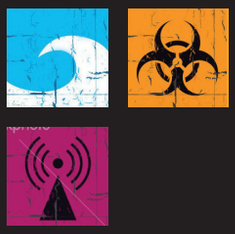

Chapter 18

Medico-Legal Issues

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Preface

Hospitals and other healthcare facilities are now functioning in an environment of ever-increasing accountability and transparency. In Ontario, hospitals are now subject to new reporting requirements for critical incidents and hospital-acquired infection rates and are required to disclose this information on the hospital websites. Some infection rates for hospital-acquired infections are also published on the Ontario Hospital Association's new myhospitalcare.ca website, which allows members of the public to compare performance indicators for Ontario hospitals, including hospital-acquired infection rates and wait times for certain procedures. Following the SARS crisis, there has been increased scrutiny by the public and by healthcare workers of the occupational health and safety precautions and staff support systems implemented by healthcare facilities for their staff.

One of the key responsibilities of the board of directors of any organization is to identify the principle risks and implement systems to manage those risks. Disaster planning is part of this responsibility. In the context of disaster planning for healthcare organizations, there are a myriad of issues that arise including occupational health and safety issues, employment and labor issues, public health reporting requirements, issues relating to regulated healthcare professionals and their duty to care, privacy concerns, and consent to treatment issues. Healthcare organizations should take a proactive approach to anticipating risks. As urged in the SARS Commission report, "we should be driven by the precautionary principle that reasonable steps to reduce risk should not await scientific certainty."[1]

This chapter gives an overview of medico-legal issues relevant to healthcare practitioners and healthcare facilities in the event of a disaster such as an outbreak of a communicable disease. Although the general issues are mirrored in other provinces, the legislation referred to in this chapter is Ontario focused. Legal advice should always be sought from counsel qualified to practice in the appropriate jurisdiction, as this chapter is not intended to replace the need for legal advice.

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Occupational Health and Safety Legislation

It was reported that during the SARS crisis in 2003, "of the almost 375 people who contracted SARS in Ontario, 72 percent were infected in a healthcare setting. Of this group, 45 percent were healthcare workers."[2] Occupational health and safety measures are evidently a key component of any risk management strategy for a healthcare organization.

Occupational health and safety legislation imposes obligations on employers, including hospitals, long-term care and other healthcare facilities and clinics, to establish measures and procedures for the health and safety of their workers and to protect, inform, and train their workers. These obligations include preparing the workplace and workers, including physicians, for disasters.

Under the *Occupational Health and Safety Act*[3] (OHSA), employers in Ontario have a duty to take every precaution reasonable in the circumstances to protect their workers.[4] In addition, employers must

- establish and implement a written occupational health and safety policy, to be reviewed at least annually,
- ensure that measures and procedures prescribed by the legislation are carried out in the workplace,[5]

- provide and maintain protective devices (such as masks) and ensure their proper fit and use,[6]
- inform, instruct, and supervise workers to protect their health and safety.

Under the OHSA, there is a specific regulation relating to healthcare and residential facilities. This regulation establishes a general duty of employers to develop, establish, and put into effect measures and procedures for the health and safety of their workers, in consultation with the joint health and safety committee or health and safety representative. Employers are required to prepare written health and safety measures and procedures, covering a list of required topics, including safe work practices and conditions; proper hygiene practices; the control of infections, immunization, and inoculation; the use of antiseptics, disinfectants, and decontaminants; the hazards of biological, chemical, and physical agents; and the use of personal protective equipment.[7]

If a worker has an occupational illness, including healthcare-associated infection due to workplace exposure, this must be reported by the employer to a director appointed under the OHSA, to the Joint Health and Safety Committee or health and safety representative, and the worker's trade union.[8]

In addition, the issue of a worker's right to refuse to work in unsafe conditions arose in the context of SARS, and more recently, in connection with H1N1.[9] Employers should be aware that under the OHSA, a worker may refuse to work or do particular work where he or she has reason to believe that any equipment, machine, device, or thing the worker is to use or operate is likely to endanger himself/herself or another worker, or if he or she is likely to be endangered by the physical condition of the workplace or the part of the workplace in which he or she works.[10] The worker may also refuse to work if any equipment, machine, device, or thing he or she is to use or operate or the physical condition of the workplace (or the part he or she works in) is in contravention of the Act or the regulations, and such contravention is likely to endanger himself/herself or another worker.[11] The right to refuse to work would not apply if the danger is inherent in the worker's work or is a normal condition of employment or the worker's refusal would endanger the life, health, or safety of another person.[12] This is discussed further under section "Duty to Treat."

- Conduct risk assessments in consultation with the Joint Health and Safety Committee or health and safety representative, as applicable.
- Establish and ensure frequent review (at least annually) of occupational health and safety policies and procedures.
- Schedule regular orientation for employees with respect to occupational health and safety policies and procedures.
- Consider whether requiring staff to be immunized is appropriate for your organization and establish an immunization policy and procedure for employees and volunteers. Ensure that employees and volunteers are educated in advance about the organization's immunization policy (see the discussion below relating to immunization policies).
- Ensure proper maintenance and storage of personal protective equipment and other safety devices.

- Ensure proper initial and ongoing training of employees with respect to the hygiene, the control of infections, the use of antiseptics/disinfectants/decontaminants, and the use of personal protective equipment.
- Document training sessions (who attended, when the session was held, materials and topics covered, etc.).

