

5. Reporting Infectious Disease

It is a cornerstone of our protection against infectious disease that doctors and hospitals and public institutions are legally required to disclose to public health authorities every case of reportable disease. Without knowledge of the prevalence and incidence of TB or SARS, who has it, who may have it, where did they get it, how, from whom, who else may be at risk, public health officials are powerless in the face of infectious outbreaks. Unless cases are reported to public health, it cannot investigate or even be aware of impending danger. Without adequate information the medical officer of health cannot protect the public.

The legal obligation to report infectious disease is a foundation of every system of public health legislation. The legal obligation is necessary not only to encourage reporting but also to ensure that the confidentiality laws, designed to protect patient privacy, do not unintentionally undermine the ability of public health authorities to fight the spread of infectious disease. To express the machinery of obligation in point form:

- The *Health Protection and Promotion Act* requires under certain conditions the reporting: to the medical officer of health;
- by hospitals, other institutions,¹⁶⁸ doctors and other health care profes-

168. Subsection 21(1) provides:

In this Part, “institution” means,

(a) “charitable institution” within the meaning of the *Charitable Institutions Act*, (b) premises approved under subsection 9 (1) of Part I (Flexible Services) of the *Child and Family Services Act*, (c) “children’s residence” within the meaning of Part IX (Licensing) of the *Child and Family Services Act*, (d) “day nursery” within the meaning of the *Day Nurseries Act*, (e) “facility” within the meaning of the *Developmental Services Act*, (f) Repealed: 2001, c. 13, s. 17. (g) “home for special care” within the meaning of the *Homes for Special Care Act*, (h) “home” within the meaning of the *Homes for the Aged and Rest Homes Act*, (i) “psychiatric facility” within the meaning of the *Mental Health Act*, (j) “approved home” and “institution” within the meaning of the *Mental Hospitals Act*, (k) “correctional institution” within the meaning of the *Ministry of Correctional Services Act*, (l) “detention facility” within the meaning of section 16.1 of the *Police Services Act*, (m) “nursing home” within the meaning of the *Nursing Homes Act*, (n) “private hospital” within

sionals and practitioners¹⁶⁹ including nurses, chiropractors, dentists, pharmacists, optometrists, and drugless practitioners;

- of the fact that a patient has or may have a disease specified in overlapping definitions as communicable, reportable, or virulent.

The conditions of reporting outlined below are unnecessarily complex and in places apparently illogical. Structural elements that require amendment include:

- the inconsistent obligations on doctors and others to report some cases and not others, depending on whether the patient is in hospital or an out-patient or someone who walked into a doctor's office;
- the limited categories of who must report;
- the absence of a broad power to allow the Chief Medical Officer of Health to obtain information, including personal health information, from any person, institution or government department, where the information is necessary to prevent the spread of an infectious disease;
- the lack of precision in the necessary timeliness of the reporting; and
- the different levels of information required to be reported, depending on the identity of the disclosing party.

SARS demonstrated the importance of notifying public health of the risk of an infectious disease in a health care setting or any other part of the community. Vital information about infectious disease typically comes to light only when a patient seeks medical treatment from a health care worker, whether it be a doctor, nurse, clinic, hospital or

the meaning of the *Private Hospitals Act*, (o) place or facility designated as a place of secure custody under section 24.1 of the *Young Offenders Act* (Canada),

and includes any other place of a similar nature; (“établissement”)

169. Subsection 25(2) defines practitioner as a member of the College of Chiropractors of Ontario, a member of the Royal College of Dental Surgeons of Ontario, a member of the College of Nurses of Ontario, a member of the Ontario College of Pharmacists, a member of the College of Optometrists of Ontario or a person registered as a drugless practitioner under the *Drugless Practitioners Act*.

indeed from any health care practitioner. This confidential patient information can only be shared with public health officials if there is a legal duty or authority to do so. Without such legal duty and authority every doctor and nurse and health care practitioner runs the risk of violating privacy legislation and public health officials will lack the power to compel the disclosure by a reluctant health information custodian. Infectious disease will not pause for a legal debate on whether the disease should be reported to public health. During an infectious outbreak it is critical that the reporting structure set out in the *Health Protection and Promotion Act* be clear and unassailable so that health professionals understand and properly discharge their reporting obligations under the Act, confident in their legal authority to do so. Only then will public health officials be armed with the information needed to protect the public.

Current Reporting Requirements

The *Health Protection and Promotion Act* puts reporting obligations on physicians, practitioners,¹⁷⁰ hospital administrators, superintendents of institutions, school principals, and laboratory operators. Pursuant to the Act, these individuals must report a case to public health in the case of a patient who has or may have a reportable or communicable disease.

Reporting obligations under the *HPPA* are triggered by the requirement that a disease be either reportable or communicable. The lists of reportable and communicable diseases are set out in the Regulations to the *Health Protection and Promotion Act*. Regulation 558/91 specifies the communicable diseases, while Regulation 559/91 specifies the reportable diseases. This designation is vital. It is only where a person has or may have a reportable or communicable disease that the obligations are triggered under the Act.

Sections 25 through 30 of the *Health Protection and Promotion Act* impose reporting duties on specific groups of individuals such as doctors, nurses, hospital administrators, superintendents of institutions, school principals, and laboratory operators. They are as follows:

170. Subsection 25(2) defines practitioner as a member of the College of Chiropractors of Ontario, a member of the Royal College of Dental Surgeons of Ontario, a member of the College of Nurses of Ontario, a member of the Ontario College of Pharmacists, a member of the College of Optometrists of Ontario or a person registered as a drugless practitioner under the *Drugless Practitioners Act*.

- s. 25(1) A physician or a practitioner as defined in subsection (2) who, while providing professional services to a person who is not a patient in or an out-patient of a hospital, forms the opinion that the person has or may have a reportable disease shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the professional services are provided.
- s. 26 A physician who, while providing professional services to a person, forms the opinion that the person is or may be infected with an agent of a communicable disease shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the professional services are provided.
- s.27 (1) The administrator of a hospital shall report to the medical officer of health of the health unit in which the hospital is located if an entry in the records of the hospital in respect of a patient in or an out-patient of the hospital states that the patient or out-patient has or may have a reportable disease or is or may be infected with an agent of the communicable disease.
- s.27(2) The superintendent of an institution shall report to the medical officer of health of the health unit in which the institution is located if an entry in the records of the institution in respect of a person lodged in the institution states that the person has or may have a reportable disease or is or may be infected with an agent of a communicable disease.
- s.27(3) The administrator or the superintendent shall report to the medical officer of health as soon as possible after the entry is made in the records of the hospital or institution, as the case may be.
- s. 28 The principal of a school who is of the opinion that a pupil in the school has or may have a communicable disease shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the school is located.

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- s. 29(1) The operator of a laboratory shall report to the medical officer of health of the health unit in which the laboratory is located each case of a positive laboratory finding in respect of a reportable disease, as soon as possible after the making of the finding.
- s. 29(2) A report under this section shall state the laboratory findings and shall be made within the time prescribed by the regulations.

In addition to these provisions, s. 30 imposes a reporting condition on a physician who signs a medical certificate of death where the cause of death or a contributing cause of death was a reportable disease.¹⁷¹

It is important to note the distinction between the reporting requirements in s. 25 and s. 26, discussed in detail below.

The overriding goal of the reporting provisions should be a clear statement of the reporting obligations of any party who could potentially have information about the presence or suspected presence of a communicable disease. Unfortunately, the current provisions contain some clear gaps addressed below, which have impeded the ability of public health officials to obtain reports regarding diseases.

In Hospital or Out of Hospital

Section 25 requires physicians and practitioners caring for patients who are not in-patients or out-patients at a hospital to report reportable diseases. Section 26 requires physicians, regardless of the status of the patient, to report communicable diseases. It is unclear why the legislation distinguishes between the reporting of reportable diseases and the reporting of communicable diseases. Perhaps physicians and other practitioners treating patients in a hospital or who are out-patients of a hospital are precluded from reporting obligations in s. 25 because of a belief that the

171. Section 30 provides:

A physician who signs a medical certificate of death in the form prescribed by the regulations under the Vital Statistics Act where the cause of death was a reportable disease or a reportable disease was the contributing cause of death shall, as soon as possible after signing the certificate, report thereon to the medical officer of health of the health unit in which the death occurred.

reporting will occur under s. 27, via the hospital administrator. However, both physicians/practitioners and hospital administrators have reporting duties where the disease is communicable, and it is unclear why reportable diseases would be treated differently, particularly since not all reportable diseases are communicable.¹⁷² If there are two categories of diseases and both are sufficiently serious threats to public health that they require reporting from a hospital administrator and from physicians and practitioners working with persons who are not in-patients or out-patients of a hospital, it is unclear why the reporting requirements are not the same regardless of the patient's location.

Whatever the logic of the distinction between reportable and communicable diseases in ss. 25 and 26, public health officials interviewed by the Commission expressed a common position that leaving reporting in any case to a hospital administrator is insufficient. Many public health officials reported to the Commission that they frequently did not receive reports from hospital administrators. In fairness, the hospital administrator can only report what they are aware of, so absent a functioning internal system requiring immediate reporting to them, they may not be aware that a case exists. Whether they are aware of a case or not, as one public health official stated, "it is the hospital doctors and the health care workers that we need access to", not hospital administrators. It is insufficient in the case of hospitals to leave reporting to the hospital administrator. The hospital administrator is unlikely to be working when the infectious patient enters the emergency room in the middle of the night. Public health officials need to connect with the emergency room physician and staff to obtain information necessary to begin their important work of ensuring the infectious disease remains contained and does not threaten the public's health.

