they panic and they want to go home. We currently have no authority to detain that person: the police do not and the medical authority does not. We can probably fake it and try and convince them to stay, but they could pose a danger to other people. They don't fit into the communicable disease sections because they're not actually sick with the disease, and they don't fit into the police sections at the moment. So we need to think about these situations."[154]

154. Justice Policy Committee, Public Hearings, August 18, 2004, p. 149.

Similarly, public health officials have noted the need for a power akin to the quarantine power, to decontaminate individuals or groups who may have been exposed to a health risk that poses a threat to themselves or to the public. Classic examples include exposure to a white anthrax-like powder or nuclear contamination. Dr. Basrur told the Justice Policy Committee:

> … if you have a white powder exposure and a whole lot of people covered with stuff, and you don't want them all heading home because they're scared, and some of them go on the subway and some go to the parking lot, you need an ability to detain them, but it's not necessarily an infectious agent that they've got on them. They need to be decontaminated, counselled, their whereabouts identified, and then sent home, with follow-up.[155]

The Ministry of Health also pointed out the need for authority in respect of:

> Decontamination in emergency situations, where such action is considered appropriate (decontamination orders are not currently found under the Act, but such procedures may be required for individuals or large groups in the event of a nuclear disaster.)[156]

Like isolation orders and treatment orders, the power to decontaminate must include the power to detain at least temporarily for the purpose of a court hearing, those who refuse voluntary decontamination. Otherwise, an exposed person could simply refuse, walk away, and expose countless members of the public. However, unlike the power to detain temporarily for the purposes of identification or to detain for the purposes of obtaining a s. 35 order, the power to detain for decontamination purposes implies that the power to decontaminate is part and parcel of the detention. But what does it mean to decontaminate someone? The U.S. Army's "Guidelines for Mass Casualty Decontamination during a Terrorist Chemical Agent Incident" describes the following decontamination process:

> Decontamination by removing clothes and flushing or showering with water is the most expedient and the most practical method for mass casualty decontamination. Disrobing and showering meets all the

155. *Ibid*, p. 160.

156. Letter to Mr. Doug Hunt, Q.C., Commission Counsel, from Mr. Phil Hassen, Deputy Minister of Health and Long-Term Care, August 4, 2004. See Appendix H to this Report.

> purposes and principles of decontamination. Showering is recommended whenever liquid transfer from clothing to skin is suspected. Disrobing should occur prior to showering for chemical agents; however, the decision to disrobe should be made by the Incident Commander based upon the situation. Wetting down casualties as they start to disrobe speeds up the decontamination process and is recommended for decontaminating biological or radiological casualties. However, this process may:
>
> - Force chemical agents through the clothing if water pressure is too high.
>
> - Decrease the potential efficacy of directly showering skin afforded by shear forces and dilution.
>
> - Relocate chemical agent within the actual showering area, thereby increasing the chance of contamination spread through personal contact and shower water runoff.
>
> The MCDRT recommends that victims remove clothing at least down to their undergarments prior to showering. Victims should be encouraged to remove as much clothing as possible, proceeding from head to toe. Victims unwilling to disrobe should shower clothed before leaving the decontamination area. It is also recommended that emergency responders use a high volume of water delivered at a minimum of 60 pounds per square inch (psi) water.[157]

This is clearly more intrusive than asking someone for identification or detaining someone for a defined period of time pending a court order for treatment. The power to decontaminate must be considered separate and apart from the power to detain for such purposes. It must be clear what decontamination means, who can order it and under what circumstances, and the nature of the consequences for refusal. Like the power to order treatment, forcing someone to undergo decontamination should only be done pursuant to judicial authorization.

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157. U.S. Army Soldier and Biological Chemical Command (SBCCOM), "Guidelines for Mass Casualty Decontamination During a Terrorist Chemical Agent Incident," January 2000.