Public Health Legislation

Each province and territory has enacted public health legislation. *Ontario's Health Protection and Promotion Act* (HPPA)[13] states that its purpose "is to provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario."[14] To carry out this purpose, the HPPA establishes reporting obligations for individual health practitioners, as well as hospitals and other institutions, and empowers medical officers of health to make orders affecting hospitals and other institutions relating to reportable or communicable diseases. At present, reporting requirements under the HPPA relate only to those reportable and communicable diseases that are listed in regulations made under the HPPA.[15]

The HPPA imposes reporting requirements on physicians and other healthcare providers to report patients, outside of the hospital setting, who may have a reportable disease.[16] Physicians and extended class nurses also have a similar requirement to report persons who are infected or may be infected with an agent of a communicable disease[17] and any persons who refuse or neglect to continue treatment for a communicable disease.[18] Physicians and all nurses also have obligations to make a report in the event they sign a death certificate where a cause of death was a reportable disease.[19] In addition, physicians, nurses, and pharmacists must make a report to the medical officer of health in the event they witness certain adverse reactions to immunization.[20]

Hospital administrators and superintendents of institutions also have reporting requirements with respect to patients who have or may have a reportable or communicable disease.[21] In addition, laboratories must make a report to the medical officer of health if a positive laboratory finding is made in respect of a reportable disease.[22]

Hospitals and other institutions should also be aware of the broad powers given to medical officers of health under public health legislation to make orders with respect to communicable disease outbreaks at a hospital or institution and to request orders from the courts to order a patient into isolation or for treatment and detention in a hospital or other facility.[23] Under Section 22 of the HPPA, a medical officer of health can make a written order requiring a person to take or refrain from taking an action in respect of a communicable disease where a communicable disease exists, may exist, or there is an immediate risk of an outbreak of a communicable disease; the communicable disease presents a risk to the health of persons in the health unit; and the requirements in the order are necessary to decrease or eliminate the risk to health posed by the communicable disease.[24] An order may include requiring the owner or occupier of premises to close the premises; requiring a person to isolate himself or herself; requiring the person to submit to an examination by a physician and deliver a

report as to whether he or she has a communicable disease or is infected with a communicable disease agent; requiring the person to place himself or herself under the care and treatment of a physician; or requiring the person to conduct himself or herself in such as way as to avoid exposing others to infection.[25] An order may be directed to a person who resides or is present in the health unit, owns or occupies any premises, owns or is in charge of any thing, or is engaged in or administers an enterprise or activity.[26]

Where a person fails to comply with an order of a medical officer of health in respect of a communicable disease that is a virulent disease, a judge of the Ontario Court of Justice can order the person into isolation, to submit to examination by a physician, to place himself or herself under the care and treatment of a physician, and to conduct himself or herself in such a manner as to not expose another person to infection.[27] In such an order, the judge may order that the person be taken into custody and detained in a hospital or other facility and be examined by a physician to determine whether the person is infected with an agent of a virulent disease, and if so, to be treated.[28] A judge may an order for detention in a hospital or facility if he or she is satisfied that the hospital or facility has the ability to provide detention, care, and treatment for the person.[29]

In addition, under recent amendments to the HPPA, the minister now has the ability to order a facility to be used as a temporary isolation facility and to seize medications and supplies, including antivirals, antitoxins, vaccines, immunizing agents, and antibiotics in the event that there exists or may exist an immediate risk to the health of persons anywhere in Ontario, the medications and supplies are necessary to address the risk, and regular procurement processes are unable to meet the needs of Ontarians.[30]

- Review applicable legislation for reporting and other requirements with legal counsel, including the information that must be included in a report and the timelines for submitting a report.
- Establish protocols for reporting communicable and reportable diseases to the medical officer of health.
- Organize education sessions for staff regarding reportable and communicable diseases and reporting requirements.

Emergency Management Legislation

The Federal *Emergency Management Act*[31] sets out the duties of the various ministries to establish, maintain, test, and implement emergency management plans.[32] The Federal *Emergencies Act* allows the government to declare emergencies, including public welfare emergencies, and to take certain temporary measures in the event of an emergency for safety and security.

Federal institutions may not intervene in a provincial emergency, unless help is requested by the province or there is an agreement in place that requires or permits assistance.[33] Each of the provinces and territories has emergency management legislation in place. For example, the Ontario *Emergency Management and Civil Protection Act* (EMCPA) sets out the requirements for emergency management programs of provincial ministries and municipalities and vests the power to declare an emergency in the Lieutenant Governor in Council or the Premier.

Public Hospitals

The vast majority of hospitals in Canada are public hospitals. In Ontario, these are governed by the *Public Hospitals Act* (PHA).[34] The PHA imposes obligations on the Board and hospital administrator, which are relevant to disaster planning.