As noted below, the scope of information that a physician must provide under s. 25 is far greater than that which a hospital administrator must provide under s. 27. Consequently, a physician in a family clinic may be required under the *Health Protection and Promotion Act* to provide far greater information on a reportable disease than a hospital administrator when the patient is an in-patient or out-patient of a hospital. This distinction makes little sense, as the importance of notifying public health of the existence or suspicion of a reportable disease does not turn on the location of the patient. Therefore, s. 27 does not compensate for the exclusion of hospital physicians in s. 25. This gap in the reporting requirements frustrates public health

172. As noted above, all communicable diseases are reportable but not all reportable diseases are communicable.

officials who require information to perform their duties. One public health expert described the problem, using tuberculosis (TB) cases as an example:

It's been an ongoing frustrating problem. We're not getting information about the most recent chest X-rays, we're not getting information about medication that patients may be on, or when they come from the hospital out into the community. We're just not getting the information that our public health docs are telling me that we need. Some hospitals are better than others. But there just seems to be a brick wall there. And we're being faced with, well, we don't have to provide anything other than name and address, date of birth, sex and date of onset of symptoms, because that's all we're required to report under s. 1(1), but 1(2) is, for example, currently not directed at the hospital administrator. And that's one of the reasons why we wanted to take out the words "who is a patient or an in-patient" at the hospital, because it's the physicians in the hospital that have all the information that aren't reporting it to us.

It would be far more effective simply to combine ss. 25 and 26 and to require all physicians, regardless of the status of the patient, to report a disease that is either reportable or communicable. This way, a physician would be legally required to report and, as a backup, the hospital administrator would also have a legal duty to report pursuant to s. 27. Duplicate reporting obligations raise potential concerns around multiple reporting and around who is primarily responsible to report. Public health officials advise, however, that over-reporting would be preferable to the current trend of under-reporting. This problem could be easily addressed by ensuring an effective internal compliance system within each hospital or institution. As one public health expert stated:

Multiple reporting doesn't happen. We get under-reporting. Now a hospital administrator has to report but they don't do it. I think it should be incumbent on the hospital to have a reporting policy. For example, if a nurse identifies a disease she can say the most responsible physician should report it, or is it the infection control people – but they need to have an internal way of doing that. Right now what mostly happens is everyone thinks everyone else does it and it is not done.

Such an internal compliance system would not only allow physicians and health care workers to ensure compliance with reporting obligations, but would serve to identify those cases where the obligations have not been fulfilled. Hospitals are busy places and physicians have enormous responsibilities in providing patient care. Clear report-

ing obligations, even if they result in multiplication of duties, can only serve to ensure that cases do not slip through the cracks.

A group of highly qualified experts involved in the SARS response advised the Commission:

Presently, section 25 of the HPPA speaks to the reporting requirements for physicians; however, this only refers to those services provided outside of hospitals. This leaves a gap in reporting of patients who are seen as either out-patients of the hospital or who are admitted to a hospital by physicians. Presently, the HPPA requires the administrator of the hospital to report cases of reportable diseases for out-patients and in-patients of a hospital. It is suggested that compelling hospital-based physicians to report consistent with requirements applicable to out of hospital will build redundancy and will assure reporting of such cases.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to repeal, in the duty of a physician to report to the medical officer of health, the distinction between hospital patients and non-hospital patients. This may be achieved by deleting from s. 25(1) the words “who is not a patient in or an out-patient of a hospital.”**
- **The Ministry of Health and Long-Term Care require each hospital, long-term care facility, nursing home, home for the aged, community care access centre, private medical or health services clinic, and any health care institution, to establish an internal system to ensure compliance with the reporting obligations set out in the *Health Protection and Promotion Act*.**

Expanding the Categories of those who must Report

As noted above, the *Health Protection and Promotion Act* imposes reporting obligations on specified groups of persons such as doctors, nurses, hospital administrators, superintendents of institutions, school principals, and laboratory operators. A gap in the system emerges where a caregiver such as a midwife has information about a

reportable or communicable disease and the caregiver does not fall into one of the categories of people listed in ss. 25 through 30.

Section 25 requires that a physician or a practitioner who, while providing professional services to a person who is not a patient in or an out-patient of a hospital, forms the opinion that the person has or may have a reportable disease, shall make a report to the medical officer of health of the health unit in which the professional services are provided. Subsection 25(2) defines “practitioner”. It provides:

- (2) In subsection (1), “practitioner” means,
- (a) a member of the College of Chiropractors of Ontario,
 - (b) a member of the Royal College of Dental Surgeons of Ontario,
 - (c) a member of the College of Nurses of Ontario,
 - (d) a member of the Ontario College of Pharmacists,
 - (e) a member of the College of Optometrists of Ontario, or
 - (f) a person registered as a drugless practitioner under the *Drugless Practitioners Act*, 1998, c. 18, Sched. G, s. 55 (3).

Pursuant to s. 27(2), a superintendent of an institution must report to the medical officer of health of the health unit in which the institution is located if an entry in the records of the institution in respect of a person lodged in the institution states that the person has or may have a reportable disease or is or may be infected with an agent of a communicable disease. “Institution” is defined in s. 21(1) as:

- “institution” means,
- (a) “charitable institution” within the meaning of the *Charitable Institutions Act*,
 - (b) premises approved under subsection 9 (1) of Part I (Flexible Services) of the *Child and Family Services Act*,
 - (c) “children’s residence” within the meaning of Part IX (Licensing) of the *Child and Family Services Act*,

- (d) “day nursery” within the meaning of the *Day Nurseries Act*,
- (e) “facility” within the meaning of the *Developmental Services Act*,
- (f) Repealed: 2001, c. 13, s. 17.
- (g) “home for special care” within the meaning of the *Homes for Special Care Act*,
- (h) “home” within the meaning of the *Homes for the Aged and Rest Homes Act*,
- (i) “psychiatric facility” within the meaning of the *Mental Health Act*,
- (j) “approved home” and “institution” within the meaning of the *Mental Hospitals Act*,
- (k) “correctional institution” within the meaning of the *Ministry of Correctional Services Act*,
- (l) “detention facility” within the meaning of section 16.1 of the *Police Services Act*,
- (m) “nursing home” within the meaning of the *Nursing Homes Act*,
- (n) “private hospital” within the meaning of the *Private Hospitals Act*,
- (o) place or facility designated as a place of secure custody under section 24.1 of the *Young Offenders Act* (Canada),

and includes any other place of a similar nature; (“établissement”)

“superintendent” means the person who has for the time being the direct and actual superintendence and charge of an institution (“chef d’établissement”).

But a health care provider may have information regarding a communicable disease and may not be a member of one of the professional bodies set out in s. 25(2) nor a superintendent of an institution as defined in the Act. In such a case, there would be no reporting obligation, and the provision of personal health information to public health authorities to prevent the spread of infectious disease may require intensive

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legal review of privacy legislation before a health care provider could be confident of their ability to disclose constitute a violation of privacy legislation. For example, recently, the case of a midwife caring for a pregnant woman with Hepatitis B came to the attention of public health officials through a mandatory report from a laboratory. Public health officials had the name of the midwife and the mother as a result of receiving the lab slip, reporting the positive Hepatitis B test. However, the lab slip did not give public health officials enough information about the patient to allow them to conduct their investigation to ensure that the newborn received the necessary vaccinations. In the normal course, public health would have contacted the treating physician or health care provider to obtain the additional information. Time was of the essence as public health officials had a relatively small window during which they could vaccinate the newborn to prevent it from contracting Hepatitis from its mother. The midwife, although wanting to cooperate with public health officials, felt that she could not disclose the required information as it was confidential health information and she had no duty under the *Health Protection and Promotion Act* to report. A midwife is not a “practitioner” as defined in the Act.

An easy solution lies in simply adding all potential custodians of health information to the list of “practitioners” under the *Health Protection and Promotion Act*. Some have suggested that the solution lies in adding to the definition of practitioners the list of professionals set out in the *Regulated Health Professions Act*.¹⁷³ Others have

 173. S.O. 1991, c. 18, Sched. 1 – SELF GOVERNING HEALTH PROFESSIONS

Health Profession Acts	Health Profession
Audiology and Speech-Language Pathology Act, 1991	Audiology and Speech-Language Pathology
Chiropractic Act, 1991	Chiropractic
Chiropractic Act, 1991	Chiropractic
Dental Hygiene Act, 1991	Dental Hygiene
Dental Technology Act, 1991	Dental Technology
Dentistry Act, 1991	Dentistry
Denturism Act, 1991	Denturism
Dietetics Act, 1991	Dietetics
Massage Therapy Act, 1991	Massage Therapy
Medical Laboratory Technology Act, 1991	Medical Laboratory Technology
Medical Radiation Technology Act, 1991	Medical Radiation Technology
Medicine Act, 1991	Medicine
Midwifery Act, 1991	Midwifery
Nursing Act, 1991	Nursing
Occupational Therapy Act, 1991	Occupational Therapy
Opticianry Act, 1991	Opticianry
Optometry Act, 1991	Optometry
Pharmacy Act, 1991	Pharmacy
Physiotherapy Act, 1991	Physiotherapy
Psychology Act, 1991	Psychology
Respiratory Therapy Act, 1991	Respiratory Therapy

suggested that this list would be overly broad, capturing people who would not have such information. As one person remarked:

. . . it might capture people where it would be of limited utility to have them be included, such as massage therapists or dieticians. One wonders how far you want the net to expand and there are some “non-traditional” professions included in the *Regulated Health Professions Act*.