Similarly, the following passage, taken from Jane's Chem-Bio Handbook,[158] a well-informed, practical handbook for first-responders on the scene of a suspected bioterrorist attack, underlines the operational necessity of being able to detain and decontaminate people:

> Some victims may become agitated and fearful and may attempt to either leave the exclusion zone (the zone containing special response personnel in PPE and victims, which is cordoned off from public access. Also known as the hot zone.) or approach, or even contact, rescue personnel. Victims must be contained if risk of further contamination is to be prevented.[159]

The power to detain is necessary for those who do not agree voluntarily to the decontamination process. Otherwise an infectious person could simply refuse, walk away, and spread the contaminant. And the power to detain for decontamination, like the power to detain for identification, must have the ultimate backup of an arrest power and police assistance if it is to work on those who refuse to cooperate. Because decontamination is akin to a medical procedure it must, in those cases where consent is refused, operate in conjunction with a legal process to secure judicial authorization before a person may be compelled to submit to decontamination. The power to detain and isolate someone pending such judicial authorization is very different from the power to force someone to undergo decontamination, and the two issues must be dealt with separately under the *Health Protection and Promotion Act*.

It must again be emphasized that the solution to public health emergencies is voluntary cooperation, not coercive legal powers. Coercive legal powers will never work in the face of significant non-cooperation. The key lies not in the coercive powers required for ultimate backup, but in the initial work of emergency responders in informing people what is medically required and why it is in their own best interest to cooperate. No matter how strongly the statutory authority for such a power is worded, it will be impossible to enforce without the support and cooperation of those directly affected.

The Commission recommends that the power to detain for decontamination and to decontaminate by court order in the absence of consent, should come under the day to

158. Sidell, Frederick R, Patrick, William C, Dashiell Thomas R, Alibek, Ken, Layne, Scott, *Jane's Chem-Bio Handbook* (Jane's Information Group Alexandria, Virginia: 2002).
159. *Ibid*, p. 17.

day powers of the *Health Protection and Promotion Act* and not be limited to a power available only during a declared provincial emergency. A problem that requires decontamination may emerge suddenly before an emergency is even contemplated, as in an unexpected terrorist attack by weaponized smallpox or anthrax.

In addition to amending the *Health Protection and Promotion Act* to allow for the power to detain temporarily for the purposes of identification and the power to detain for decontamination, the provisions, which now authorize detention for the purposes of examination, treatment, isolation or to prevent the spread of disease, need to be strengthened.

As noted above, s. 35 allows a court to order detention of a person who refuses to submit to an examination, treatment, isolation or to conduct themselves in such a way so as to avoid the spread of disease. The power can only be exercised by court order. What do you do with a virulently infectious person in an area thronged with people on a Saturday evening, who refuses to go for treatment? A medical officer of health, under s. 22 of the *Health Protection and Promotion Act,* could order the person to submit to an examination, treatment and to isolate themselves. But if the infectious person thumbs his nose at the authorities, they can do nothing under the present law absent a court order under s. 35 of the Act. There is no power to detain the person while an application is being made to court. The person can continue to infect the throng or can wander away and disappear and infect others. Under the present law nothing can be done to stop them. This is unsatisfactory.

The medical officer of health requires the authority to order a person temporarily detained, for the purposes of isolation or to prevent the spread of disease, pending a court hearing under s. 35. The detention would be temporary, requiring that the person be brought before a justice within 24 hours, to ensure their detention is justified and that they are given their due process rights. The order would be available only where a person refuses to comply with the s. 22 order. The power to detain, like the other powers to detain discussed above, must be backed up by the power to arrest in the case of non-cooperation and the power to invoke police assistance. The power should be valid whether made in writing or orally by a medical officer of health.

It is important to note that this temporary power of detention would not include any power in relation to treatment. It is a key component of our law that no person shall be treated without their consent, without a court order. To obtain such a court order there must first be a hearing, which meets all the rules of natural justice. That fundamental protection must apply and should not be diluted in any manner.

While the power to detain a person, however temporarily, amounts to a violation of their liberty, such a power may be found to be reasonable and justified where it is necessary to protect the public from a virulent disease. It must come with strong protection, to make it as temporary as possible, pending a court order. It should only be available to a medical officer of health and the Chief Medical Officer of Health.

