2. Roles, Responsibilities and Frameworks for Decision-Making

> To have any chance in alleviating the devastation of the [1918 influenza] epidemic required organization, coordination, implementation. It required leadership and it required that institutions follow that leadership.
>
> The Great Influenza, John M. Barry

Ontario's health plan for an influenza pandemic is based on and reflects:

- the global pandemic planning phases developed by the World Health Organization (WHO)
- the Canadian pandemic planning phases developed by the Public Health Agency of Canada
- a collaborative approach to pandemic planning and direction provided by the Canadian Pandemic Influenza Plan
- emergency management and incident management systems used in Canada and Ontario
- an ethical framework to guide decision-making
- relevant provincial legislation.

2.1 WHO Pandemic Periods and Phases

To help guide response planning for an influenza pandemic, the WHO has identified the phases of a pandemic.

Table 2.1: WHO Pandemic Periods and Phases

Period	Phase	Description
Interpandemic Period*	Phase 1	No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk* of human infection is considered to be low.
	Phase 2	No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.
Pandemic Alert Period**	Phase 3	Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.
	Phase 4	Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.
	Phase 5	Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).
Pandemic Period	Phase 6	Increased and sustained transmission in general population.
Postpandemic Period		Return to interpandemic period

Source: World Health Organization, 2005.

* The distinction between phase 1 and phase 2 is based on the risk of human infection or disease from circulating strains in animals.

** The distinction between phase 3, phase 4 and phase 5 is based on the risk of a pandemic.

2.2 Canadian Activity Levels

The WHO phase number reflects the international risk or activity level with respect to the new influenza virus subtype, but it may not reflect virus activity in Canada especially during the pandemic alert period. To help guide pandemic planning and response in Canada, the Public Health Agency of Canada has developed a numbering system to reflect pandemic influenza activity in Canada:

- 0 indicates no activity in Canada
- 1 indicates low activity and low risk in Canada
- 2 indicates higher activity and risk in Canada.

The Canadian activity level number will be used with the WHO phase number to indicate the level of pandemic activity in Canada (see Table 2.2).

2.3 A Collaborative Interjurisdictional Approach to Pandemic Planning

Ontario's plan is also based on coordination and collaboration among governments and jurisdictions. Because viruses do not respect borders, planning must occur at all levels: internationally, nationally, provincially and locally. Each level of government has a different role depending on their jurisdictional authority, but their plans and activities must be coordinated.

A coordinated collaborative approach will ensure effective communication between local health authorities (who will be the first to detect influenza in their communities) and the provincial and federal governments, with other countries, and with international health authorities. The Ontario Health Plan for an Influenza Pandemic is consistent with the Canadian Pandemic Influenza Plan (CPIP) and implements the activities set out in the federal plan. The OHPIP also draws on resources and information in the CPIP. Ontario will continue to work closely with the Public Health Agency of Canada (PHAC) to plan its response to an influenza pandemic.

The Role of Government

Figure 2.1 (next page) illustrates the respective roles of different levels of government in pandemic planning.

Table 2.2: Example of WHO and Canadian Pandemic Activity Levels

WHO Phase	CAN Phase	WHO/CAN Phase	Definition
6	0	6.0	Outside Canada increased and sustained transmission in the general population has been observed. No cases have been detected in Canada.
6	1	6.1	Single human case(s) with the pandemic virus detected in Canada. No cluster(s) identified in Canada.
6	2	6.2	Localized or widespread pandemic activity observed in the Canadian population.

Figure 2.1: Roles and Responsibilities in Collaborative Interjurisdictional Pandemic Planning

In addition to government, other stakeholders will play a key role, including health care providers and their regulatory colleges and associations, and the public.

Role of Health Services

Each part of the health care system has a role to play in pandemic planning and response. The primary focus will be on responding to the population's influenza-related needs as well as maintaining other critical health services (e.g., maternity care, trauma services, and treatment of life-threatening illnesses, chronic care, and palliative care).