On the other hand, it is better to cast the net too widely than too narrowly, and to include health care providers, whether traditional or non-traditional, who have information vital to public health. When the Act was drafted in the early 1980’s, and through all its amendments since then, clearly no one contemplated the scenario where a midwife might hold critical information. The danger in trying to predict every possible category of person or institution is that one that does not seem relevant today suddenly becomes relevant in the future.

Another suggested solution has been to redefine practitioner in the *Health Protection and Promotion Act* to match the definition in the *Personal Health Information Protection Act*. In s. 2 of the *Personal Health Information Protection Act*, “health care practitioner” is defined as follows:

“health care practitioner” means,

- (a) a person who is a member within the meaning of the Regulated Health Professionals Act, 1991 and who provides health care,
- (b) a person who is registered as a drugless practitioner under the Drugless Practitioners Act and who provides health care,
- (c) a person who is a member of the Ontario College of Social Workers and Social Service Workers and who provides health care, or
- (d) any other person whose primary function is to provide health care for payment; (“praticien de la santé”)

This definition is quite broad. It includes not only everyone who is a member within the meaning of the *Regulated Health Professionals Act*, but also has a broad catch-all provision that includes any person whose primary function is to provide health care for payment. It is important that the definition of “practitioner” in the *Health Protection and Promotion Act*, be amended to conform with that in the *Personal Health*

Information Protection Act.

Even beyond the definition of “practitioner” and “institution,” the list of custodians who are identified in the *Personal Health Information Protection Act* as being potential custodians of personal health information, is far broader than those with reporting obligations under the *Health Protection and Promotion Act*. In s. 3(1) of the *Personal Health Information Protection Act*, “health information custodian” is defined as follows:

In this Act, “health information custodian,” subject to subsections (3) to (11), means a person or organization described in one of the following paragraphs who has custody or control of personal health information as a result of or in connection with performing the person’s or organization’s powers or duties or the work described in the paragraph, if any:

1. A health care practitioner or a person who operates a group practice of health care practitioners.
2. A service provider within the meaning of the *Long-Term Care Act, 1994* who provides a community service to which that Act applies.
3. A community care access corporation within the meaning of the *Community Care Access Corporations Act, 2001*.
4. A person who operates one of the following facilities, programmes or services:
 - i. A hospital within the meaning of the *Public Hospitals Act*, a private hospital within the meaning of the *Private Hospitals Act*, a psychiatric facility within the meaning of the *Mental Health Act*, an institution within the meaning of the *Mental Hospitals Act* or an independent health facility within the meaning of the *Independent Health Facilities Act*.
 - ii. An approved charitable home for the aged within the meaning of the *Charitable Institutions Act*, a placement coordinator described in subsection 9.6 (2) of that *Act*, a home or joint home within the meaning of the *Homes for the Aged and Rest Homes Act*, a placement coordinator described in subsection 18 (2) of that *Act*, a nursing home within the meaning of the *Nursing Homes Act*, a placement coordinator described in subsection 20.1 (2) of that *Act* or a care home within

the meaning of the *Tenant Protection Act*, 1997.

iii. A pharmacy within the meaning of Part VI of the *Drug and Pharmacies Regulation Act*.

iv. A laboratory or a specimen collection centre as defined in section 5 of the *Laboratory and Specimen Collection Centre Licensing Act*.

v. An ambulance service within the meaning of the *Ambulance Act*.

vi. A home for special care within the meaning of the *Homes for Special Care Act*.

vii. A centre, program or service for community health or mental health whose primary purpose is the provision of health care.

5. An evaluator within the meaning of the *Health Care Consent Act*, 1996 or an assessor within the meaning of the *Substitute Decisions Act*, 1992.

6. A medical officer of health or a board of health within the meaning of the *Health Protection and Promotion Act*.

7. The Minister, together with the Ministry of the Minister if the context so requires.

8. Any other person prescribed as a health information custodian if the person has custody or control of personal health information as a result of or in connection with performing prescribed powers, duties or work or any prescribed class of such persons.

The definition of “health information custodian” in the *Personal Health Information Protection Act* is far broader than that contained in the *Health Protection and Promotion Act*. It follows that a broad spectrum of health care providers have strong duties to protect the patient privacy with no corresponding duty to override that privacy where necessary to tell public health authorities and so prevent the spread of deadly infection. For example, ambulance services do not have reporting obligations under the *Health Protection and Promotion Act*. Service providers within the meaning of the *Long Term Care Act*, are not included in the definition of either “practitioner” or “institution” in the *Health Protection and Promotion Act*. While s. 29(1) requires that the operator of a laboratory report, it does not include a laboratory specimen collection centre.

Community Care Access Corporations are not included in the reporting sections of the *Health Protection and Promotion Act*. Nor are pharmacies included in the *Health Protection and Promotion Act*. The drafters of the *Personal Health Information Protection Act* obviously contemplated that these groups and individuals might have personal health information and it necessarily follows that they might have health information in relation to a communicable disease. It follows that they should have clear reporting obligations.

The list of “practitioners” and “institutions” as defined in the *Health Protection and Promotion Act* should be kept up-to-date and should be easily amended to ensure that all those who may receive personal health information about a patient infected with a communicable disease have reporting obligations. There should also be consistency between the *Health Protection and Promotion Act* and the *Personal Health Information Protection Act* to avoid the current situation where some have a clear duty not to disclose without the concurrent duty to disclose in the case of a communicable disease.

Recommendations

The Commission therefore recommends that:

- **The definition of “practitioner” in the *Health Protection and Promotion Act* be amended to coincide with that set out in the *Personal Health Information Protection Act*.**
- **The list of “institutions” as defined in s. 21(1) of the *Health Protection and Promotion Act*, be amended to coincide with that set out in the *Personal Health Information Protection Act*.**
- **The *Health Protection and Promotion Act* be amended to ensure consistency between those who are defined as “health information custodians” under the *Personal Health Information Protection Act* and those who have reporting obligations under the *Health Protection and Promotion Act*.**
- **The *Health Protection and Promotion Act* be amended to authorize the Minister of Health and Long-Term Care to amend the definition of “practitioner” or “institution” by regulation.**

Broad Powers to Obtain Information

It is a band-aid solution to amend the *Health Protection and Promotion Act* each time a new health care provider or a gap in the existing legislation is identified. It may be impossible to predict every potential custodian of information relevant to public health officials in communicable disease prevention and control. As the case of the midwife illustrated above, an investigation into a potential infectious disease will very likely require speed. This cannot be achieved if the only solution lies in amending the *Health Protection and Promotion Act* every time a person with important health information turns out to be exempt from the Act. Medical officers of health must have the power to ask for personal health information from any person or institution, where the information is required to prevent the spread of infectious disease or any other risk to the public's health. Their ability to protect the public from health threats, in particular infectious diseases, should not turn on the ability of legislative drafters to foresee each and every possible source of information.

This problem became apparent early into SARS, when it became necessary to amend the *Hospital Management Regulation*¹⁷⁴ under the *Public Hospitals Act* to require hospitals to provide medical information to public health officials in respect of SARS. Section 23.2¹⁷⁵ of the *Hospital Management Regulation* was added to provide:

23.2 (1) A hospital shall provide information from records of personal health information to the following persons for the purposes of the diagnosis of persons who may have contracted SARS and the investigation, prevention, treatment and containment of SARS:

1. The Chief Medical Officer of Health within the meaning of the *Health Protection and Promotion Act*.
2. A medical officer of health within the meaning of the *Health Protection and Promotion Act*.
3. A physician designated by the Chief Medical Officer of Health.

(2) In subsection (1), "SARS" means severe acute respiratory syndrome.

174. R.R.O. 1990, Regulation 965.

175. O. Reg. 201/03, s. 1., made under the *Public Hospitals Act*.

It demonstrates a fundamental weakness in the structure of the *Health Protection and Promotion Act* reporting system that this amendment was necessary in the middle of SARS. Public health legislation must be robust enough to require the flow of necessary information from hospitals to public health officials at all times. It should not be necessary to amend the reporting requirements in the middle of an outbreak of some new disease.

The problem of collecting information about risks that are not defined as either a health hazard or as a reportable disease arose after SARS, as individual health units were required to collect information and attempt to be informed and proactive in respect of febrile respiratory illnesses within hospitals. One public health lawyer described the problem for the Commission:

I think it's important for us to know these things are happening, as well. For example, if there's some sort of strange trend going on at a hospital, everyone has this high fever, we never find out about it, because it's not a reportable disease, it's not a communicable disease, and then we find out about it when there's a SARS outbreak. There's nothing really for us to be sharing information so that we know there might be something that can happen here and can we do something to prevent it. Can we implement some infection control protocols? Can we be prepared for it? There's nothing really allows us to foreshadow that something like this is going to occur. And I think the Ministry is asking us to collect information about febrile respiratory illness and severe respiratory illness, and all the health units are asking well, what is our authority to require the hospitals to give us that information? And the hospitals are calling us saying, we're not giving it to you, because there's nothing in the statute that requires us to report that. And the Ministry I think was trying to get something that would allow us to forecast. Well if there's some weird thing, a lot of people with a fever, certain other symptoms, maybe there's something that we need to investigate, we need to have discussions about and see whether it's happening in other places. And there's nothing really that allows us to do that.

One hospital in particular took the position that there was not only an absence of legal authority to report cases of febrile respiratory illness to public health officials, but that to do so would be a contravention of privacy legislation. As noted later in this chapter, respiratory infection outbreaks were recently added to Regulation 569, as requiring reporting to public health officials to address this issue.