All of these recommended powers involve the ultimate assistance of the police in those cases where there is non-cooperation to the point where police assistance is required. There is no greater source of potential enforcement problems than the boundary line between two separate agencies who are required suddenly and without warning to cooperate smoothly in the face of an unexpected crisis. It is therefore of the utmost importance that police and public health authorities develop protocols, education packages, and training exercises to ensure smooth and effective cooperation.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order temporarily detained for identification any person who refuses to provide their name, address and telephone contact information when required to do so for the purpose of identifying those who are leaving, or have been in a place of infection. The detained person, unless immediately released, must be brought before a justice as soon as possible and in any event within 24 hours for a court hearing. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.**

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order the temporary detention of, for the purpose of a court hearing, any person suspected of having been exposed to a health hazard, and who refuses to consent to decontamination. The detained person must be brought before a justice as soon as possible and in any event within 24 hours. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.**

- **The *Health Protection and Promotion Act* be amended to authorize the Chief**

Medical Officer of Health or a medical officer of health to order the temporary detention of anyone who there is reason to suspect is infected with an agent of a virulent disease, for the purposes of obtaining a judicial order authorizing the isolation, examination or treatment of the person, pursuant to s. 35 of the *Health Protection and Promotion Act*. The detained person must be brought before a justice as soon as possible and in any event within 24 hours. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.

Power to Enter A Dwelling-House

Public health officials are of the view that in some cases they require the power to enter a dwelling-house. In their view, this power is important to enforce orders under the Act.

Most public health officials agree that the *Health Protection and Promotion Act* should be amended to include a power of entry when enforcing a judicial order to apprehend made after a court application under s. 35 of the Act. As one medical officer of health described the problem to the Commission:

> Public health agencies face the difficulty of trying to enforce an Order under HPPA s. 35, authorizing a police service to "locate, apprehend and deliver" a person with an infectious disease to a hospital named in the Order. The specific difficulty is the lack of any provision in the HPPA authorizing the police to enter into a private dwelling for the purpose of apprehending and delivering the subject of the Order to a hospital. We have become aware that, in the absence of any such authorizing provision, the police take the view that they do not have any powers of entry. In a situation where a person is the subject of a s. 35 Order to locate, apprehend and deliver him or her to a hospital for treatment in accordance with the terms of the Order, the lack of police powers of entry means that in order for the apprehension of the subject individual to occur, inordinate resources must be spent by the public health agency or the police on surveillance, etc. to identify an opportunity when the subject of the Order can be apprehended outside of whatever private dwelling they may be located in. As well, there may be delay and concomitant opportunity for the subject of the Order to evade apprehension. The resulting opportunity to spread the infectious disease sought to be treated pursuant to the s. 35 Order is obvious.

This is not a remote hypothetical situation. Public health officials reported to the Commission the example of a woman in a major urban center in Ontario who was infected with tuberculosis (TB). Public health officials issued a s. 22 order against the woman, requiring that she isolate herself and seek treatment. She refused to comply. They obtained a court order under s. 35 of the *Health Protection and Promotion Act*, authorizing that she be apprehended, isolated and treated. Because the order did not authorize entry to her home, public health officials had to sit outside her home waiting for her to leave. In the meantime, she continued to reside with other family members in the house, while she was infectious. Public health officials were unable to constantly maintain surveillance on the home. She managed to leave her home, travel to the airport and leave the country, exposing countless other people on her journey. She was later apprehended while attempting to re-enter Canada.

Had the court been able to authorize as part of the s. 35 order entry to her home to apprehend her and ensure she was isolated and treated, the risk she posed to countless people in the community and abroad could have been prevented.

The references to rights of entry are contained in Part V of the *Health Protection and Promotion Act*. Section 41 of the Act authorizes public health inspectors, inspectors, a medical officer of health or a person acting under the direction of a medical officer of health, to enter any premises, other than a private dwelling, to enforce the Act, exercise a power or carry out a duty under the Act, or carry out a direction given under the Act.[160] Subsection 43(1) authorizes issuance of a warrant permitting entry to a

160. Subsection 41(1) provides:

> Rights of entry and powers of inspection
>
> Interpretation persons
>
> The persons referred to in subsections (3) to (5) and (8), (10) and (11) are the following:
>
> 1. An inspector appointed by the Minister.
>
> 2. A medical officer of health.
>
> 3. A public health inspector.
>
> 4. A person acting under a direction given by a medical officer of health.
>
> Interpretation purposes
>
> (2) The purposes mentioned in ss. (3) to (5) and (11) are the following:

premises for the purpose of enforcing the Act or Regulations, and for exercising a power or carrying out a duty or direction under the Act. Subsection 43(1) provides:

> Where a justice of the peace is satisfied on evidence upon oath,
>
> (a) that there is reasonable and probable grounds for believing that it is necessary,
>
> (i) to enter and have access to, through and over any premises,
>
> (ii) to make examinations, investigations, tests and inquiries, and
>
> (iii) to make, take and remove samples, copies or extracts related to an examination, investigation, test or inquiry,
>
> or to do any of such things, for the purpose of this Act, the enforcement of any section of this Act or the regulations, the exercise of a power or the carrying out of a duty under this Act or the regulations or the carrying out of a direction given under this Act; and
>
> (b) that an inspector appointed by the Minister, a medical officer of health, a public health inspector or a person acting under a direction given by a medical officer of health,
>
> (i) has been denied entry to the premises,

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1. The purpose of this Act.

2. The enforcement of any section of this Act or the regulations.

3. The exercise of a power or the carrying out of a duty under this Act or the regulations.

4. The carrying out of a direction given under this Act.

Entry

(3) A person mentioned in s. (1) may enter and have access to, through and over any premises for a purpose mentioned in s. (2).

Private Residence

(7) Subsection (3) is not authority to enter a private residence without the consent of the occupier.

> (ii) has been instructed to leave the premises,
>
> (iii) has been obstructed, or
>
> (iv) has been refused production of any thing or any plant or animal related to an examination, investigation, test or inquiry,
>
> by the occupier of the premises,
>
> the justice of the peace may issue a warrant in the form prescribed by the regulations authorizing an inspector appointed by the Minister, a medical officer of health, a public health inspector and any person who is acting under a direction given by a medical officer of health, or any of them, to act as mentioned in clause (a) in respect of the premises specified in the warrant, by force if necessary, together with such police officer or officers as they call upon to assist them.

While the power contained in s. 43 authorizes entry into "any premises," it confers no explicit authority to enter a private dwelling to apprehend a person. The fact that s. 43(1) does not expressly prohibit such entry into a private dwelling is hardly relevant because the law requires explicit language to authorize such entry into a dwelling and the courts will not read that power into a statute unless it is expressly conferred. The activities identified in paragraph (a) refer to testing things, removing samples, and accessing premises, not to entry for the purposes of apprehending a person and to doing "any of such things." If the drafters intended this section to contain the power to enter a private dwelling to apprehend a person, one of the most serious of all enforcement actions, one would expect they would have clearly said so. The absence of any reference to apprehending a person strongly suggests that this section is not intended to authorize such an action.

It is questionable whether the authority to enter a private dwelling and apprehend a person is provided in the *Provincial Offences Act*.[161] Section 158(1) allows the issuance of a warrant authorizing entry to any place, but the language of that section speaks to

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161. R.S.O. 1990, c. P-33. Section 158(1) provides:

> Search Warrant
>
> Where a justice is satisfied by information upon oath that there is reasonable ground to believe that there is in any building, receptacle or place,

entry for the purposes of searching for and seizing evidence, not the apprehension of an individual.

These sections, s. 43 of the *Health Protection and Promotion Act*, and s. 158 of the *Provincial Offences Act*, do not clearly authorize entry to a private dwelling and apprehension of an individual who is the subject of an order under s. 35 of the Act. The Court should have the power in appropriate circumstances to authorize entry into a home for the purpose of enforcing a court order to take a person into custody. Given the scarcity of resources available to public health and the other critical demands on the time and resources of police services, neither should be expected to establish around the clock surveillance for an indeterminable amount of time until the person who is the subject of the order decides to leave their home. Under the present system, however, that is the only method available to prevent the person from leaving home and spreading a virulent disease throughout the community. The power to enter a private dwelling to execute an order under s. 35 of the Act is an important one. It must be clearly authorized in the *Health Protection and Promotion Act* so as to avoid legal debate and confusion regarding whether or not the authority exists.