The steps that each part of the system will take during a pandemic are described in detail in Part III of OHPIP 2006.

Role of Regulated Health Professions and Regulatory Colleges

Health professionals and their regulatory colleges have an important role to play in a consistent, coordinated provincial response to an influenza pandemic. They will help ensure effective communication within their profession, and high levels of professional respect and collaboration (based on a clear understanding of roles) among health professionals during a pandemic.

As part of OHPIP, regulatory colleges are being encouraged to develop action plans consistent with the principles of the ***Regulated Health Professions Act*** (i.e., protection from harm, quality of care, access, accountability, equity, equality) and with the OHPIP ethical framework for decision-making framework (see 2.5). The plans will help Ontario provide the best care possible during a pandemic. They will also encourage a consistent province-wide response that supports Ontario's proposed competency-based approach to optimizing deployment of health care providers during a pandemic (see Chapter 8). These plans should consider the following issues:

Communications

- appropriate communications strategies with staff, College Council, and members and accompanying infrastructure (e.g. web-based, telephone/teleconference; automated information services, fax, mail)
- collaboration with the Ministry of Health and Long-Term Care to develop a co-ordinated communications strategy.

Regulatory

- consideration, where appropriate, of accountability issues
- the need for complementary guidelines and/or policies for influenza care during a pandemic between regulatory colleges
- the need to develop co-ordinated policies on delegation during an influenza pandemic
- the need for emergency (expedited) registration policies and standards for *qualified* individuals supported by appropriate regulations.

Corporate

- co-operation between regulatory bodies and other stakeholders in planning for an influenza pandemic, including but not limited to, dissemination of information by jurisdiction (e.g., number of members in a given jurisdiction)
- inter-provincial co-operation on regulatory issues that could affect response to an influenza pandemic, such as the mobility and registration of health care providers
- the role of the Federation of Health Regulatory Colleges of Ontario
- the ability to maintain critical College operations during a pandemic (e.g., website or automated telephone messages)

- the ability to provide practice advice to members and employers 24/7 during a pandemic (e.g., website).

Role of the Public

The public is expected to actively participate in efforts to reduce the spread of the influenza, to comply with any public health measures, and to participate in their own care in a pandemic.

2.4 Emergency Management in Ontario

An influenza pandemic will have an impact throughout society and will involve the broader emergency management system. The health response will have to coordinate with the emergency response. Emergency management in Ontario and Canada is organized into five stages: prevention, mitigation, preparedness, response and recovery.

- Prevention involves activities taken to prevent or avoid an emergency or disaster. The eradication of smallpox is an example of a prevention strategy.
- Mitigation involves actions that can reduce the impact of an emergency or disaster. Influenza immunization and infection prevention and control standards and guidelines are health-specific examples of mitigation. They will not prevent a pandemic, but they will lessen its impact by reducing disease transmission.
- Preparedness involves measures that are put in place before an emergency occurs that will enhance the effectiveness of response and recovery activities, such as developing plans, tools and protocols; establishing communication systems; conducting training; and testing response plans.
- Response involves the coordinated actions that would be undertaken to respond to an emergency or disaster. In the case of the MOHLTC, this could involve a host of activities, including the mobilization of providers (hospitals, paramedics) and the coordination of health care services (isolation, treatment), and the acquisition and distribution of medical supplies and pharmaceuticals.
- Recovery involves activities that are conducted to help communities recover from an emergency or disaster and return to a state of normalcy. This includes activities to repair damage, rebuild infrastructure, restore services, provide financial assistance and the ongoing treatment and care for the sick or injured. It may also include prevention/mitigation measures designed to avert a future emergency (e.g., vaccination to prevent a future outbreak). The recovery phase also applies to those involved in response who need time to recuperate and renew themselves.

The activities described in this iteration of Ontario's Health Plan for an Influenza Pandemic focus primarily on mitigation, preparedness and response. Plans for the recovery stage are still being developed.