The fundamental weakness in the *Health Protection and Promotion Act* is that it does not enable public health authorities to acquire the information from hospitals and other health care institutions that is needed to protect the public against infectious disease. This fundamental weakness is not cured by a narrow spot amendment restricted to SARS in an obscure hospital regulation outside the framework of the *Health Protection and Promotion Act*. The amendment applies only to SARS and not to any other infectious or communicable or reportable or virulent disease. Nor does it apply to any new disease that might at first, like SARS, not even have a name.

It is essential to ensure that public health officials, in the event of any infectious disease outbreak, have access to whatever information they require to protect the public. Tinkering is not enough. The fundamental weakness in reporting requirements, demonstrated by the SARS spot amendment to the *Public Hospitals Act*, should be remedied by a *Health Protection and Promotion Act* amendment to provide that hospitals must provide to public health the information it needs to fight infectious outbreaks.

Quebec has addressed this problem in its *Public Health Act*, through a power available to the public health director. Under s. 96 of the Act the public health director may conduct an epidemiological investigation in any situation where he or she believes on reasonable grounds that the health of the population is or could be threatened and, in particular, where the director receives a report of an intoxication, infection or disease as required by the Act and regulations. Section 100 sets out the powers of the public health director in the course of an epidemiological investigation. One of these powers, set out in s. 100(8), provides the public health director the power to obtain information relevant to an epidemiological investigation from any source. It states:

[The Public Health Director may] 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.

The Quebec legislation strikes a balance between the need to identify cases and access private health information quickly, and the need to ensure privacy is respected and that the power is not over utilized.

If a similar provision were added to the *Health Protection and Promotion Act*, the local medical officer of health would still have the power recommended below to request further details on reported cases from parties with reporting obligations under the

Act. A general power for the Chief Medical Officer of Health to request and obtain information, similar to that set out in Quebec's *Public Health Act*, would fill a gap in cases where the person with vital information about a disease, or any other health risk, did not happen to be listed as someone with a legal duty to report. The power must be broad, to allow for access to information where a disease or health risk is previously unknown or unidentified.

Required information may not be limited to details about specific cases. It may also include the provision of specimens. The Ministry of Health and Long-Term Care in its written submission to the Commission,¹⁷⁶ stressed the need for an amendment to the *Health Protection and Promotion Act* to provide the authority for the Chief Medical Officer of Health to:

... order the collection, analysis, and retention of any laboratory specimens from any person, animal, plant or anything the Chief Medical Officer of Health specifies, and to acquire previously collected specimens and test analyses from anyone, and to disclose the results of test analyses as the Chief Medical Officer of Health considers appropriate.

Dr. Basrur, in her appearance before the Justice Policy Committee, explained this proposed power:

Authorizing the Chief MOH to order the collection, analysis and retention of any lab specimen from any person, plant or anything that he or she specifies: That sounds pretty open-ended. You might want that if you come across an incident that you've never anticipated in your life.

Authorizing the Chief MOH to acquire previously collected specimens: My neighbour to my left gave blood when she was expecting a baby. That blood is in storage and, in an emergency, I can take that and use it for some other purpose. You might want to think about what kinds of safeguards would be necessary to protect the individual and, frankly, to protect the official and the government so that they're doing the right thing and not more than is absolutely necessary.¹⁷⁷

176. Letter to Mr. Douglas 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.

177. Justice Policy Committee, Public Hearings, August 18, 2004, p. 142.

The Commission accepts this proposal with a few qualifications. First, it should not include the power to take a bodily sample or specimen from a person without their consent or, absent consent, without court approval. The power must only apply to specimens already taken. The protection of one's bodily integrity is a fundamental part of our law¹⁷⁸ that must be protected from unreasonable state intrusion. Second, the collection must be limited to the purpose of investigating and preventing the spread of infectious disease. The specimen must be used only for this express purpose. For example, a specimen taken for the purposes of investigating whether a person is infected with a virulent disease should not then be available to the state for any other purpose.¹⁷⁹ Third, this power should not override any other provisions of the Act, which set out a specific process for the obtaining of samples.

The above proposed amendments would give Ontario's public health authorities the ability to acquire information about cases of infectious disease necessary to protect the public. By making the power available only to the Chief Medical Officer of Health, it would ensure that the Chief Medical Officer of Health is aware and kept informed of new and unidentified risks throughout the province.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to include a provision similar to the provisions in Quebec's *Public Health Act*, by which the Quebec**

178. In *R. v. Stillman* (1997), 133 C.C.C. (3rd) the Supreme Court of Canada stated that seizures that infringe upon a person's bodily integrity, may constitute the "ultimate affront to human dignity" (at p. 341). The Court said:

It has often been clearly and forcefully expressed that state interference with a person's bodily integrity is a breach of a person's privacy and an affront to human dignity (at p. 342).

Recently, in *R. v. Tessling*, [2004] S.C.J. No. 63, the Supreme Court of Canada said:

Privacy of the person perhaps has the strongest claim to constitutional shelter because it protects bodily integrity, and in particular the right not to have our bodies touched or explored to disclose objects or matters we wish to conceal. [para. 21]

179. The Supreme Court of Canada has ruled that seizure of a blood sample that is authorized by law for the purposes of the provincial *Coroner's Act* cannot be used for the purpose of a *Criminal Code* prosecution for impaired driving. See *Colarusso v. The Queen* (1994), 87 C.C.C. (3d) 193. [1994] 1 S.C.R. 20.

public health director may 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.

- **This power should be broadly defined, to enable the Chief Medical Officer of Health to require any person, organization, institution, government department or other entity, to provide information, including personal health information, to the Chief Medical Officer of Health, for the purposes of investigating and preventing the spread of infectious disease.¹⁸⁰**
- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health to order the collection, analysis and retention of any laboratory specimen from any person, animal, plant or anything the Chief Medical Officer of Health specifies, and to acquire previously collected specimens and test analysis from anyone, and to disclose the results of test analysis as the Chief Medical Officer of Health considers appropriate for the purpose of investigating and preventing the spread of infectious disease.¹⁸¹ This power, however, should be subject to the following restrictions:**
 - **It should not include the power to take a bodily sample or specimen directly from a person without their consent or, absent consent, without court order. The power should only apply to specimens already taken;**
 - **The collection should be limited to the purpose of investigating and preventing the spread of infectious disease. The specimen should be used only for this express purpose; and**
 - **The power should not override any other provisions of the Act, which set out a specific process for the obtaining of samples.**

180. As noted above, this is not drafting language. The use of the term “infectious disease” is intended to include but not be restricted to diseases already designated as communicable, reportable or virulent under the *Health Protection and Promotion Act*. The provision should be defined broadly enough to cover bioterrorism risks. It should not, however, extend to every health risk, such as obesity or other lifestyle problems.

181. *Ibid.*

Timing

Neither the *Health Protection and Promotion Act* nor the Regulations specify how soon a report must be made.¹⁸² The reporting sections set out in ss. 25 through 30 of the Act simply state that the report must be made “as soon as possible” after the opinion is formed, which is not defined. Is that within an hour, a day, or a few days? What if the physician or the administrator is busy or overworked? Does it mean as soon as is convenient for them? Many medical officers of health have raised this issue and have noted the need for immediate notification to enable them to respond to a problem before it spreads out of control. As one public health expert stated:

We need to set a timeframe within which the reports have to be made. This is a chronic problem for public health where the legislation says you have to report but it doesn't say within what timeframe. This doesn't help public health in terms of their ability to do work. It leaves us with little enforcement alternatives as physicians who are not reporting cannot be prosecuted for breaching legislation because there is no time frame.

Given the importance of timely public health intervention in the case of a communicable or infectious disease, it is important to specify that the reporting must be immediate in those cases where time is of the essence. But it may not be necessary for every reportable disease to be reported immediately. It may be necessary to require immediate reporting only for those diseases where immediate notification and intervention is necessary for public health protection.

For example, in Quebec, the Minister's Regulation under the *Public Health Act*¹⁸³ requires that for certain diseases¹⁸⁴ the report must be made to both the national public health director and the public health director in the territory, immediately, by telephone and also in writing within 24 hours. For other diseases, however, the report must be made to public health, in writing, within 24 hours.¹⁸⁵

182. The Ministry of Health and Long-Term Care distributes an information sheet that contains a list of diseases which they request be reported immediately. This list however does not carry with it the force of law, but merely acts as a guideline for reporting institutions.

183. R.S.Q., c. S-2.2, ss. 47, 48, 79, 81 to 83 and s. 136, paras. 6, 8 and 9.

184. Section 1 provides that in the case of Anthrax, Botulism, Cholera, Plague, Smallpox, Viral haemorrhagic fever, Yellow fever, a report must be made “immediately, by telephone, by any physician and any chief executive officer of a laboratory or of a department of medical biology to the national public health director and the public health director in the territory” and that “A written report must also be transmitted to those authorities within 48 hours by the person making the report.”

185. See the *Minister's Public Health Regulations*, ss. 2 through 5.

Recent amendments to the reporting regulations set out in Regulation 569, amended to O. Reg. 1/05, identify the need for immediate reporting from the local level to the provincial level. Subsection 6(1) previously stated:

Where a medical officer of health receives a report made under section 25, 26, 27 or 28, subsection 29(2) or section 30 of the Act, he or she shall forward a copy to the Public Health Branch of the Ministry.

It has been amended to state:

Where a medical officer of health receives a report made under section 25, 26, 27 or 28, subsection 29(2) or section 30 of the Act, he or she shall immediately forward a copy to the Public Health Branch of the Ministry in a secure manner.