Hospitals' boards of directors are required under the PHA to ensure that contingency plans and procedures are in place in the event of a disaster and that appropriate health and safety mechanisms are established. Under the PHA, boards must ensure that the administrator, medical staff, chief nursing executive, staff nurses, and nurse managers develop business continuity plans to anticipate increased demand on hospital services, disruptions to hospital routines, and the risk that service providers will not be able to provide needed services during an emergency.[35] Mechanisms for ongoing oversight of health and safety must also be established. Specifically, hospital boards must ensure that the by-laws establish a committee for infection control[36] and establish and provide for the operation of an occupational health and safety program.[37]

In addition, hospital boards must also establish and provide for the operation of a health surveillance program, including a communicable disease surveillance program in respect of all persons carrying on activities in the hospital,[38] including not only employees and professional staff but also service providers who carry on activities on the hospital's premises and volunteers. The communicable disease surveillance program must include the tests and examinations set out in the applicable communicable disease surveillance protocols jointly developed by the Ontario Hospital Association and Ontario Medical Association and approved by the Ministry of Health and Long-Term Care.[39] There are currently 16 such protocols, including protocols for influenza and tuberculosis, as well as a template for medical directives. Intended as a minimum standard and to supplement the hospital's existing processes, the protocols are reviewed and updated from time to time. Current copies of these protocols may be downloaded from the Ontario Hospital Association website (www.oha.com) for reference.[40]

Hospitals have both internal reporting obligations within the organization and external reporting obligations to the Minister of Health and Long-Term Care that may be relevant in a disaster. Within the organization, physicians, oral and maxillofacial surgeons, or midwives who admit a patient who is or may become dangerous to himself/herself or other persons must notify the administrator of the hospital immediately.[41] An attending physician, dentist, midwife, or extended class nurse who knows or suspects his or her patient is suffering from an infectious disease or condition must immediately notify the administrator and either an infection control officer or an infection control nurse.[42]

Hospitals are also required to report hospital-acquired infections to the minister and to disclose such information on the hospital's website. Eight new reporting requirements were announced in the fall of 2008, including *C. difficile*, and were rolled out between September 30, 2008, and April 30, 2009. The new Ontario Hospital Association myhospitalcare.ca website also discloses hospital-acquired infection rates for *C. difficile* and wait times for certain procedures for Ontario hospitals.

Many of the health and safety requirements set out in the PHA are required by the PHA to be codified in the hospital's by-laws, including the requirement for the establishment and operation of the occupational health and safety and health surveillance programs.[43]

Boards are also responsible for appointing the professional staff of the hospital on an annual basis and for ensuring that the by-laws of the hospital set out the criteria for appointment and reappointment to the professional staff.[44] Many hospitals are now including in their by-laws the requirement that applicants to the professional staff provide evidence of their immunization status in compliance with the communicable disease surveillance protocols and disclose any health issues that may affect safety or the applicant's ability to practice.

- Review the organization's communicable disease surveillance program and adopt the practices that meet or exceed the standards set out in communicable disease surveillance protocols for your jurisdiction.
- Develop a business continuity plan to anticipate potential disruptions (involving personnel, supplies, transportation, utilities, etc.) and schedule a review of the business continuity plan at least annually
- Ensure new staff are oriented to their reporting obligations and schedule regular education sessions for staff on reporting obligations, infection control, and other occupational health and safety issues.
- Ensure that by-laws and credentialing forms reflect best practices and comply with the requirements of the *Public Hospitals Act.*
- Develop a communications strategy in case of pandemic or other disaster.

Private Hospitals

In Ontario, regulations under the *Private Hospitals Act* include requirements for testing employees for tuberculosis within 30 days of their employment. Employees testing positive will not be permitted to work, and the superintendent must report the case to the medical officer of health. Legally qualified medical practitioners who believe or suspect a patient has tuberculosis must make a report to the superintendent. In addition, employees who are detailed to care for a patient with tuberculosis must first receive training into how to protect himself or herself and others from infection, and where possible, the employee shall be a reactor to tuberculin. On ceasing to be employed, every employee shall receive an x-ray of his or her lungs.[45]

Long-Term Care Facilities

At present, there are 3 pieces of legislation that govern long-term care homes in Ontario: the *Nursing Homes Act*, the *Homes for the Aged and Rest Homes Act*, and the *Charitable Institutions Act*. A new piece of legislation that will replace these 3 acts, the *Long-Term Care Homes Act, 2007*, received Royal Assent in 2007, but has not yet been proclaimed in force.

Each of the *Nursing Homes Act*, the *Homes for the Aged and Rest Homes Act*, and the *Charitable Institutions Act* contains requirements for the licensee with respect to the protection of the health and safety of residents and implementation of communicable disease protocols. Each of these 3 acts sets out a resident's bill of rights that includes the right of residents to live in a safe and clean environment.[46] Facilities governed by one of these 3 acts must also

comply with any communicable disease surveillance protocols provided by the ministry[47] and ensure that fire safety mechanisms are in place.[48] They also have reporting requirements with respect to communicable disease outbreaks, injuries, accidents, and deaths resulting from accidents or unknown causes.[49]

Nursing home administrators must also comply with the broad requirement to "ensure that all hazards to health and safety are eliminated from the nursing home."[50] Nursing homes must also be maintained at all times in such a way as to be free from anything that might be hazardous to the health or safety of the residents.[51] Furthermore, nursing homes are subject to an immediate investigation by the ministry-appointed director in the event the director has reasonable grounds to believe that the health, safety, or welfare of a resident may be at risk.[52] Nursing homes must also test residents for tuberculosis on admission.[53]

The *Charitable Institutions Act* also includes the ability of the minister to take over the home if the minister believes on reasonable grounds that the home's physical state or the way the home is being operated is causing or is likely to cause harm to or an adverse effect on the health of a person or impair the safety of a person or if the home is not being operated or is not likely to be operated with the competence, honesty, integrity, and concern for the health, safety, or well-being of its residents.[54]