Incident Management System (IMS)

The Incident Management System is an international emergency management structure that has been adopted by Emergency Management Ontario (EMO) as the operational framework for emergency management for the Government of Ontario. It provides the basic command structure and functions required to manage an emergency situation effectively. The IMS has five components: Command, Operations, Planning, Logistics and Finance, and Administration.

This simple structure can be applied to any organization involved in emergency management. This allows them to standardize contact information across organizations, make communication and cooperation among the groups easier, and make the process of managing an emergency more efficient. Planning staff will be able to communicate directly with their peers in other jurisdictions.

During a pandemic, health organizations can use the IMS to help mobilize and distribute medical supplies from federal and provincial stockpiles to the front line. The Logistics groups of each organization would work together to plan distribution while the Operations groups would work with the Ministry of Transportation to transport supplies into affected areas.

The Ministry of Health and Long-Term Care will use this model for its Emergency Operations Centre (MEOC) at the Emergency Management Unit. Other organizations provincially and locally (e.g., acute care hospitals) are also using this model, which will help increase the effectiveness of emergency management across the province.

Figure 2.2 illustrates the relationship between Ontario's health response to an influenza pandemic and the broader emergency response.

Emergency Response Activities

Emergency response is the broad range of activities required to respond to any emergency, including a health emergency, such as an influenza pandemic. It includes measures to prepare for emergencies, such as developing and testing plans and establishing communication systems. It also includes the services provided during an emergency by emergency responders, such as police and firefighters, and by workers who provide critical community services, such as utility and telecommunications workers, and social service providers.

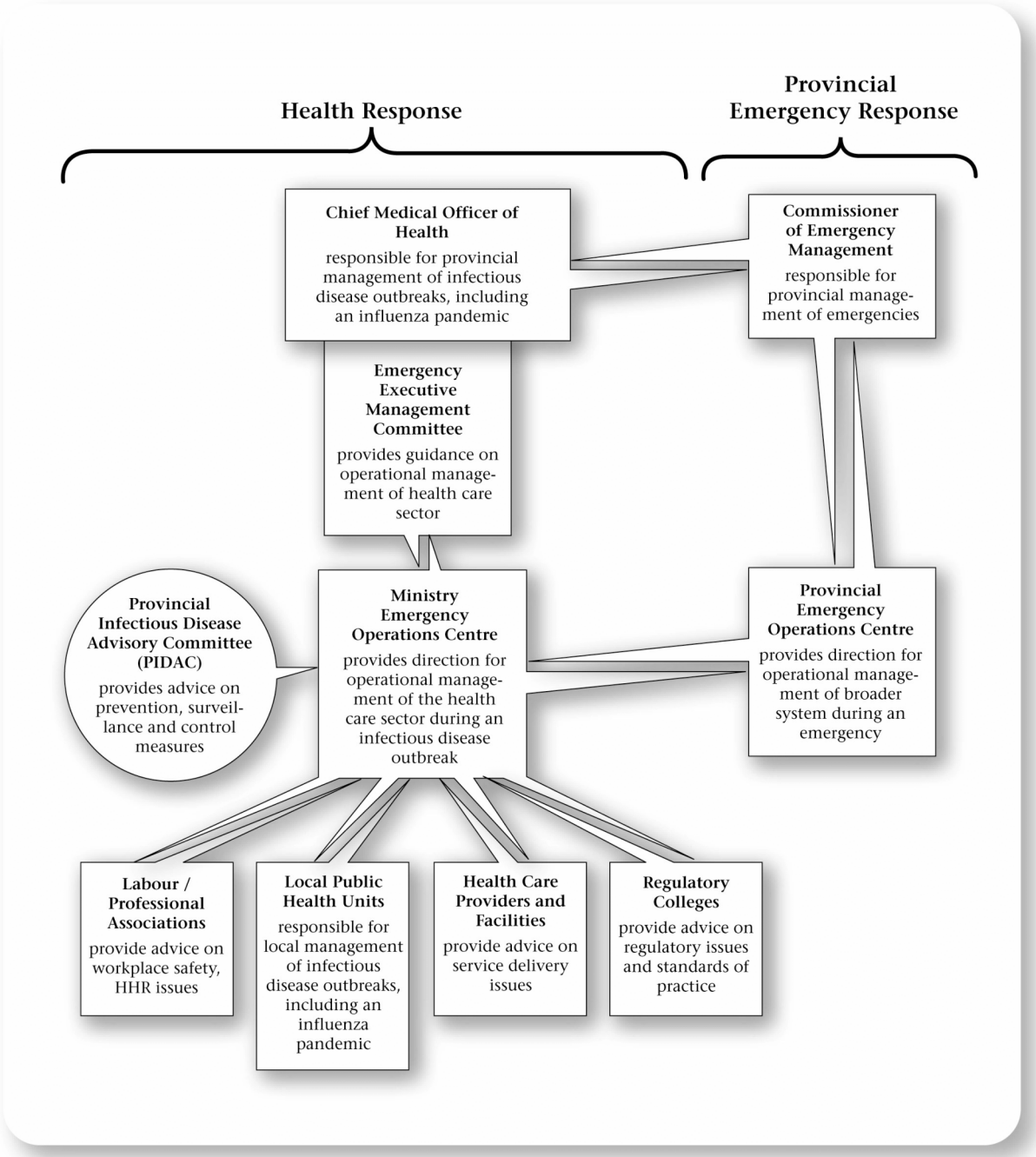
A timely, comprehensive emergency response to an influenza pandemic requires:

- effective **coordination/communication** between the health and emergency response systems at all levels (i.e., federal, provincial, municipal)
- business continuity plans/continuity of operations plans to ensure continuity of **critical services** and infrastructure during a pandemic
- a mechanism to identify **emergency response resources** that can be mobilized to help respond to the health demands of a pandemic.

Emergency response activities for a pandemic focus on building on the emergency plans already in place, in order to provide critical services for the pandemic (e.g., protecting workers in critical industries from exposure to influenza, providing critical services to people isolated in their homes, maintaining critical services when a significant proportion of workers may be ill with influenza).

Emergency Management Ontario, in collaboration with other ministries, is developing a Provincial Coordinating Plan for an Influenza Pandemic. That plan addresses pandemic planning issues outside the health sector, and focuses on maintaining critical infrastructure and meeting human needs during a pandemic.

Figure 2.2: Emergency Management Roles and Relationships



Ontario is working with the federal government to develop and conduct planning exercises that will test the ability of existing emergency response plans to maintain critical services during an influenza pandemic, and give communities the information they need to refine their plans.

During a pandemic, the health system may also need to call on emergency responders and other workers to assist in providing health services, transporting medical supplies and services, and ensuring the safety and security of vaccine and antiviral supplies. EMU is working with EMO to identify these resources before a pandemic occurs, so they can be mobilized quickly.

2.5 Ethical Framework for Decision Making[1]

During an influenza pandemic, governments and public health authorities will have to make difficult decisions (e.g., access to vaccines and antivirals, reallocation of people and resources). Stakeholders (e.g., members of the public, patients, health care workers, other organizations) are more likely to accept the difficult decisions if the decision-making processes are:

- Open and transparent – The process by which decisions are made must be open to scrutiny and the basis for decisions should be explained.
- Reasonable – Decisions should be based on reasons (i.e., evidence, principles, values) and be made by people who are credible and accountable.
- Inclusive – Decisions should be made explicitly with stakeholder views in mind and stakeholders should have opportunities to be engaged in the decision-making process.
- Responsive – Decisions should be revisited and revised as new information emerges, and stakeholders should have opportunities to voice any concerns they have about decisions (i.e., dispute and complaint mechanisms).
- Accountable – There should be mechanisms to ensure that ethical decision-making is sustained throughout the pandemic.

Ontario's response to an influenza pandemic will be based on the following core ethical values (not listed in priority order). More than one value may be relevant in any given situation, and some values will be in tension with others. This tension is the cause of the ethical dilemmas that may emerge during a pandemic, and reinforces the importance of shared ethical language as well as decision-making processes that can assign a moral weight to each value when values are in conflict.