It is easy to understand why the Ministry would want to ensure immediate reporting from the local level to the provincial level. However, unless the local level also benefits from a similar legal requirement that reports from the field be made immediately to them, the effectiveness of the entire reporting regime will be undermined. There is little benefit to the Ministry of receiving an “immediate” report from the local level when the local level has received news of an infectious disease days or weeks after the fact.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to require that in the case of specific diseases, designated by regulation, information be reported “immediately” by telephone to the local medical officer of health, and that such report be followed up in writing within 24 hours.**
- **The *Health Protection and Promotion Act* be amended to require that as in the case of those diseases not designated for immediate reporting, a written report must be provided to the local medical officer of health within 24 hours.**

Content of the Report

The *Health Protection and Promotion Act*, and its accompanying regulations, must be clear not only as to who must report and when, but must also be clear as to what information must be reported. It is frustrating for a medical officer of health to request information that he or she knows is relevant and necessary to control the spread of an infectious disease or to investigate a possible outbreak of an infectious disease, only to be told that he or she is not legally entitled to the information. It is similarly frustrating for the physician or practitioner who wants to assist public health but does not want to violate privacy laws. The law should be so clear that the physician and the practitioner need no longer grapple with these legal puzzles in the midst of a busy practice and other important demands on their time. The Regulation, which sets out the type of information that must be provided in a report, was recently amended. While the changes go a long way to improving the inadequacy of the previous version of the Regulation, there are still improvements that need to be made for the sake of clarity for public health officials and for those with reporting obligations.

The amendments are a positive step towards the goal of arming medical officers of health with greater information to allow them to prevent the spread of an infectious disease. With a little clarification and a little more strength the new Regulation will go a long way to address the concerns of local medical officers of health in respect of their difficulties in obtaining necessary details about reported cases from health care providers.

The *Health Protection and Promotion Act* does not specify what information must be reported to the medical officer of health. It simply provides that a report must be made. Regulation 569 specifies the type of information that must be provided to the medical officer of health. A number of problems with the Regulation have recently been addressed in Regulation 1/05. Two specific problems were the limited list of information required to be included in a report under the Act, and the limited class of people who were required to provide additional information as requested by the medical officer of health.

Regulation 569, both previous and current, state that the following information is required when making a report under the Act:

- 1(1) A report required under s. 25, 26 or 27 of the Act shall, with respect to the person to whom the report relates, contain the following information:

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1. Name and address in full.
2. Date of birth in full.
3. Sex.
4. Date of onset of symptoms.

1(2) A report required under section 28 of the Act shall, with respect to the pupil to whom the report relates, contain the following information:

1. Name and address in full.
2. Date of birth in full.
3. Sex.
4. Name and address in full of the school that the pupil attends.

1(3) A report made under subsection 29(1) of the Act [by a laboratory operator] shall, with respect to the person to whom the finding was made, be made within twenty-four hours of the making of the finding and shall contain the following information:

1. Name and address in full.
2. Date of birth in full.
3. Sex.
4. Date when the specimen was taken that yielded the positive finding.
5. Name and address in full of the physician or dentist attending the person.

1(4) A report made under subsection 30 of the Act [by a physician who signs a death certificate] shall, with respect to the deceased, contain the following information:

1. Name and address in full.
2. Date of birth in full.
3. Date of death in full.
4. Name and address in full of the physicians who attended the deceased.

Section 5 of the Regulation specifies in what cases additional information must be reported, together with what additional information must be provided with the report of disease. Prior to the recent amendment, there were seven diseases listed in s. 5,¹⁸⁶

186. Syphilis, Gonorrhoea, AID, Lassa Fever, Marburg virus disease, Ebola virus disease and Plague.

requiring that additional, specified information be provided when reporting. The amendments to Regulation 569, effected by O. Reg 1/05, have significantly expanded both the list of diseases for which additional information must be reported, and the type of information that must be reported. Under the new amendments, some 66 diseases now require additional information beyond the basic information set out in s. 1(1) of Regulation 569. The amendments cover all diseases listed in the three categories of disease specified by regulation: communicable, reportable and virulent. Although at first blush Regulation 569 seems to require the provision of very limited information; name, sex, date of birth and date of onset, the result of the amendments to s. 5 of the Regulation is that virtually every disease listed under the regulations, whether it is communicable, reportable or virulent, now requires the provision of additional information as specified in the amendment sections. The information required by the amendment is detailed and broad. In some cases it includes such things as travel history, lab findings, immigration status, contacts identified, contacts traced, history of exposure and the potential for community transmission.

This amendment brings into force an important change in the scope of information required to be reported. Under the new amendments, those with reporting obligations under the Act are no longer simply required to provide the most basic patient information. The amendments require that significant information about the condition, treatment and history of a patient be reported to the medical officer of health. One expert group described the importance of broadening the reporting requirements under the Act as follows:

Involved health units during the SARS outbreak encountered difficulties in acquiring diagnostic imaging, laboratory results and clinical status updates on suspect or probable cases of SARS who were hospitalized. It appeared that some hospitals interpreted the *Health Protection and Promotion Act* too narrowly, resulting in their restricting access of the health units to this clinical information feeling that this information was not required to be reported unless dealing with a confirmed “reportable disease”. We recommend that appropriate sections be added to the reporting regulations to provide the medical officer of health with the authority to acquire additional information as required to allow control of the disease or an outbreak. This may include information about contacts as well as information about diagnostic and laboratory tests and results of negative laboratory tests, treatment and prognosis of cases from hospitals, clinics and schools. The rationale for this recommendation is to facilitate local Medical Officers of Health and the Chief Medical Officer of

Health in investigating and managing an outbreak that often requires more than just minimal demographic information.

While the amendments are a helpful start to rectifying the difficulties experienced by public health in obtaining additional information in relation to reportable diseases, they appear to have been drafted with little input from local medical officers of health in the field or their counsel, who assist them in interpreting the Act and its regulations. A number of inconsistencies and ambiguities in the language used in the Regulation should be addressed in order to strengthen the Regulation.¹⁸⁷

The Regulation requires that a number of pieces of information be reported, of which the reporting party may not have knowledge. The Regulation fails to make it clear

187. A few examples of ambiguity and inconsistency are as follows: In relation to reporting of contacts, s. 5(1)(xii) requires that the number of contacts be reported yet says nothing about reporting the name of the contacts. This problem likewise exists in ss. 5(5), 5(6), 5(9), 5(10), 5(11), 5(12) and 5(17). All require the reporting of numerical information about contacts, such as the number identified, the number traced, the number quarantined, and the number tested, but say nothing about reporting their names. Subsection 5(5)(xxii) refers to the “number of contacts of the person who have been traced,” whereas the other sections that require reporting on contacts refer to the “number of contacts traced.” Subsection 5(7)(iv), however, refers to “the contacts who have been traced.” Although a minor point, there should be consistency in language in the Regulation. Similarly, the sections that require contact information, identified above, require reporting of “the number of contacts tested and number of contacts treated,” yet s. 5(5)(xxiii) refers to “number of contacts tested and treated, if applicable.” Again, although a minor discrepancy, it reflects a lack of overall clarity in some aspects of the drafting of the regulation. Another apparent inconsistency can be found in respect of the requirement to report the use of an ambulance. Subsection 5(4)(ix) requires that the reporting party state if an ambulance was used and date of use. This information may be important to both identify ambulance personnel involved in transporting the patient to determine their exposure and risk and where a disease is either airborne or spread by droplets to ensure that the ambulance and the machinery inside have been properly cleaned and is not itself a vector for contagion. This was critical during SARS as some ambulance personnel did contract SARS while attending to and transporting infectious patients. Yet this reporting requirement is only required in relation to Lassa Fever, Hemorrhagic fevers, including Ebola virus disease, Marburg virus disease and Hemorrhagic fevers from other viral causes and Plague. While these are clearly highly infectious and deadly diseases, identifying those cases transported by ambulance could also be important for cases such as SARS, yet it is not a listed piece of information in relation to that disease. Another potential problem can be found in s. 5(12)(vi), which sets out the information that must be reported in relation to respiratory infection outbreaks in institutions. One of the reporting requirements is to report the date of the outbreak and the outbreak number. This is followed by the requirement the date the outbreak was declared over. The unfortunate use of the past tense and the wording of that subsection leads the reader to wonder if it may be permissible to report an outbreak after the outbreak is over rather than when it first comes to the attention of the health care provider or institution. Perhaps the reporting hospital should be required to report the date the outbreak “is” declared over or the ongoing status of the outbreak in the hospital. To require them to report the date the outbreak was declared over suggests that the reporting is going to occur after that fact.

that the reporting parties need only report what is known to them, and that they are not obliged to conduct their own independent investigation to obtain all of the information set out in the regulations. As noted below, the names and personal information of contacts, where known, should clearly be reported, but it should not be the job of the physician or hospital to track down contacts of which they have no knowledge. To take another example, the reporting party should not be required to investigate the patient's immigration status, if the patient or a relative are unable to communicate it.

It seems curious that the reporting party is required to identify the health unit responsible for reporting contacts, a fact more appropriately within the knowledge of the public health authorities. It is open to question whether the reporting party should be obliged to identify the "case classification," or whether this is a matter for public health authorities to determine in their internal reporting from the local health unit to the province and their external reporting to Health Canada or the World Health Organization. If the "case designation" has to do with reports made by public health after the information is received from the physician, it might be better to separate the reporting obligations of physicians to public health from the reporting obligations that arise within the public health system after the physician makes the report.