Long-Term Care Homes Act, 2007

Ontario's new *Long-Term Care Homes Act, 2007*, although not yet in force, contains more specific requirements with respect to infection prevention and control than its predecessor legislation. As with the existing legislation, it includes the broad requirement that every licensee of a long-term care home ensure that the home is "a safe and secure environment for its residents."[55] Beyond this general requirement, the act contains specific requirements for an infection prevention and control program,[56] emergency plans for relocating and evacuating residents and staff, and orientation of staff and volunteers to infection control and emergency procedures.[57]

The *Long-Term Care Homes Act* and its proposed regulations require the infection prevention and control program to include daily monitoring to detect infection in residents and measures to prevent the transmission of infection.[58] Under the proposed regulations, the infection prevention and control program must include the implementation of any communicable disease protocol provided to the licensee by the ministry,[59] and the establishment of an outbreak management system and a written plan for responding to infectious disease outbreaks.[60] A staff member with appropriate education and experience must be designated to coordinate the program.[61] Licensees are also required to provide appropriate personal protective equipment, a hand hygiene program including access to point-of-care hand hygiene agents, and training for staff at least annually in routine infection prevention and control practices.[62]

The *Long-Term Care Homes Act* also requires that licensees establish emergency plans to deal with emergencies and procedures for evacuating residents and staff and relocating residents in the event of an emergency. Emergency plans must be tested annually or at least once every 3 years depending on what the plan is related to, evaluated, updated and reviewed at least annually[63] In addition, orientation of staff must include fire prevention and safety, emergency and evacuation procedures, and infection prevention and

control.[64] Volunteers must also be oriented on fire safety and universal infection control practices.[65]

The proposed regulations under the *Long-Term Care Homes Act* also include requirements for screening and immunization of staff and residents.[66]

- Establish infection prevention and control program and outbreak management program and schedule regular reviews of the programs.
- Plan regular orientation sessions and training for staff and volunteers regarding infection prevention and control, emergency and evacuation procedures, and fire prevention and safety and maintain documentation of the sessions, when they were held, attendees and materials and topics covered.
- Review communicable disease protocols regularly and ensure implementation and compliance with protocols as a minimum standard.
- Ensure appropriate supply and maintenance of personal protective equipment and hand hygiene supplies.

Accreditation Canada

In Canada, many organizations participate in a voluntary accreditation process administered by Accreditation Canada. To receive accreditation, an organization must demonstrate compliance with the standards established by Accreditation Canada, including those relating to infection prevention and control. These standards were developed based on best practice and standards of the Public Health Agency and the Community and Hospital Infection Control Association of Canada. Infection control and risk assessment is also one of 7 required organization practices identified by accreditation Canada, although passing the accreditation process does not in and of itself provide confirmation of disaster preparedness.

Employment Standards Legislation and Special Legislation (e.g., SARS)

Employers must be prepared for a significant number of staff absences during a disaster. Despite the fact that the H1N1 pandemic of 2009 had a relatively low morbidity, the Ontario government has estimated in the Ontario Health Plan for an Influenza Pandemic (OHPIP). Brief that "during the period of peak activity in a pandemic wave during a moderately severe pandemic, about 20% to 25% of the workforce will be absent from work for at least half a day" and that "regardless of the severity of the pandemic, there will be an illness attack rate of 35%, which means that over the course of a pandemic about 35% of the population will be sick enough with influenza to take at least a half-day off work." The OHPIP also estimates that "during a pandemic, the public health and healthcare workforce could be reduced by up to 25% due to illness, concern about disease transmission in the workplace, and family caregiving responsibilities."[67] In addition, during the SARS outbreak, Toronto quarantined about 30,000 people.[68]

Employment standards legislation in the provinces and territories provides statutory requirements for emergency and personal leave for employees. In Ontario, the *Employment and Standards Act*[69] provides for emergency leave during emergencies declared under the *Emergency Management and Civil Protection Act*, where the employee is subject to an order under the *Emergency Management and Civil Protection Act* or an order under the HPPA or is required to provide care to certain relatives.[70] Employees are also entitled to personal emergency leave for illness, injury, or medical emergency, as well as in the event of death, illness, injury, or medical emergency or urgent matters concerning certain listed family members.[71]

In response to the SARS outbreak in 2003, the *SARS Assistance and Recovery Strategy Act, 2003*,[72] was passed and included emergency leave entitlements in addition to those provided for in the *Employment Standards Act*. The act provided for additional unpaid leave for employees who were unable to work because he or she was under medical investigation, supervision, or treatment related to SARS; subject to an order certain sections of the HPPA; quarantined or isolated in relation to SARS; directed not to work by the employer out of concern that the individual would expose other individuals in the workplace to SARS; or was required to care for a person because of a SARS-related matter.

Employers should be aware that it is possible for the government to enact special legislation that may impact on employee rights in the event of an outbreak or other disaster.

- Establish policies consistent with the *Employment Standards Act* for emergency leave and prepare contingency plans for the absence of key personnel.
- Establish Human Resources policies for employee absences.
- Establish support services for employees during a pandemic or other disaster, including counselling.