Individual Liberty. Individual liberty (i.e., respect for autonomy) is a value enshrined in our laws and in the health care practice. During a pandemic, it may be necessary to restrict individual liberty in order to protect *the public* from serious harm. Individual liberty can be preserved to the extent that the imposed limits and the reasons for them are transparent. Restrictions to individual liberty will:

- be proportional to the risk of public harm
- be necessary and relevant to protecting the public good
- employ the least restrictive means necessary to achieve public health goals

1 Adapted from: Gibson J et al. Ethics in a Pandemic Influenza Crisis. Framework for Decision Making. Joint Centre for Bioethics. University of Toronto 2005.

- be applied without discrimination.

Protection of the Public from Harm. Public health authorities have an obligation to protect the public from serious harm. For public health to fulfill this obligation and minimize serious illness, death and social disruption, public health may isolate people or use other containment strategies, require health care facilities to restrict public access to some areas or limit some services. For these protective measures to be effective, citizens must comply with them. The ethical value of individual liberty is often in tension with the obligation to protect the public from harm; however, it is also in individuals' interests to serve the public good and minimize harm to others. When making decisions designed to protect the public from harm, public health authorities will:

- weigh the benefits of protecting the public from harm against the loss of liberty of some individuals (e.g., isolation)
- ensure all stakeholders are aware of the medical and moral reasons for the measures, the benefits of complying, and the consequences of not complying
- establish mechanisms to review decisions as the situation changes and to address stakeholder concerns or complaints.

Proportionality. Restrictions on individual liberty and measures to protect the public from harm should not exceed the minimum required to address the actual level of risk or need in the community. Ontario will:

- use the least restrictive or coercive measure possible when limiting or restricting liberties or entitlements
- use more coercive measures only in circumstances where less restrictive means have failed to achieve appropriate [public health] ends.

Privacy. Individuals have a right to privacy, including the privacy of their health information. During a pandemic, it may be necessary to balance the right to privacy with the responsibility to protect the public from serious harm; however, to be consistent with the ethical principle of proportionality, Ontario will:

- determine whether the good intended is significant enough to justify the potential harm of suspending privacy rights (e.g., potential stigmatization of individuals and communities)
- require private information only if there are no less intrusive means to protect public health
- limit any disclosure to only that information required to achieve legitimate public health goals
- take steps to prevent stigmatization (e.g., public education to correct misperceptions about disease transmission).

Note: Where the plan contains any reference to the collection, use or disclosure of information or data, it is referring to non-identifiable information or data whenever possible. Any collection, use or disclosure of personal information will be done in compliance with governing legislation, including the Health Information and Protection Act, 2004.

Equity. All patients have an equal claim to receive the health care they need, and health care institutions are obligated to ensure sufficient supply of health services and materials. During a pandemic, tough decisions may have to be made about who will receive antiviral medication and vaccinations if they are in short supply, and which health services will be temporarily

suspended. Depending on the extent of the pandemic, measures taken to contain the spread of disease may limit access to emergency or critical services. In these circumstances, decision makers will:

- strive to preserve as much equity as possible between the needs of influenza patients and patients who need urgent treatment for other diseases
- establish fair decision-making processes/criteria.

Duty to Provide Care. Health care workers have an ethical duty to provide care and respond to suffering. During a pandemic, demands for care may overwhelm health care workers and their institutions, and create challenges related to resources, practice, liability and workplace safety. Health care workers may have to weigh their duty to provide care against competing obligations (i.e., to their own health, family and friends). When providers cannot provide appropriate care because of constraints caused by the pandemic, they may be faced with moral dilemmas. To support providers in their efforts to discharge their duty to provide care, Ontario will:

- work collaboratively with stakeholders, regulatory colleges and labour associations to establish practice guidelines
- work collaboratively with stakeholders, including labour associations, to establish fair dispute resolution processes
- strive to ensure the appropriate supports are in place (e.g., resources, supplies, equipment)
- develop a mechanism for provider complaints and claims for work exemptions.