As helpful as the amendments are, they do not eliminate the need for the power of the medical officers of health and the Chief Medical Officer of Health to request additional information from any person or institution making a report under the Act, if that information is required in order to respond to that report. SARS taught us many lessons about the wide variety of information required to fight an infectious disease. Things such as travel history, employment status (is the patient a health care worker) and contact information became critically important during SARS. A piece of information that seems irrelevant now may suddenly become relevant in the face of a new disease. A new disease may necessitate the provision of a detail not currently identified in the regulations.

To that end, s. 1(2) of Regulation 569 allows the medical officer of health to request additional information from the reporting party. Prior to the amendments in Regulation 01/05, this power to request additional information was limited to those making a report under s. 25 and s. 26, failing to include hospital administrators who have obligations to report under s. 27. The new amendments address this, adding reports made under s. 27 to s. 1(2).

The Commission recommends that the power of the medical officer of health to request additional information from a party with reporting obligations under the Act should apply to all those individuals and institutions required to report. Thus, those

parties with obligations to report under s. 28 (school principals), s. 29 (labs), and s. 30 (a physician who signs a medical certificate of death where the cause of death or a contributing cause of death was a reportable disease) may also be legally required to provide any additional information requested by the medical officer of health in relation to the report.

The Commission further recommends that the power currently contained in s. 1(2), of the Regulation, which enables the medical officer of health to request additional information from any party reporting under the Act, be entrenched in the Act itself, protected from any subsequent amendment without legislative debate and openness as to the reasons for the amendment. Rather than being limited to the current specific categories of people and institutions required to report, the power should be directed at any person or institution who makes or is required to make a report under the Act.

Recommendation

The Commission therefore recommends that:

- **Subsection 1(2) of Regulation 569 be expanded to apply to any person who makes a report under the *Health Protection and Promotion Act*. Thus any person who gives information in accordance with a duty under the *Health Protection and Promotion Act*, shall, upon the request of the medical officer of health, give to the medical officer of health such additional information respecting the reportable disease or communicable disease as the medical officer of health considers necessary.**
- **This portion of Regulation 569 (s. 1(2), additional information) be moved to the Act itself, to form an integral part of the reporting obligations set out in the Act and to ensure that the power is protected, absent legislative debate, from subsequent amendment.**
- **Amendments to the *Health Protection and Promotion Act* and Regulations be preceded by consultation with the public health community who have to apply them in the field.**

Reporting Contacts of Cases

Another gap in the legislation that became apparent during SARS is that the *Health Protection and Promotion Act* only requires that information be given in respect of a patient. Nothing in the Act requires a physician or hospital to provide information about contacts of the patient. This information turned out to be crucial during SARS, as the management of SARS required the identification and isolation of contacts to prevent the spread of the disease. Information about the identification of contacts became particularly critical in the context of health care workers exposed to SARS patients, as they often became a vector for transmission requiring early identification and isolation to stop the spread of SARS.

The reporting of contacts is important for diseases beyond SARS. As one public health expert stated:

I think there are a number of diseases where it's really important to identify contacts. We need to keep them away from people ... for example, people we don't know about have been around people with TB and they then develop it themselves and then pass on to other people.

A submission to the Commission from a group of experts, who were all closely involved in the SARS response, recommended that the reporting sections of the *Health Protection and Promotion Act* be amended to support the work of health units in tracing the contacts of patients with infectious diseases:

The current HPPA does not give specific reference to contacts of infectious cases. Release of information on the cases as well as contacts is essential for infectious disease control. This was a major obstacle during the management of the SARS outbreak. We believe that the requirement to report contacts referred to specifically in the legislation will allow practitioners to provide this information to their medical officer of health.

The amendments to Regulation 569, effected in Regulation 01/05, address this issue. Contacts initially identified or later traced are included in most of the lists specifying additional information that must be reported to the medical officer of health. In particular, it is included in the case of SARS, TB, influenza and febrile respiratory illness. This means that those who have reporting obligations under the Act are now required to provide contact information.

Standardizing Reporting

The amendments to Regulation 569 impose significant additional responsibilities, in respect of the type and amount of information that must be provided, on those with reporting obligations under the Act. While this is a positive step for public health, it must be matched with the recognition that health care institutions and facilities are busy places and health care professionals have many demands on their time. An emergency room physician does not, for example, have the time or luxury to sit and spend hours completing reports while ill patients wait to be treated.

Some have complained that there was a lack of uniform reporting requirements during SARS. Different public health units at different times wanted different information transmitted in different ways. Often a health care facility would provide information to a local health unit, only to be called a few moments later by someone from the provincial Public Health Division or some other part of the government, requesting the same information. In the first interim report, the Commission noted the impossible burden imposed on front line workers by the repetitive and overwhelming demands for information. Professionals will loathe and avoid reporting if the process is overly time consuming or unclear, or if the obligation it imposes changes depending on the recipient of the report. Public health therefore requires a uniform reporting protocol and standardized reporting formats applicable to all institutions. Hospitals must establish internal reporting policies to ensure reporting. Hospitals, physicians and other health care professionals must work together to develop standardized reporting forms, systems and protocols.

As one health expert noted in respect of the expansion of reporting requirements:

Reporting mechanisms should not be made too onerous. Report either electronically or through a simple fax and ensure there is someone on receiving end. Part of the problem that public health has been plagued with is under funding. As long as [the reporting system] is something relatively quick and easy, I don't think it will be really bad. It comes down to mechanisms for reporting and lack of standardization, something we suffer from constantly. We are going through it now with pandemic flu. No one wants to say you have to do it this way. It irritates everyone and nothing is fixed. Hospitals report in different ways. Some by Excel, some by fax, most by e-mail. If a fixed method in the way a report gets there, whether by a portal in the net ... hit it and say I'm hospital number ABC, without lab confirmation I have two cases of TB – looks like it and

walks like it, then public health can do what they want to do from there ... If you don't mandate what you want and how you want it you are going to get it 350 ways. If hospital A is collecting temperatures in degrees Fahrenheit and hospital B in Celsius, or they are doing blood pressure different ways, you create scenarios where accidents will happen and mistakes will be made. The data ends up being noncomparable. Reproducibility and comparability - if you can't compare your data you will never be able to use it. It needs to be fixed, whoever does it, whether it is done by the Chief Medical Officer of Health in collaboration with a crew of very important people who know what is going on. Someone needs to say what they want and how they want and when they want it. SARS was perfect example of this.

The expansion of reporting obligations requires clarity around who receives the report, who follows up with the information providers when required, and how the information flows after it reaches the hands of public health. Currently, reporting goes from institutions to local public health to the Public Health Division at the Ministry of Health. During SARS however, some health providers, even though they were already supplying all necessary information to their local public health branch, were called directly by the Public Health Division or by the Minister's staff:

During SARS we had examples of phone calls from political staff asking for nominal information on those who were ill from the local medical officers of health. The MOH's were just downright irritated by it.

Recommendations

The Commission therefore recommends that:

- **Local public health officials and the Public Health Division, in collaboration and consultation with hospitals, other health care institutions and professional organizations, develop a standardized form and means for reporting under the *Health Protection and Promotion Act*.**
- **The standardized reporting include clarity around to whom the report must be made, and to clearly confirm that the chain of transmission goes from the hospital and health care facilities, to the local health units, to the province, so as to avoid multiple requests for information.**

Reporting – Education and Awareness

As noted in the following chapter, Privacy and Disclosure, Ontario has entered a new era of restriction in the sharing of personal health information with the passage of the *Personal Health Information Protection Act*. Much effort has gone into educating health care workers, professionals and administrators about the Act and ensuring that they understand the importance of maintaining the privacy of personal health information. This laudable objective becomes dangerous if it emphasizes overwhelmingly the duty not to disclose without a corresponding emphasis on the duty to disclose to public health officials when required. The duty under the *Health Protection and Promotion Act* to disclose information for the sake of public safety is not discretionary and there should be no mistake about the fact that this duty to disclose overrides any discretionary powers in the *Personal Health Information Protection Act* to withhold information.

Health care professionals and institutions must be educated on the importance of reporting cases immediately to public health, and involving them in discharge decisions of infectious patients. Public health continues to learn about infectious cases long after they have been admitted into hospital and, at times, long after their discharge. Often public health finds out when the patient is readmitted, having spent time in the community while infectious. As one public health official described the problem:

One of the ongoing issues that public health experiences with TB prevention and control is the lack of reporting on the part of physicians.

In general, the Central Public Health Lab does most of the reporting of new cases. When a specimen is sent to the lab and a positive smear for TB is identified, the lab will send the results to the local health unit. Physicians, although obligated to report TB, rarely report to public health. The majority of the time this lack of reporting is compensated for by the lab. However, about 15 to 20 % of the cases of TB in Toronto are diagnosed clinically, that is there is no lab evidence to support the diagnosis. This may occur because the physician does not bother to confirm the diagnosis by sending off specimens, or specimens are sent off and they are of poor quality so the lab cannot confirm the diagnosis, or the TB is diagnosed in an organ or structure such as kidney where it may be difficult to obtain a specimen. It is these cases where the lack of physician reporting can be very serious ...

... It is essential that physicians understand the obligation to report and it is essential that they do so in a reasonable period of time to allow public health to assist in the management of the case and to conduct the contact follow-up investigation.