Immunization of Employees and Access to Antivirals and Vaccines for Staff

The Influenza Surveillance Protocol for Ontario Hospitals jointly developed by the Ontario Hospital Association and the Ontario Medical Association provides minimum standards for influenza surveillance in hospitals. As part of the stated rationale for the protocol, the OHA and OMA referred to the views of the National Advisory Committee on Immunization:

> The National Advisory Committee on Immunization considers the provision of influenza vaccine for health care workers who have direct patient contact to be an essential component of the standard of care for the protection of their patients. Health care workers who have direct patient contact should consider it their responsibility to provide the highest standard of care, which includes undergoing annual influenza vaccination. In the absence of contraindications, refusal of health care workers who have direct patient contact to be immunized against influenza implies failure in their duty of care to their patients.[73]

The protocol provides that hospitals should establish a policy for annual influenza surveillance, immunization, and outbreak control and use of a neuraminidase inhibitor antiviral agent, such as Oseltamivir, for unvaccinated healthcare workers. It recommends that documentation should be kept by the hospital of each person's status, including any refusal of vaccination. Unvaccinated healthcare workers working in the outbreak area or unit should be required to take antiviral prophylaxis in the event of an outbreak, and unless contraindicated, the vaccine should be provided. The protocol also provides that if influenza is suspected or diagnosed, the person must remain off work until the period of peak symptoms and the period of communicability (5 days from onset) have passed.[74]

As discussed earlier, healthcare and residential facilities are required to develop, establish, and put into effect measures and procedures for the health and safety of their workers, which can include immunization and inoculation against infectious diseases.[75] Many hospitals and healthcare institutions have implemented immunization programs for their employees, given the increased risk of exposure for healthcare workers, and the vulnerability of the patients to whom they provide care.

Through their unions, healthcare employees have challenged the legitimacy and reasonableness of employers' policies requiring that nonimmunized workers remain off work without pay during an outbreak, on the basis that the policies infringe on rights to security of the person or interfere with economic rights. Generally, the cases have considered the underlying purpose and rationale for the policy, the options and accommodation available to employees, the content of the collective agreements in place, and the balancing of employees' rights with patients' rights and have upheld the mandatory immunization program.

In one Ontario case, however, a labor arbitrator found that the hospital's immunization policy violated employees' rights to security of the person. In that case—*St. Peter's Health System v. Canadian Union of Public Employees, Local 778 (Flu Vaccination Grievance)*—following an outbreak of influenza, the hospital suspended 15 employees who chose not to be vaccinated or take medication in accordance with the hospital's flu policy. The employees filed a grievance. The union raised the issue that "with neither statutory or collective agreement authority, the hospital has no right to impose as a condition of employment forced medical treatment either by virtue of a flu shot or the requirement to take medication, and therefore this is the most serious form of invasion of privacy, because it gives the employer a right to invade the person."[76] In turn, the hospital argued that the policy is part of the core of sound infection control and that the hospital was acting with good faith and for bona fide patient care reasons to reduce transmission of flu in a high-risk population.[77] In allowing the grievance, the labor arbitration board found that suspending employees for refusing to undergo medical treatment is a violation of their common law Section 7 rights under the *Charter of Rights and Freedoms*. The board noted that in virtually all cases, enforced medical treatment is an assault if there is no consent.[78] It also observed that it was unusual given the seriousness of what was being asked of employees that the hospital did not seek statutory authority to do so through the Ministry of Health and Long-Term Care or attempt to bargain for it.[79]

In contrast, in *Health Employers Assn. of British Columbia v. British Columbia Nurses' Union*,[80] the arbitrator found the employer's immunization policy to be reasonable and not in violation of Section 7 of the *Charter of Rights and Freedoms*. In contrast to the *St. Peter's* case, in this instance, the provincial medical health

officer had issued a direction requiring health employers to implement a policy that required nonimmunized staff to be excluded from work in the event of an influenza outbreak within the facility. The British Columbia Interior Health Authority implemented such a policy. In dismissing the grievance, the arbitrator distinguished the case from the *St. Peter's* case, noting that the St. Peter's case had not considered the question of the protection of economic rights under Section 7 and that it had been framed as an "assault/battery" case instead. The arbitrator held that that the implementation of the policy had not caused the deprivation of the liberty or security of a person such that Section 7 of the Charter is engaged.[81] In reaching this conclusion, the arbitrator observed:

> It is not evident that a loss of a number of days or weeks of work during the flu season would meet the threshold set out above to reach the conclusion that there had been a loss of liberty or security protected under Section 7 of the Charter. . . . It is not evident the economic consequences of failing to become immunized are so severe that they effectively deny an individual choice over her body.[82]

Furthermore, the arbitrator found that the leave was not considered disciplinary.[83] In addition, the arbitrator found that the rationale for the policy—to assist in preventing the spread of influenza among a vulnerable population—is clear, and furthermore, the employees had the choice of refusing the vaccine and/or the antiviral medication.[84]

In *Trillium Ridge Retirement Home and Service Employees Union, Local 183*,[85] the arbitrator also reached the conclusion that the employer's influenza vaccination policy was reasonable and designed to meet the employer's legitimate and crucial objectives. In that case, the employer's policy provided staff with a choice to be immunized; to be immunized in the event of an outbreak and to wait 2 weeks for the acquisition of immunity; or to take antiviral medication and be able to report for work within 48 hours. If neither option was chosen, the staff member would be granted time off work without pay. Employees who had a medical contraindication (allergy, pregnant/nursing, or other sound medical basis) would be exempted from the requirement to be immunized or to take antiviral medication. Staff were encouraged to seek advice from their own physician, and in addition, the employer took steps to educate staff through notices and phone calls of the options available to them, and to advise that nonimmunized staff would not be permitted to work. The policy was also in keeping with recommendations from the Medical Officer of Health.