Reciprocity. Society has an ethical responsibility to support those who face a disproportionate burden in protecting the public good. During a pandemic, the greatest burden will fall on public health practitioners, other health care workers, patients, and their families. Health care workers will be asked to take on expanded duties. They may be exposed to greater risk in the workplace, suffer physical and emotional stress, and be isolated from peers and family. Individuals who are placed in isolation may experience significant social, economic, and emotional burdens. Decision-makers will:

- take steps to ease the burdens of health care workers, patients, and patient's families.

Trust. Trust is an essential part of the relationship between government and citizens, between health care workers and patients, between organizations and their staff, between the public and health care workers, and among organizations within a health system. During a pandemic, some people may perceive measures to protect the public from harm (e.g., limiting access to certain health services) as a betrayal of trust. In order to maintain trust during a pandemic, decision-makers will:

- take steps to build trust with stakeholders before the pandemic occurs (i.e., engage stakeholders early)
- ensure decision making processes are ethical and transparent.

Solidarity. Stemming an influenza pandemic will require solidarity among community, health care institutions, public health units, and government. Solidarity requires good, straightforward communication and open collaboration within and between these stakeholders to share information and coordinate health care delivery. By identifying the health of

the general public (and service providers) as a good worth promoting, these stakeholders can model values of solidarity and encourage others to broaden traditional ethical values focused on the rights or interests of individuals.

Stewardship. In our society, both institutions and individuals will be entrusted with governance over scarce resources, such as vaccines, antivirals, ventilators, hospital beds and even health care workers. Those entrusted with governance should be guided by the notion of stewardship, which includes protecting and developing one's resources, and being accountable for public well-being. To ensure good stewardship of scarce resources, decision makers will:

- consider both the benefit to the public good and equity (i.e., fair distribution of both benefits and burdens).

Family-centred Care. The health system will respect a family's right to make decisions on behalf of a child, consistent with the capacity of the child. Health care providers will respect families' unique beliefs and values, and acknowledge that their choices will be informed by their beliefs and values.

Respect for Emerging Autonomy. When providing care to young people, the health system will respect their emerging autonomy, and disclose age appropriate information.

Ontario will use this ethical framework to guide decision-making in pandemic planning and management.

2.6 Relevant Provincial Legislation

During a pandemic, individuals and institutions responsible for managing the response will require the legal authority to implement pandemic plans. Much of that legislation is already in place (e.g., the *Health Protection and Promotion Act*, and the *Emergency Management Act*), and some is now under development. During pandemic planning and during a pandemic, Ontario will work within a legal framework that attempts to balance the rights of individuals (e.g., privacy, liberty, equity) with the responsibility to protect the public from harm and the rights of workers to work in safety. The following legislation will guide Ontario's response to a pandemic.

Emergency Legislation

The ***Emergency Management Act*** (EMA), 2003 addresses public safety risks in Ontario. The Act governs all municipalities in Ontario, ministers presiding over a provincial ministry, and agencies, boards, commissions and other branches of the provincial government designated by the Lieutenant Governor in Council. Under the Act:

- the Premier may declare that an emergency exists throughout Ontario or in any part thereof and may take action and issue orders necessary to implement the emergency plans of ministers and designated provincial bodies, and to protect property and the health, safety and welfare of the inhabitants of the emergency area
- a head of municipal council may declare that an emergency exists in the municipality and may take action and issue orders to implement the emergency plan of the municipality and to protect property and the health, safety and welfare of the inhabitants of the emergency area
- the Premier may at any time declare that an emergency has been terminated
- heads of municipal councils and ministers presiding over a provincial ministry and designated agencies,

boards, commissions and branches of government are required to develop and implement emergency management programs which must consist of:

- an emergency plan
- training programs and exercises for municipal and Crown employees and other persons
- public education
- any other element required by regulation.