An example of the negative consequences of not reporting can be illustrated through the discussion of a case managed by a local public health unit in the early part of 2004. A man visited a very busy community hospital emergency room with gastrointestinal complaints. After investigation, the patient was started on treatment for TB. This was an appropriate clinical decision as the patient had significant risk factors for TB; he had been in a country where the rate of TB is very high and was intermittently homeless, living in the shelter system. Unfortunately, the physician did not order any confirmatory tests such as a sputum smear, did not report the case to public health, and started the patient on an incorrect treatment regiment. As the physician was feeling uncomfortable with treating TB, he consulted the infectious diseases (ID) service in the hospital and made many attempts to transfer this patient's care to the infectious disease physician. Unfortunately, as this patient was difficult to deal with and presented mental health issues, the ID service was not interested in taking over his care and would only agree to consult. It took more than two weeks for this case to be reported to the local public health unit. By that time, the gastrointestinal physician was overwhelmed with the case as TB was not his area of expertise. He was getting ready to discharge this still infectious patient into the community where he would most likely have ended up back in the shelter system. The public health unit, finally alerted to the situation, interceded, sent in a public health nurse that day to collect a sputum sample to confirm the diagnosis and quickly arranged for this patient's transfer to another hospital able to treat a TB patient. The delay in reporting led to a delay in the ability of the local health unit to initiate a contact follow-up investigation, which ultimately involved two large homeless shelters. The patient had been living in the shelter system for many months while he was symptomatic and infectious with TB. Public health officials described the consequences of this delay in reporting:

The delay in reporting led to many significant consequences. First, this infectious patient was almost discharged back into the shelter system. More important, the delay in reporting led to a delay in public health being able to initiate a contact follow-up investigation, which ultimately involved two large shelters. This case had been living in the shelter system for many months while he was symptomatic and infectious with TB. A delay in contact follow-up could have meant a delay in finding other infectious cases in the shelter system as a result of exposure to this patient. Fortunately, our contact follow-up investigation did not find

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other cases of active disease in the involved shelter. However, it is important to note that this population is highly mobile and so the quicker public health can initiate contact follow-up the more likely we are to successfully find the identified contacts. In this case, although we didn't find active cases, we also had difficulty locating a significant proportion of the contacts as too much time had lapsed since the exposure and our setting up of contact follow-up clinics. This again was the consequence of a significant reporting delay.

Another example emerged from a TB case in late 2004. The patient had initially entered a busy emergency room suffering from TB. He was briefly treated and released into the community, to reside in the shelter system, without any notification to public health. Shelter workers, upon seeing the ill man, sent him to a different local hospital, as he appeared to them very ill and in desperate need of treatment. Although the patient was admitted to a second hospital where he was treated for TB, public health officials did not become aware of the case for a few days, delaying their initiation of contact tracing.

It is essential that physicians, other health professionals, and health care administrators, understand the obligation to report, and it is essential that they do so quickly to enable public health to do what is required by way of management, investigation and follow-up to protect the public. Physicians and health care providers must understand the important role of public health officials in the management of infectious disease cases. As noted above, it is not only vital to notify public health immediately, but public health must also be kept updated on the status of the patient and discharge plans. Yet public health officials report that this continues to be a frequent problem. The consequences for noncompliance can be severe.

Consider the example of another TB patient admitted to hospital in the early part of 2004. The patient had been diagnosed and treated approximately five years earlier for fully sensitive pulmonary TB. This person unfortunately did not complete the appropriate treatment regimen for TB, was not cured, and as a result the disease "reactivated" in 2004. The patient initially did not take the drugs as prescribed and developed resistance to the most important first line drugs in TB control. When his disease reactivated he was hospitalized for six months and treated for Multi-Drug Resistant [MDR] TB. During hospitalization the patient was compliant with the treatment plan. As MDR TB is the most serious form of TB from a public health point of view due to the resistance to the two most important first line drugs, patients can be hospitalized for up to two years to ensure that the disease has been completely cured. In this case, the hospital planned for discharge six months into this patient's

treatment. Local public health officials were not notified of this discharge plan because the hospital was planning to discharge this patient into a region other than that in which the hospital was located. Public health officials described to the Commission the important work that lay ahead for public health officials following a discharge of a patient in this situation:

It is important to note that when sending an MDR patient home prior to the completion of treatment, the health care provider and public health officials must be completely confident that the individual will comply with isolation at home, take the drugs as directed through complying with directly observed therapy (DOT), and regularly appear for the intensive follow-up at the TB clinic. This follow-up can often be as intensive as every two weeks. The reason for these strict discharge conditions is to allow for strict monitoring of the case's level of infectivity. It is to prevent a case of MDR TB from becoming infectious after discharge and inadvertently infecting close contacts and members of the community with the same strain. Preventing transmission of this type of TB is paramount as it is difficult to treat and cure, and it has a very poor prognosis. Transmission of this strain in the community could lead to catastrophic public health consequences as was experienced in the New York City MDR TB outbreak in the 1990's that led to significant morbidity and mortality, transmission across state borders, and cost billions of dollars to contain.

When this patient was discharged, none of the discharge criteria were met. The patient had no fixed address, was highly mobile, often homeless, and had substance abuse issues. The likelihood of compliance in the community was low prior to discharge. The hospital notified the involved health unit approximately two days before discharge. Although the health unit was not in support of the early discharge, the patient was released to a rooming house in an unfamiliar area in June 2004, with the stipulation of complying with directly observed therapy. Not surprisingly, the patient was noncompliant with treatment and within a short period of time became infectious again. The patient was eventually readmitted to the same hospital that had discharged him. In the summer of 2004 he was back in hospital, however, public health officials were not informed until approximately one month later that the patient had been taking the bus every day into another nearby large community during the period of time that he was out in the community. Upon further investigation and interviewing of the patient it became clear that he was circulating within our shelter system and amongst the homeless population while infectious. As a result of this non-reporting, public health officials were unable to identify all those with whom

the infectious patient came in contact. The potential for a major outbreak and the cost to public health and the community was very real. As one public health official noted:

The potential of having an unknown group of contacts exposed to MDR TB in the shelter system who could develop active disease and infect others is daunting, and very similar to what occurred in New York City in the 1990's ...

... Due to the resistance pattern of the case, there are currently no drugs that can be effectively used to treat the identified contacts. As a result, this group will have to be followed intensely, at least every 3 months, by the TB clinic to ensure they have not become symptomatic. This will not only stretch the capacity of the TB clinics but it will stretch the capacity of public health. Many of the identified contacts will likely be homeless and highly mobile. Public health will have to ensure that people get to their appointments, which will often mean trying to locate contacts that may have moved to a different shelter or even a different jurisdiction. This type of follow-up will continue for two years. Should any of the identified contacts become symptomatic within these two years or beyond, they will require immediate hospitalization for medical assessment.

In summary, the consequences of this inappropriate discharge include needless exposure of a serious strain of TB to a vulnerable and still ill-defined population, increased use of resources now and in an ongoing manner by public health and the hospital TB clinic, readmission of this patient with an expanded resistance pattern (over the month while he was taking his drugs erratically he developed resistance to more medications) worsening his prognosis, and the use of key resources at Health Canada to assist in this investigation. The consequences that are less measurable will be the fear and anxiety that is caused when contacts are notified and the anxiety that this will likely cause within the shelter system once public health initiates this investigation in conjunction with Health Canada. This could have been prevented had the hospital been obligated to consult with public health and have the consent of public health before discharging this patient into the community.

It is essential that the Ministry make every effort to educate all those with reporting duties under the Act of their legal obligation to do so. They must do so on an ongoing basis, with a clear emphasis on the important relationship between health care profes-

sionals and institutions and public health in protecting the public from infectious diseases. Misunderstanding of Ontario's complex system of privacy laws cannot be permitted to interfere with the duty to report that is required by law to protect the public from infectious disease. Where education fails, enforcement should begin.¹⁸⁸

Recommendation

The Commission therefore recommends that:

- **The Ministry of Health and Long-Term Care, Public Health Division, in collaboration with local medical officers of health, health care facilities and professional organizations, engage in broad-based education of reporting requirements under the *Health Protection and Promotion Act* and that such education be maintained on a regular basis.**

Reciprocal Reporting Obligations

All hospitals have a clear interest in ensuring that infectious disease outbreaks do not occur in their facilities. Many hospitals who made submissions to the Commission remarked on the need for a two-way relationship between them and public health. Hospitals want to know when an investigation reveals that their institution is a source of an infectious disease so they can take immediate steps to fix the problem. One hospital put it this way:

Public health authorities should be mandated, under the *Health Protection and Promotion Act* to provide public hospitals with the confidential health information of persons about whom a report is made, where the investigation of that report gives rise to information that a communicable disease was acquired or may have been acquired at a public hospital. This information is essential to the hospital's ability to determine the extent of a nosocomial outbreak and to take measures to respond to and control the outbreak. The amendments should provide

188. Subsection 100(2) provides:

Any person who contravenes a requirement of Part IV to make a report in respect of a reportable disease, a communicable disease or a reportable event following the administration of an immunizing agent is guilty of an offence.

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that the information must be communicated as soon as it comes into the possession of the public health authority. Hospitals and physicians are simply not in a position to respond to a potential infectious disease outbreak within the hospital, where information relevant to the outbreak is held outside the hospital.

This recommendation makes great sense.

Section 39(1) of the *Health Protection and Promotion Act* specifically prohibits the medical officer of health from disclosing information received pursuant to a report under the Act. It states:

39(1) No person shall disclose to any other person the name of or any other information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, a reportable disease, a virulent disease or a reportable event following the administration of an immunizing agent.