The arbitrator concluded that the policy was not mandatory in requiring employees to be immunized or take the antiviral medication. The employee could choose to refuse either measure, although there was a cost to such refusal in that the employee could not attend at work and be paid during an outbreak.[86] The arbitrator further found that the policy was not arbitrary or unreasonable and did not violate the collective agreement. Leave without pay was not considered a disciplinary penalty or constructive lay off. Moreover, the cost did not vitiate consent to immunization or the administration of antiviral medication. The arbitrator further recognized that in a long-term care setting, employees must realize that special measures may be needed to safeguard the health and safety of the frail elderly population they serve.[87] This objective was found to be of sufficient importance and the serious consequences of ineffective immunization on residents were considered sufficiently grave that the policy was reasonable and not arbitrary in the circumstances. Finally, the arbitrator advised

that the policy should be posted in accessible locations in all departments of its facility to ensure there would be no misunderstanding about the content or application of the policy.[88]

Employers who provide immunization and antiviral medication for their employees and/or their family members should ensure that they have appropriate consent documentation and waivers for this purpose.

- Review immunization policy and collective agreement with legal counsel.
- Consider posting copies of policy in accessible locations in the hospital.
- Schedule education sessions for staff to explain the immunization policy in advance and include the policy in orientation materials for new staff members.
- Review consents and waivers relating to immunization or provision of antiviral medication.

Ontario Human Rights Code

The Ontario *Human Rights Code* protects against discrimination in employment on certain prohibited grounds. Section 5(1) of the Human Rights Code provides: "Every person has a right to equal treatment with respect to employment without discrimination because of race, ancestry, place of origin, color, ethnic origin, citizenship, creed, sex, sexual orientation, age, record of offences, marital status, family status or disability."[89]

The Ontario Human Rights Tribunal recently held that a worker's bronchitis was not a disability under the *Human Rights Code*, as it is commonly experienced by many and does not impact on the individual's ability to fully participate in our society.[90] In its decision, the Tribunal referred to the decision of the Board of Inquiry in *Ouimette v. Lily Cups Ltd.* in which it held that the flu, a temporary illness, was not a disability under the Code and that to include commonplace illnesses under the ground of disability would have the effect of trivializing the Code's protections.[91] The Tribunal further observed that "even where the courts have applied a broad and contextual definition to the notion of disability, everyday illnesses have been excluded."[92]

Privacy

The federal *Personal Information Protection and Electronic Documents Act* (PIPEDA) applies to organizations that collect, use, or disclose personal information, including personal health information, in the course of commercial activity. Tracey Bailey et al. report that Industry Canada's view is that PIPEDA does not apply to hospitals, but would apply to physicians in private practice and laboratories.[93] A number of provinces have enacted their own private sector legislation and/or legislation to deal specifically with the collection, use, and disclosure of personal health information. Where provincial privacy legislation has been declared to be "substantially similar" to PIPEDA, it takes precedence.

Ontario's *Personal Health Information Protection Act, 2004* (PHIPA) has been determined to be "substantially similar" to PIPEDA, and therefore, the collection,

use, and disclosure of personal health information are governed in Ontario by PHIPA. With respect to personal health information, PIPEDA applies in Ontario only in relation to extra-provincial and international disclosures.

Under PHIPA, the individual's consent must be obtained for the collection, use, or disclosure of his or her personal health information.[94] Health information custodians, such as hospitals, clinics, and physicians, must comply with PHIPA when dealing with patient's personal health information.

In an emergency, there may be instances where obtaining the patient or substitute decision maker's consent for the collection, use, and disclosure of personal health information will not be possible.[95] In certain circumstances, a health information custodian may disclose personal health information to certain other health information custodians.[96] These circumstances include when disclosure is in the public interest or there is a grave hazard to the public; where the disclosure would reduce or eliminate a significant risk of serious bodily harm to a person(s)[97]; disclosure for a public health purpose[98]; compassionate circumstances; to allow a family member of deceased person to make decisions about their own health or to identify the deceased[99]; and finally, where consent cannot be obtained in a timely manner and disclosure is reasonable necessary for the purpose of providing health care.[100]

The HPPA also creates an exception for medical officers of health to collect, use, and disclose personal information, subject to any conditions in the regulations, for the purposes of the HPPA or for purposes related to the administration of a public health program or service that is prescribed in the regulations.[101]

- Privacy policies should be reviewed to ensure that emergency exceptions are addressed and that staves are aware of when these exceptions apply.

Regulated Health Professionals and the Regulatory Colleges

Regulated health professionals should familiarize themselves with and follow the guidelines and policies of their regulatory colleges, including those with respect to emergencies, pandemics, influenza, delegation, scope of practice, and discontinuing or withdrawing care. Both the College of Physicians and Surgeons of Ontario (CPSO) and the College of Nurses of Ontario (CNO) have policies in place relating to expectations of their members during an emergency, which we discuss further later.[102]

The colleges may also issue helpful practice guidelines to assist their members with respect to infection prevention and control. See for example, the CPSO's practical guide to Infection Control in the Physician's Office and the CNO's practice standard on Infection Prevention and Control.[103]

Regulated health professionals should also comply with licensing and registration requirements with respect to health disclosure to their colleges and ensure they provide up to date information regarding their immunization status and health concerns to the hospital/employers, as may be required by the by-laws and/or policies of their facility.