For example, Dr. Henry explained to the Justice Policy Committee how this power would enhance the ability to enforce isolation orders:

> Who has the authority to detain somebody who's not actually sick but might be a hazard, but we don't know? Who has the authority if we have a section 35 order on somebody who is sick with tuberculosis but they are in their private home? Nobody has the right, right now, to go in and actually get them. We can't do that. Should we have that? I don't know. I

(a) anything upon or in respect of which an offence has been or is suspected to have been committed; or

(b) anything that there is reasonable ground to believe will afford evidence as to the commission of an offence,

the justice may at any time issue a warrant in the prescribed form under his or her hand authorizing a police officer or person named therein to search such building, receptacle or place for any such thing, and to seize and carry it before the justice issuing the warrant or another justice to be dealt with by him or her according to law.

Section 100 of the *Health Protection and Promotion Act* provides that anyone who does not comply with an order under the Act is guilty of an offence:

100. Any person who fails to obey an order made under this Act is guilty of an offence

> think those are authorities that need to be looked at very closely in the legislation.[162]

A local medical officer of health proposed a solution as follows:

> In my respectful submission, one way of dealing with this would be to provide police powers of entry into private dwellings in order to exercise the direction from a Court to locate, apprehend and deliver the subject of a s. 35 Order to a hospital. Such powers of entry would not be unique or unusual. For example, s. 36 (5) of the *Children's Law Reform Act* gives the police the power to enter and search any place for the purpose of locating and apprehending a child who has been wrongfully withheld from a parent, and who is the subject of an Order under s. 36. When a CLRA s. 36 Order is made, there are certain guidelines that must be followed by the police with respect to the times when such a power of entry may be exercised.
>
> Certainly, police powers of entry must be authorized by law and exercised judiciously when circumstances require. Certainly, we highly value the concept of a person's home being their castle. However, equally certainly, there are circumstances when public health concerns with respect to mandating treatment and preventing the spread of infectious diseases mitigate in favour of allowing police to enter into a private dwelling to carry out an Order under s. 35. Carefully crafted amendments to the *Health Protection and Promotion Act* could address these competing interests, and might be critical in dealing with any future outbreaks similar to the one we experienced during the SARS crisis.

The need for this amendment is clear.

However, others have submitted to the Commission that there is a need for a broader power of entry, without a warrant or prior judicial authorization, in cases where the medical officer of health has reasonable and probable grounds to believe there is a risk to health due to a health hazard or an infectious disease.

The Ministry of Health in its submission to the Commission proposed the following amendment:

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162. Justice Policy Committee, Public Hearings, August 18, 2004, p. 152.

> Authorizing medical officers of health to enter any premises, including a private residence, without a warrant, where the medical officer has reasonable and probable grounds to believe there is a risk to health due to a health hazard or an infectious disease.[163]

Dr. Basrur, the Chief Medical Officer of Health for Ontario, in her testimony before the Justice Policy Committee, explained the rationale for such a power:

> Finally, extraordinary powers may be needed for a local medical officer of health to enter any premises, including a private residence, without a warrant – and I take a breath when I say this – where he or she has reasonable grounds to believe that a risk to health exists due to a health hazard or an infectious disease, if there is a declared emergency under the Emergency Management Act. By way of a small example that gives you the kind of dilemma we face, on a day-to-day basis we have authority to regulate food premises. Yet you can have a catering operation that operates out of someone's private residence, and the duty to inspect, the right of access to enter those premises where it is also a private home, is not crystal clear. That may just be the way it is in a free and democratic society on a day-to-day basis, but if you're in an emergency situation, you probably want some additional authority to be able to kick in.[164]

Reasonable though this may seem to those with the difficult task of protecting the public against infectious disease, the power to enter a dwelling house without judicial authorization is an extraordinary power. The distinction between the power to enter a home without a warrant and the power to enter a business or factory without a warrant is vital not only in a legal sense but also as a matter of public policy. Mr. Mike Colle, the acting Chair of the Justice Policy Committee, asked the following questions about the right of entry under the *Environmental Protection Act*:

> Could they enter a home without a warrant? This is what came up yesterday. Dr. Young felt that they had no power to enter private property. They would be charged with trespassing. Yet the Ministry of the Environment has already solved the problem.
>
> . . .

163. Letter to Mr. Doug Hunt, Q.C., Commission Counsel, from Mr. Phil Hassen, deputy Minister of Health and Long-Term Care, August 4, 2004. See Appendix H to this Report.
164. Justice Policy Committee, Public Hearings, August 18, 2003, p. 143.