Pursuant to Order-in-Council 167/2004 (February 2, 2004), the Minister of Health and Long-Term Care is responsible for two areas in formulating emergency plans: human health disease and epidemics; and provision of health services during an emergency (e.g., floods, ice storm).

The Emergency Management Statute Amendment

On June 20, 2006, Ontario passed Bill 56, legislation amending the ***Emergency Management Act***, 2003, the ***Employment Standards Act***, 2000 and the ***Workplace and Insurance Act***, 1997. These amendments are designed to provide a balance between giving the government the extraordinary powers it needs to protect Ontarians in the case of an emergency and the need for accountability. The legislation, which brings Ontario more in line with emergency legislation in other jurisdictions, gives the Premier and/or Cabinet the power to:

- order the evacuation of an area, control travel into an area and requisition property
- stop price gouging
- authorize those who would not otherwise be eligible to do so, to perform certain duties (e.g., allowing doctors from other jurisdictions to work in Ontario for the duration of the declared provincial emergency)
- close certain private or public places, such as beaches, if necessary
- authorize facilities, such as electrical generating facilities, to operate as necessary to address the emergency.

The amendments include strict guidelines for determining whether or not a provincial emergency should be declared. There is also a maximum 14-day limit for the initial declaration and the Premier must file a report on the emergency in the legislature within 120 days of the declaration being lifted.

Public Health Legislation

Under the ***Health Protection and Promotion Act***:

- physicians, laboratories, school principals and others must report certain diseases, including influenza to medical officers of health
- persons who pose a risk to the public health may be ordered to do, or to stop doing anything to reduce the risk of disease transmission
- information about patients who are infected with communicable diseases may be disclosed to the ministry and medical officers of health, while protecting the confidentiality of sensitive health information
- physicians are required to report to the medical officer of health the name and residence address of any person who is under the care and treatment of the physician in respect of a communicable disease and who refuses or neglects to continue the treatment in a manner and to a degree satisfactory to the physician

- appropriate action may be taken to prevent, eliminate or decrease a health risk
- premises may be required to be used as temporary isolation facilities.

Pre-Hospital Care Legislation

Regulations under the ***Ambulance Act*** include provisions concerning education, protection, prevention of disease transmission, reporting of possible exposure and sterilization of equipment. They also deal with issues surrounding the immunization of emergency medical attendants

Hospital Legislation

Under the ***Public Hospitals Act***:

- hospitals are required to obtain ministry approval before using additional sites for hospital services
- Cabinet is authorized to appoint a hospital supervisor on the recommendation of the Minister of Health and Long-Term Care
- the Minister is authorized to make regulations, subject to Cabinet approval, to address the safety of any hospital site and to deal with patient admissions, care and discharge
- the administrator, medical staff, chief nursing executive, staff nurses and nurses who are managers are required to develop plans to deal with: (i) emergency situations that could place a greater than normal demand on the services provided by the hospital or disrupt the normal hospital routine, and (ii) the failure to provide services by persons who ordinarily provide services in the hospital.

Under the ***Private Hospitals Act***:

- private hospitals are required to obtain ministry approval before constructing or adding to, altering or renovating a private hospital building or enlarging the patient bed capacity of a private hospital building
- private hospitals are required to be used for the treatment only of the number of patients permitted by the license, except in the case of emergency; only for purposes in respect of which the license is issued; and only for patients of a class permitted by the license
- cabinet is authorized to make regulations considered necessary for the alteration, safety, equipment, maintenance and repair of private hospital sites; the management, conduct, operation and use of private hospitals; prescribing the type and amount of surgery, gynaecology or obstetrics that may be preformed in any class of private hospital and the facilities and equipment that shall be provided for such purposes; the admission, treatment, care, conduct, discipline and discharge of patients; and the classification of patients.

