JP-7

ISSN 1710-9442

Legislative Assembly of Ontario

First Session, 38th Parliament

Assemblée législative de l'Ontario

Première session, 38e législature

Official Report of Debates (Hansard)

Wednesday 18 August 2004

Journal des débats (Hansard)

Mercredi 18 août 2004

Standing committee on justice policy

Emergency Management Statutes Review

Comité permanent de la justice

Examen des lois ontariennes sur les mesures d'urgence

Chair: David Orazietti
Clerk: Katch Koch

Président : David Orazietti
Greffier : Katch Koch

Hansard on the Internet

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

Le Journal des débats sur Internet

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

http://www.ontla.on.ca/

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-3708.

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7410 ou le 325-3708.

Copies of Hansard

Information regarding purchase of copies of Hansard may be obtained from Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Exemplaires du Journal

Pour des exemplaires, veuillez prendre contact avec Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311, ou sans frais : 1-800-668-9938.

Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON JUSTICE POLICY

COMITÉ PERMANENT DE LA JUSTICE

Wednesday 18 August 2004

Mercredi 18 août 2004

The committee met at 0907 in room 228.

EMERGENCY MANAGEMENT STATUTES REVIEW

The Acting Chair (Mike Colle): Could I have your attention to bring the committee to order. Good morning, ladies and gentlemen. If you could find your seat, that's the first test.

Interjections.

The Acting Chair: We have nameplates there. It's part of the test the committee has imposed on MPPs, primarily, and guest panellists to find out where their seats are.

Anyway, welcome here this morning, taking time from your extremely busy schedules. We're here sitting as members of the justice policy committee. I'll just let our guest panellists know that the mandate of this committee is "to review and report on the adequacy of Ontario's emergency management statutes; and that the committee be authorized to adopt the text of a draft bill on the subject matter of this order of reference...." So we're here essentially to review the existing statutes, to see their adequacies and recommend in a report potential changes and improvements, and also to draft a bill to meet, perhaps, some of the issues raised by presenters to this committee.

I'll just outline this morning's format. In the first portion we're going to have presentations by Dr Sheela Basrur, the chief medical officer of health for the province of Ontario, and Allison Stuart from the Ministry of Health, the emergency management director, if I'm not mistaken.

We'll leave about an hour for that. The presenters will put forth a statement of 15 or 20 minutes and there will be questions from MPPs for the remaining period. Then, after the first hour, we'll go into the round table panel whereby we'll have other panellists—Dr Low will make a 10-minute presentation, followed by others who will make 10-minute presentations—and then there will be questions and comments by other MPPs or other panellists. We hope to get comments and questions perhaps from the panellists. That will be allowed, which is quite outside the norm of the way this committee works. But we hope that will generate some good dialogue and expand on some of the issues that all of us would benefit from.

Just bear with us as we work our way through this process. It's worked fairly well so far as we're trying this new, more interactive approach to committee hearings for this very important topic. So we'll start with—

Mr David Zimmer (Willowdale): Mr Chair, I wonder if you might consider just introducing the members of the committee.

The Acting Chair: Who the MPPs are? Yes. Just for our guests, normally what happens is that we have the opposition on one side and the government on the other side in these committee hearings. To make it somewhat more informal and interactive, we've changed the seating format. So on our right, in the corner, we have Wayne Arthurs, MPP. Representing the NDP, we have Peter Kormos, MPP. We have MPP Laurel Broten, MPP Liz Sandals—

Mr Peter Kormos (Niagara Centre): She's the parliamentary assistant to the Premier.

The Acting Chair: —MPP Jim Brownell. I think we're all parliamentary assistants to someone here, but the Premier is above and beyond all of us other PAs.

Mr Zimmer: Don't forget me.

The Acting Chair: And David Zimmer, yes, MPP from Willowdale.

Mr Jim Brownell (Stormont-Dundas-Charlottenburgh): *[inaudible]* the introductions?

The Acting Chair: Have you heard the introductions? Yes, they have.

OK, let's begin then with the first portion, the presentation from the Ministry of Health and Long-Term Care, Dr Sheela Basrur or Allison Stuart. Who would like to begin?

SHEELA BASRUR

Dr Sheela Basrur: I'll begin. Thank you very much, Mr Chair and members of the committee. We have a slide deck that is winging its way over to you, so there is no need to take detailed notes on what I'm about to describe for you. As I understand it, the committee is most interested in understanding what existing authorities we have under present legislation, what authorities we would like to have in order to better deal with future emergencies, whatever those hazards may be, and then to open it up for questions. So that's what you can expect. We'll see if that works.