Some colleges may institute emergency registration procedures to address human resources shortages in the event of a disaster. Under the Registration regulations under the *Medicine Act*, physicians may be registered for a short

duration, under supervision, for the purpose of providing services that would not otherwise be available due to a lack of persons to provide them.[104] Similarly, the CNO has created a Special Assignment Class for registration in the event the CNO's Executive Director declares an emergency.[105] In a declared emergency, the CNO can expedite the registration of new members from other jurisdictions by registering them temporarily in the Special Assignment Class for a maximum of 60 days.[106]

- Regularly canvas College websites for new policies and updates to existing policies.
- Set up education sessions for health professionals relating to College policies.

Duty to Treat

Following the SARS outbreak in 2003, the issue of the duty of healthcare practitioners to provide care in an emergency came to the fore. Healthcare workers found themselves weighing their duties to their families and their own well-being, with their professional duties to provide care to others in an emergency.

A study of the Joint Centre for Bioethics at the University of Toronto regarding the duty to care in communicable disease outbreaks demonstrated a lack of clarity and consensus among healthcare providers regarding the duty to care. The study notes that their findings "are in accordance with a recent study of family physicians who felt their duty and ability to care is contingent on an implicit duty of government to provide appropriate education, training and supply of equipment,"[107]

The traditional view was that there is no legal duty to provide care to a person with whom there was no pre-existing physician–patient relationship.[108] A recent British Columbia Supreme Court decision, however, suggests that this view is evolving.[109] In that case, a physician declined to attend to a patient awaiting emergency care and whom he had been advised was experiencing a possible myocardial infarction. The court held that the physician had been informed that the patient may be suffering from a life-threatening condition and that the nurse had requested that he treat the patient, and that while the physician was not on call, he was still on duty in the hospital. The court found that he knew or ought to have known that the physician on-call and all other physicians were otherwise engaged in the operating room and that the code of ethical conduct of the medical profession required him to assess the patient. In those circumstances, although it ultimately declined to find there was causation for the patient's damages, the court found there was sufficient proximity between the physician and the patient to support a duty of care to the patient.[110] *It should be noted, however, that this case occurred in the emergency room setting where there may be a greater duty to provide care then in a pandemic or mass emergency scenario.*

In addition to the potential to find a legal duty to provide care, there is support for an ethical duty to provide care based on the Canadian Medical Association (CMA) *Code of Ethics* (updated 2004), the Code of Ethics of the Canadian Nurses Association, and college policies. Members of the regulated health professions should familiarize themselves with the guidelines available

from their professional associations and regulatory colleges with respect to expected conduct during an emergency.

The CMA *Code of Ethics* provides that physicians ought to consider the well-being of society in matters affecting health. They must not discriminate against any patient based on the patient's medical condition, and they are expected to provide whatever appropriate assistance they can to any person with an urgent need for medical care. Finally, physicians must also "recognize the profession's responsibility to society in matters relating to public health, health education, environmental protection, legislation affecting the health or well-being of the community and the need for testimony at judicial proceedings.[111]

Similarly, the Canadian Nurses Association Code of Ethics applicable to registered nurses in Canada states clearly that "during a natural or human-made disaster, including a communicable disease outbreak, nurses have a duty to provide care using appropriate safety precautions."[112] The Canadian Nurses Association recognizes that there are situations where the duty to provide care may result in an unreasonable burden:

> Nurses also encounter personal risk when providing care for those with known or unknown communicable or infectious disease. However, disasters and communicable disease outbreaks call for extraordinary effort from all heath-care personnel, including registered nurses… A duty to provide care refers to a nurse's professional obligation to provide persons receiving care with safe, competent, compassionate and ethical care. However, there may be circumstances in which it is acceptable for a nurse to withdraw from providing care or to refuse to provide care. Unreasonable burden is a concept raised in relation to the duty to provide care and withdrawing from providing or refusing to provide care. An unreasonable burden may exist when a nurse's ability to provide safe care and meet professional standards of practice is compromised by unreasonable expectations, lack of resources or ongoing threats to personal well-being.[113]

A recent disciplinary case supports the existence of an ethical duty to provide treatment in an emergency, based on the Code of Ethics applicable to physicians. In that case, the College des Médécins du Quebec sanctioned a physician for turning away a patient who was en route to the hospital's emergency room by ambulance. Although the physician was aware that the patient had suffered a heart attack, because the emergency room had just closed for the evening, the physician followed hospital policy and informed the dispatcher for the ambulance that they would need to divert the ambulance to the next closest emergency room, which was some distance away.[114] The patient died in the ambulance on the way to the second hospital. The Discipline Committee found the physician guilty of failing to come to the assistance of a patient in contravention of the Code of Ethics, notwithstanding the physician had followed the hospital's policy.

College policies also support an ethical duty to provide care. Very recently, the CPSO, the licensing and regulatory body for physicians in Ontario, released a new policy entitled "Physicians and Health Emergencies" in September 2009.[115] The policy sets out the CPSO's expectation that physicians will provide medical care during a health emergency, in accordance with any federal, provincial, and local emergency plans. Although the policy notes that physicians also have obligations to themselves and their families, which may need to be balanced with their obligation to provide care to patients, the CPSO leaves the balancing of these obligations to the physician's professional judgment.