Other Facility Legislation

The ***Nursing Homes Act***, the ***Charitable Institutions Act***, and the ***Homes for the Aged and Rest Homes Act*** (which govern long-term care facilities in Ontario) in conjunction with the service agreements entered into with these operators require the operators of long-term care facilities to:

- implement surveillance protocols for a particular communicable disease provided by the MOHLTC
- report all communicable disease outbreaks to the medical officer of health
- comply with the Long-Term Care Facility Program Manual
- provide information to the MOHLTC relating to the operation of the facility

(e.g., bed occupancy rates, service levels, staffing levels).

Legislation Governing Community Health Services

The ***Long-Term Care Act***, 1994 and the ***Community Care Access Corporations Act***, 2001 in conjunction with the memorandum of understanding and funding agreements between the ministry and community-based agencies, give the ministry the authority to require CCACs and other approved community-based agencies to:

- provide reports and information
- comply with all ministry directives, policies, guidelines and procedures, including surveillance protocols for communicable diseases
- comply with the most recent Planning, Funding and Accountability Manual.

Legislation Governing Health Information

Schedule A to Bill 31, the ***Health Information Protection Act***, 2004 is the ***Personal Health Information Protection Act***, 2004. That Act, effective November 1, 2004, governs the collection, use, and disclosure of personal health information by health information custodians, including physicians, hospitals, long-term care facilities, boards of health, medical officers of health and the Ministry of Health and Long-Term Care. It includes provisions providing for the disclosure of personal health information to the Chief Medical Officer of Health or a medical officer of health by health information custodians without the consent of the individuals to whom the information relates where the information is disclosed for a purpose of the ***Health Protection and Promotion Act***. It also includes provisions providing for the disclosure of personal health information by health information custodians without the consent of the individuals to whom the information relates to public health authorities in other jurisdictions where the disclosure is made for a purpose that is substantially similar to a purpose of the ***Health Protection and Promotion Act.***

Legislation Governing Regulated Health Professionals

Under the authority of the ***Regulated Health Professions Act***, 1991 (RHPA), the power to register physicians, nurses and other regulated health professionals is provided to the College which governs the health profession, not the Ministry of Health and Long-Term Care.

Temporary registration in the event of an emergency is possible under the RHPA, the Health Professions Procedural Code (Code), which is Schedule 2 to the RHPA and the health profession specific Acts. See, for example, the registration regulations made under the ***Medicine Act***, 1991, ***Nursing Act***, 1991 and the ***Medical Laboratory Technology Act***, 1991. Specific requirements and procedures for temporary registration vary from College to College under their registration regulations.

Depending on the provisions within the Colleges' registration regulations, temporary registration of a regulated health professional in an emergency situation may be available. Under Regulation 865/93 – Registration, made by the College of Physicians and Surgeons of Ontario (CPSO), a certificate of registration may be issued for supervised, short duration practice without first requiring an order of the CPSO's Registration Committee. In these circumstances, the appointment must be for the purpose of providing, among other things, medical services for a short interval that would otherwise be unavailable due to a lack of persons to provide them.

The applicant must also meet all the criteria under the regulation relating to supervised

practice of short duration. The certificate expires thirty days after it is issued unless a panel of the Registration Committee orders an extension. Some Colleges may be unable to issue temporary certificates in emergency circumstances. Under the Code, a College Registrar may grant a certificate of registration with terms and conditions, for example, limiting the time or location of the professional's practice, but only with the approval of a panel of the Registration Committee. Other Colleges have developed expedited processes for use in emergency circumstances.

Legislation Governing Workplace Health and Safety

The Ministry of Labour enforces the *Occupational Health and Safety Act* (OHSA) and the Health Care and Residential Facilities Regulation (HCRF). Under the OHSA, an employer has the duty to take all reasonable precautions in the circumstances for the protection of a worker. Further, under the HCRF Regulation, there is a duty for employers in health care facilities to establish measures and procedures including the following:

- control of infections
- immunization
- the use of disinfectants
- the handling, cleaning and disposal of soiled linen, sharp objects and waste.

Employers, in consultation with the Joint Health and Safety Committee (JHSC) in the workplace, are required to develop these procedures and provide workers with relevant training.