> The question I want clarified is that this is essentially private property, whether it be a plant, a place of business or a residence. I think this is very crucial for our committee, given Dr. Young's presentation yesterday. He felt one of the encumbrances to dealing with an emergency was that they really had no power to trespass or to enter a person's home.[165]

The Supreme Court of Canada in *R. v. Feeney* ruled that warrantless entry of a dwelling house to make an arrest, offended the *Charter of Rights and Freedoms* even in a case where the police were in fresh pursuit of a murder suspect.[166] The courts have recognized however that in cases of "exigent circumstances" a police officer may enter a home without a warrant. Although courts have been reluctant to define "exigent circumstances" in general terms, obvious cases include emergency response to a 911 call suggesting that someone's life is in danger, or entry to a burning house to save an occupant.

After *Feeney,* Parliament amended the *Criminal Code* to provide tightly defined powers to enter a dwelling house without a warrant when there are reasonable grounds to suspect it is necessary to prevent imminent bodily harm or death to any person.[167]

Although rare, cases may arise where a corresponding power is necessary to enter a residence to secure the immediate detention of someone who poses a grave immedi-

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165. *Ibid,* August 4, 2003, p. 43.
166. *R. v. Feeney*, [1997] 2 S.C.R. 13.
167. Section 529.3 provides:

> (1) Without limiting or restricting any power a peace officer may have to enter a dwelling-house under this or any other Act or law, the peace officer may enter the dwelling-house for the purpose of arresting or apprehending, a person, without a warrant referred to in section 529 or 529.1 authorizing the entry, if the peace officer has reasonable grounds to believe that the person is present in the dwelling-house, and the conditions for obtaining a warrant under section 529.1 exist but by reason of exigent circumstances it would be impracticable to obtain a warrant.
>
> (2) For the purposes of subsection (1), exigent circumstances include circumstances in which the peace officer
>
> (a) has reasonable grounds to suspect that entry into the dwelling-house is necessary to prevent imminent bodily harm or death to any person; or
>
> (b) has reasonable grounds to believe that evidence relating to the commission of an indictable offence is present in the dwelling-house and that entry into the dwelling-house is necessary to prevent the imminent loss or imminent destruction of the evidence.

ate risk to the health of others if not detained. However, in the view of the Commission, the power should be a limited one. It is one thing to have these powers to enforce an isolation order under s. 35, where the goal is preventing the spread of infectious disease, but it is quite another to have these powers in respect of other public health activities, such as food safety.

The Commission therefore recommends that the *Health Protection and Promotion Act* be amended to provide for a court to authorize, by warrant, entry into a dwelling, by a medical officer of health or specially designated public health official with police assistance, for the purpose of enforcing an order under s. 35 of the Act.

But the power to enter without a warrant must be limited by conditions analogous to those in the *Criminal Code Feeney* amendments and further limited by a court hearing as soon as possible and in any event within 24 hours.

The Commission therefore recommends that the *Health Protection and Promotion Act* be amended to provide that a medical officer of health or specially designated public health official with police assistance may under exigent circumstances enter a dwelling house for the purpose of apprehending a person where there are reasonable and probable grounds to believe that a basis for a s. 35 warrant exists and reasonable grounds to believe that the delay required to obtain such a warrant might endanger the public's health. The detention must be the subject of a court hearing as soon as possible and in any event within 24 hours.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to provide for a court to authorize, by warrant, entry into a private dwelling, by a medical officer of health or specially designated public health official with police assistance, for the purpose of enforcing an order under s. 35 of the Act.**

- **The *Health Protection and Promotion Act* be amended to provide that a medical officer of health or specially designated public health official with police assistance may under exigent circumstances enter a dwelling-house for the purpose of apprehending a person where there are reasonable and probable grounds to believe that a basis for a s. 35 warrant exists and reasonable grounds to believe that the delay required to obtain such a warrant**

might endanger the public's health. The detention must be the subject of a court hearing as soon as possible and in any event within 24 hours.

Conclusion

As noted at the beginning of this chapter, the *Health Protection and Promotion Act*, which provides the legal machinery for our defence against infectious disease, needs to be stronger. It is the daily powers in the *Health Protection and Promotion Act*, powers of investigation, mitigation, and risk management that prevent public health emergencies from developing. It is these daily powers that require strengthening.