Similarly, the CNO policy on preparing for an influenza pandemic[116] states that it expects nurses to actively assume their obligation as self-regulating health professionals by providing nursing care during an epidemic.[117] The CNO further "expects nurses to fulfill their commitment to clients, the profession and the public during an influenza pandemic by providing nursing care within their individual professional competencies. It also expects nurses to keep informed about pandemic plans and public health communication systems."[118]

Regulated health professions should also familiarize themselves with the professional misconduct regulations made under the various health professions acts. These regulations make in an act of professional misconduct to withdraw or refuse to provide care, except in limited circumstances.

Regulated health professionals in Ontario are protected from liability under the *Good Samaritan Act, 2001* for providing emergency healthcare services or first aid, when such care is provided voluntarily and without reasonable expectation of compensation. The protection only applies to care that is provided outside of a hospital or other place having appropriate healthcare facilities and equipment.[119] An individual who is not a member of a regulated health profession who provides first aid assistance to a person who is ill, injured, or unconscious as a result of an accident or other emergency is also protected, if the individual provides the assistance at the immediate scene of the accident or emergency.[120] A number of other Canadian jurisdictions have also enacted similar legislation for providing first aid in an emergency.

Healthcare facilities, whether hospitals, long-term care facilities, clinics, or medical offices, must recognize that if there is a duty to treat by healthcare professionals, there is a concomitant duty on the healthcare facilities to keep the healthcare professionals well-informed and provide them with appropriate protective devices and training. The Canadian Nurses Association Code of Ethics states:

> Nurses have a right to receive truthful and complete information so that they can fulfil their duty to provide care. They must also be supported in meeting their own health needs. Nurses' employers have a reciprocal duty to protect and support them as well as provide necessary and sufficient protective equipment and supplies that will "maximally minimize risk" to nurses and other healthcare providers.[121]

- Establish a policy for obtaining up-to-date information and communicating with healthcare professionals on staff in an emergency.
- Ensure appropriate personal protective devices and other emergency equipment are provided and maintained and that regular training is provided.
- Schedule education sessions for professional staff regarding College policies and applicable Codes of Ethics.

Scope of Practice Issues

In an emergency, regulated health professionals may be required to render care in an area that is outside their normal scope of practice, training, and expertise. Several of the regulatory colleges have issued policies to guide their members when they are required to act outside of their normal scope of practice.

The CPSO's policy states that a physician should only practice outside his or her area of expertise during a health emergency if the care needed is urgent, a more skilled physician is not available, and not providing the care would lead to worse consequences than providing it.[122] The physician should not practice in the new area once the emergency is over.[123]

The CNO states that:

> The RHPA allows members of the public and regulated healthcare providers to perform controlled acts without authorization when providing first aid or temporary assistance in an emergency. Emergency procedures that are performed within a healthcare facility technically meet the emergency exception. The College maintains, however, that in situations in which it is anticipated that emergencies will likely occur, such as in a hospital or long-term care facility, it is necessary to have a standardized process to enable nurses to attain and maintain competence in performing emergency procedures that are outside the controlled acts authorized to nursing. This process includes the:
>
> - education and ongoing assessment of competence with the involvement of a health professional authorized and competent to perform the procedure;
> - documentation of the process;
> - written criteria to select appropriate clients and identify treatment parameters; and
> - necessary authority and/or resources to manage client outcomes.
>
> Such a process helps to ensure that nurses have the necessary preparation to perform a procedure that carries a risk of harm. This process is in keeping with the intent of the controlled acts model and the College's mandate to protect the public.[124]

Individuals who are not members of a regulated health profession may also be called on in an emergency to perform acts that normally must be performed by authorized regulated health professionals. The *Regulated Health Professions Act* contains an exception that allows persons to perform controlled acts reserved to certain health professions in emergency situations, if the act is performed while rendering first aid or temporary assistance in an emergency.[125]

Consent Issues

In providing medical care to a patient, physicians and other healthcare practitioners must obtain their patient's consent to the treatment or procedure or the consent of their substitute decision maker. Touching a patient without consent may amount to battery. In the event of an emergency, however, the patient may be unable to provide consent and in limited circumstances, a physician or healthcare practitioner may be permitted to proceed without obtaining the patient's consent.

The *HealthCare Consent Act*[126] (HCCA) defines an emergency as occurring when "the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm."[127] The HCCA provides that treatment may be administered without consent to a person who is incapable

with respect to the treatment, if the practitioner is of the opinion that there is an emergency and that a delay in treatment will prolong the suffering that the person is apparently experiencing or put the person at risk of sustaining serious bodily harm.[128] Treatment without consent to a person who is apparently capable is also permitted where there is an emergency; there is a language barrier that prevents communication needed to obtain consent; reasonable steps have been taken to find a practical means to enable such communication without success; the delay necessary to find such a practical means would prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm; and there is no reason to believe the person does not want the treatment.[129] Such treatment can only continue for as long as reasonably necessary to find a practical means of enabling the communication necessary to obtain the patient's consent.[130] Examinations and diagnostic procedures may also be permitted without consent, in certain circumstances, as set out in the HCCA.[131] The Act also contemplates that emergency treatment may be administered contrary to the wishes of a substitute decision maker, where there is an emergency and the substitute decision maker did not comply with the principles for giving or refusing consent set out in Section 21 of the HCCA.[132]

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