While s. 39(2) provides exceptions to this prohibition, the exceptions do not appear to relate to preventing the spread of an infectious disease.¹⁸⁹ One hospital described the problem to the Commission as follows:

In particular, there is a need for greater clarity around the hospitals' ability to request health information back from public health with respect to

189. Subsection 39(1) does not apply,

(a) in respect of an application by a medical officer of health to the Ontario Court of Justice that is heard in public at the request of the person who is the subject of the application;

(b) where the disclosure is made with the consent of the person in respect of whom the application, order, certificate or report is made;

(c) where the disclosure is made for the purposes of public health administration;

(d) in connection with the administration of or a proceeding under this Act, the *Regulated Health Professions Act, 1991*, a health profession Act as defined in subsection 1 (1) of that Act, the *Public Hospitals Act*, the *Health Insurance Act*, the *Canada Health Act* or the *Criminal Code* (Canada), or regulations made thereunder; or

(e) to prevent the reporting of information under section 72 of the *Child and Family Services Act* in respect of a child who is or may be in need of protection.

tracing ill staff and transferred patients, who are diagnosed and treated at other institutions, but whose illness is linked to the index hospital. This is essential to the hospital's ability to assess the extent of a nosocomial outbreak internally. Section 39(1) of the *Health Protection and Promotion Act* provides that all information obtained by public health authorities with respect to a person about whom a report has been made will be held in confidence and shall not be disclosed. Section 39(2) of the statute provides certain exceptions allowing disclosure, but it is unclear whether any of these exceptions would permit the disclosure to hospitals required to manage a nosocomial outbreak. It would greatly assist the hospital sector to amend the *Health Protection and Promotion Act* to require public health authorities to report back to a hospital, where public health is in possession of information that suggests a reportable disease may have been acquired through exposure at that hospital. This amendment should not be left to special health emergency legislation, as timely reporting of such information may assist in stemming an outbreak prior to it reaching emergency proportions.

These recommendations are sensible. Hospitals and other health care facilities need information about cases originating or having been treated in their facilities, to enable them properly to assess their risk and respond so as best to protect the safety of other patients and staff. As one medical officer of health also noted, a two-way reporting system between public health and health care institutions can only strengthen the vital relationship between these two partners:

... it is important in terms of relationship building in an ongoing way to have that ability to do it so. Where in doubt, it ought to be included to allow us to do that.

The wording of such a section would undoubtedly require that there be some assessment by the medical officer of health that the information was linked to a potential risk to the health of other patients as well as the amount of information that would be necessary to provide to mitigate the risk. As one medical officer of health noted:

I think there has to be a potential risk to the health of other patients, visitors, and staff. So it implies that there's a risk assessment done by the medical officer of health or staff of the health unit that warrants the provision of this information, both to reduce the clutter of reports coming back that are not actionable by the hospital or the long-term care facility and also to protect information unless it's required.

The ultimate goal is to arm hospitals and other health care institutions with information so they can protect their staff and patients. If information in the hands of public health officials would help hospitals do a better job, public health should give hospitals that information. It has to be a two-way street. Just as public health requires information from hospitals, so do hospitals and other health care facilities require information from public health. It is completely unhelpful for an institution to learn months after the event that an infectious patient passed through their hospital or that an infectious staff member had been working while ill without the hospital's knowledge. If public health has such information no legal barrier should prevent public health from sharing it with the hospital or any other health care facility. Currently, both s. 39(1) of the *Health Protection and Promotion Act* and the *Personal Health Information Protection Act* may prohibit the sharing of personal health information in such a manner. This should be remedied for the protection of all patients and staff who work in health care institutions.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to require public health authorities to report to a hospital or any other health care facility, including family medical clinics, any information in the hands of public health that suggests a reportable disease may have been acquired through exposure at that site.**
- **Section 39(2) of the *Health Protection and Promotion Act* be amended to include an exception permitting public health officials to provide hospitals and other health care facilities, with the personal health information of persons about whom a report is made, where they are of the opinion that the information may reduce the risk of exposure or transmission to staff, patients or visitors.**

Conclusion

Medical officers of health and the Chief Medical Officer of Health can only protect the public if they are aware of the existence of a threat to the health of the public. In respect of communicable diseases it is critical that health care providers are aware of and vigilant in complying with their reporting obligations under the Act. This

requires both education of health care workers and health care institutions as well as a collaborative effort between public health, health care providers and professional bodies to ensure, so much as possible, ease in complying with the reporting obligations under the Act. If the reporting structure or requirements are too onerous they will invite noncompliance. On the other hand, legal duties that are vague or unenforced will similarly invite noncompliance. It could take only one failure to report the presence or suspected presence of a communicable disease to lead to a serious outbreak in a health care institution or in the community at large.

The Chief Medical Officer of Health requires broad powers to compel information from health information custodians where necessary to protect the public from an infectious disease. The Act and its regulations cannot predict and provide for unknown diseases, such as SARS, which may come upon us suddenly and which require a strong and swift public health response.

There must also be an open exchange of information between health care professionals and public health with a common goal of investigating and preventing the spread of infectious disease.

Recommendations

The Commission therefore recommends that:

- **The *Health Protection and Promotion Act* be amended to repeal, in the duty of a physician to report to the medical officer of health, the distinction between hospital patients and non-hospital patients. This may be achieved by deleting from s. 25(1) the words “who is not a patient in or an out-patient of a hospital.”**
- **The Ministry of Health and Long-Term Care require each hospital, long-term care facility, nursing home, home for the aged, community care access centre, private medical or health services clinic, and any health care institution, to establish an internal system to ensure compliance with the reporting obligations set out in the *Health Protection and Promotion Act*.**
- **The definition of “practitioner” in the *Health Protection and Promotion Act* be amended to coincide with that set out in the *Personal Health Information Protection Act*.**

- **The list of “institutions” as defined in s. 21(1) of the *Health Protection and Promotion Act*, be amended to coincide with that set out in the *Personal Health Information Protection Act*.**
- **The *Health Protection and Promotion Act* be amended to ensure consistency between those who are defined as “health information custodians” under the *Personal Health Information Protection Act* and those who have reporting obligations under the *Health Protection and Promotion Act*.**
- **The *Health Protection and Promotion Act* be amended to authorize the Minister of Health and Long-Term Care to amend the definition of “practitioner” or “institution” by regulation.**
- **The *Health Protection and Promotion Act* be amended to include a provision similar to the provisions in Quebec’s *Public Health Act*, by which the Quebec public health director may 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.**
- **This power should be broadly defined, to enable the Chief Medical Officer of Health to require any person, organization, institution, government department or other entity, to provide information, including personal health information, to the Chief Medical Officer of Health, for the purposes of investigating and preventing the spread of infectious disease.¹⁹⁰**
- **The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health to order the collection, analysis and retention of any laboratory specimen from any person, animal, plant or anything the Chief Medical Officer of Health specifies, and to acquire previously collected specimens and test analysis from anyone, and to disclose the results of test analysis as the Chief Medical Officer of Health considers appropriate for the purpose of investigating and preventing the spread of**

190. As noted above, this is not drafting language. The use of the term “infectious disease” is intended to include but not be restricted to diseases already designated as communicable, reportable or virulent under the *Health Protection and Promotion Act*. The provision should be defined broadly enough to cover bioterrorism risks. It should not, however, extend to every health risk, such as obesity or other lifestyle problems.

infectious disease.¹⁹¹ This power, however, should be subject to the following restrictions:

- It should not include the power to take a bodily sample or specimen directly from a person without their consent or, absent consent, without court order. The power should only apply to specimens already taken;
 - The collection should be limited to the purpose of investigating and preventing the spread of infectious disease. The specimen should be used only for this express purpose; and
 - The power should not override any other provisions of the Act, which set out a specific process for the obtaining of samples.
- The *Health Protection and Promotion Act* be amended to require that in the case of specific diseases, designated by regulation, information be reported “immediately” by telephone to the local medical officer of health, and that such report be followed up in writing within 24 hours;
 - The *Health Protection and Promotion Act* be amended to require that as in the case of those diseases not designated for immediate reporting, a written report must be provided to the local medical officer of health within 24 hours.
 - Subsection 1(2) of Regulation 569 be expanded to apply to any person who makes a report under the *Health Protection and Promotion Act*. Thus any person who gives information in accordance with a duty under the *Health Protection and Promotion Act*, shall, upon the request of the medical officer of health, give to the medical officer of health such additional information respecting the reportable disease or communicable disease, as the medical officer of health considers necessary.
 - This portion of Regulation 569 (s. 1(2), additional information) be moved to the Act itself, to form an integral part of the reporting obligations set out in the Act and to ensure that the power is protected, absent legislative debate, from subsequent amendment.

191. *Ibid.*

- **Amendments to the *Health Protection and Promotion Act* and Regulations be preceded by consultation with the public health community who have to apply them in the field.**
- **Local public health officials and the Public Health Division, in collaboration and consultation with hospitals, other health care institutions and professional organizations, develop a standardized form and means for reporting under the *Health Protection and Promotion Act*.**
- **The standardized reporting include clarity around to whom the report must be made, and to clearly confirm that the chain of transmission goes from the hospital and health care facilities, to the local health units, to the province, so as to avoid multiple requests for information.**
- **The Ministry of Health and Long-Term Care, Public Health Division, in collaboration with local medical officers of health, health care facilities and professional organizations, engage in broad-based education of reporting requirements under the *Health Protection and Promotion Act* and that such education be maintained on a regular basis.**
- **The *Health Protection and Promotion Act* be amended to require public health authorities to report to a hospital or any other health care facility, including family medical clinics, any information in the hands of public health that suggests a reportable disease may have been acquired through exposure at that site.**
- **Section 39(2) of the *Health Protection and Promotion Act* be amended to include an exception permitting public health officials to provide hospitals and other health care facilities, with the personal health information of persons about whom a report is made, where they are of the opinion that the information may reduce the risk of exposure or transmission to staff, patients or visitors.**