Public health officials, to protect us from disease and to prevent small problems from growing into emergencies, require access to health risk information and the authority, resources, and expertise to investigate, intervene, and enforce.

The powers and safeguards recommended above are necessary to achieve these ends.

Recommendations

The Commission therefore recommends that:

- **The role and authority of public health officials in relation to hospitals be clearly defined in the *Health Protection and Promotion Act* in accordance with the following principles:**
  - **The requirement that each public health unit have a presence in hospital infection control committees should be entrenched in the Act; and**
  - **The authority of the local medical officers of health and the Chief Medical Officer of Health in relation to institutional infectious disease surveillance and control should be enacted to include, without being limited to, the power to monitor, advise, investigate, require investigation by the hospital or an independent investigator, and intervene where necessary.**
- **The Ministry of Health and Long-Term Care, in consultation with the Provincial Infectious Diseases Advisory Committee, and the wider health care and public health communities, define a broad reporting trigger that**

would require reporting to public health where there is an infection control problem or an unexplained illness or cluster of illness.

- **Whether or not a workable trigger can be defined for compulsory reporting, a provision be added to the *Health Protection and Promotion Act*, to provide that a physician, infection control practitioner or hospital administrator may voluntarily report to public health officials the presence of any threat to the health of the population.**

- **The *Health Protection and Promotion Act* be amended to include powers similar to those set out in Quebec's *Public Health Act*, to allow for early intervention and investigation of situations, not limited to reportable or communicable diseases, that may pose a threat to the health of the public.**

- **The *Health Protection and Promotion Act* be amended to clarify and regularize in a transparent system authorized by law, the respective roles of the Chief Medical Officer of Health and the medical officer of health, in deciding how a particular case should be classified.**

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health to issue directives to hospitals, medical clinics, long-term care facilities, and all other health care providers, private or public, in respect of precautions and procedures necessary to protect the public's health. All directives should be issued under the signature of the Chief Medical Officer of Health alone.**

- **The Ministry of Health and Long-Term Care appoint a working group of health care professionals from various institutions who are tasked, and paid, to translate the directives into a form that can be understood and applied by staff, without altering the content of the message. The Commission recommends further the development of an educational programme to ensure that everyone affected by the directives knows how they work, what they mean and how they should be applied.**

- **The Ministry of Health and Long-Term Care, in consultation with the affected health care communities, develop feedback machinery driven by health care workers in the field, to ensure the directives are clear and manageable from a practical point of view in the field.**

- **The *Health Protection and Promotion Act* and the directives provide explicitly**

that they in no way diminish the procedures and precautions required by the circumstances that prevail in any particular institution, that they represent the floor, not the ceiling, of medical precaution, and do not relieve any institution of the obligation to take further precautions where medically indicated.

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order temporarily detained for identification any person who refuses to provide their name, address and telephone contact information when required to do so for the purpose of identifying those who are leaving, or have been in a place of infection. The detained person unless immediately released, must be brought before a justice as soon as possible and in any event within 24 hours for a court hearing. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.**

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order the temporary detention of, for the purpose of a court hearing, any person suspected of having been exposed to a health hazard, and who refuses to consent to decontamination. The detained person must be brought before a justice as soon as possible and in any event within 24 hours. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.**

- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order the temporary detention of anyone who there is reason to suspect is infected with an agent of a virulent disease, for the purposes of obtaining a judicial order authorizing the isolation, examination or treatment of the person, pursuant to s. 35 of the *Health Protection and Promotion Act*. The detained person must be brought before a justice as soon as possible and in any event within 24 hours. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.**

- **The *Health Protection and Promotion Act* be amended to provide for a court to authorize, by warrant, entry into a private dwelling, by a medical officer of health or specially designated public health official with police assistance, for the purpose of enforcing an order under s. 35 of the Act.**

- **The *Health Protection and Promotion Act* be amended to provide that a medical officer of health or specially designated public health official with police assistance may under exigent circumstances enter a dwelling-house for the purpose of apprehending a person where there are reasonable and probable grounds to believe that a basis for a s. 35 warrant exists and reasonable grounds to believe that the delay required to obtain such a warrant might endanger the public's health. The detention must be the subject of a court hearing as soon as possible and in any event within 24 hours.**