Overall, the enabling legislation for public health is the Health Protection and Promotion Act. This was first

enacted in 1983, the regulations in 1984, and it establishes the mandate and role for boards of health, for medical officers of health, and thereby for all of the staff in public health units across Ontario.

There are about 37 health units at the moment and there are varying governance structures for boards of health, depending upon whether they're in regional municipalities, free-standing boards, multi-municipal or single-municipal environments etc. But generally speaking, there is one enabling legislation that applies for all.

The purpose of the act "is to provide for the organization and delivery of public health programs and services," with particular reference to prevent the spread of disease and to promote and protect the health of the people of Ontario. Of course the act binds the crown, so in any action, deliberation, policy, value or principle, the primary consideration is the health of the public and what means are necessary in order to protect the health of the public. It may not mean protecting an individual from themselves—that may be a mental health issue—but it certainly involves protecting the health of people from the actions of another that they may be exposed to beyond their consent or against their will in some fashion.

The second thing is that, under the act, every board of health must either provide or ensure the provision of health programs and services that are set out in the act or in what are known as mandatory guidelines, which are set out by the minister from time to time and fall under a number of different categories: family health, communicable disease control, environmental health issues and the like.

In addition to the mandated programs and services that are set out under the act, there are a number of statutory authorities that fall to medical officers of health, and in some cases to public health inspectors as well, to prevent, reduce or eliminate the effects of health hazards in their community and to take steps to prevent, reduce or eliminate the risks from communicable diseases or the risks or reality of outbreaks of communicable disease.

That's the general framework of the law under which we operate on a day-to-day basis. In a time of either anticipated or real emergency, we may scale those powers up for greater and greater application. If they prove to be insufficient, then the local medical officer of health would call upon the province for advice and assistance and we would take it from there.

There are a number of different ways in which diseases are classified. As you are aware, Justice Campbell is right in the midst of considering the issuance of another interim report, which will likely be in September. I expect that he will be commenting on the current classification of diseases. Suffice it to say, if you know it and understand it, it makes sense, and on first blush you wonder why there are all these different lists and rules and so forth. But the current scheme is that there are reportable diseases, namely those we wish to maintain surveillance of. We want to count how many cases of influenza there are, how many cases of chicken pox there are, so we can monitor trends over time to determine whether programs are effective or not, whether additional resources are required in certain parts of the province and so on. That's reportable, and those are designated in a regulation.

The second list is communicable diseases. Those are diseases that can spread from person to person and for which public health control measures may be necessary in order to reduce the risk to the health of the public. That's a subset of the reportable disease. So we've got two lists now.

The third is virulent. Virulent diseases are those that are so contagious, if I may, that they require extraordinary powers in order to ensure that the health of others is not threatened. Lassa fever would be a virulent disease; tuberculosis is a virulent disease. Just to pick on tuberculosis for a moment, it is a preventable, treatable, curable disease but, if untreated, it will kill the person, and more to the point, will spread the disease to other people. We, under the act, have the ability, if all else fails, to require the person to be treated and, if all else fails in seeking to have them treated, require them to be placed in a facility to have monitored treatment on a daily basis until they're rendered non-infectious.

That extraordinary degree of authority is limited to a very prescribed number of diseases, of which tuberculosis is one. A disease for which there is no good treatment is not going to be subject to those kinds of powers because there's no point in putting someone in a facility and then just leaving them there.

Mr Kormos: How readily does a new disease get put on this list?

Dr Basrur: In the normal course of government it can take months to years. In the case of SARS, where we had a very rapid escalation of a hitherto unknown disease, it literally happened over a weekend that it was made reportable, communicable and virulent, all in one. That's not the norm.

The Acting Chair: Usually we'll wait till you're finished before we ask questions, but, given the fact that we're all novices at this, who designated SARS as virulent? Who has the power to do that?

Dr Basrur: That's an authority of the minister under the act. In addition to the Lieutenant Governor in Council, the minister can make certain regulations, and it's the minister who has the authority to designate diseases as falling into one of these three—

0920

The Acting Chair: He did that by regulation? He or she can do that by regulation?

Dr Basrur: Correct.

The Acting Chair: In the case of SARS, who did it?

Dr Basrur: It would have been Minister Clement at the time.

The Acting Chair: OK. Thank you.

Mr Kormos: Not by regulation?

The Acting Chair: Just for our interest, did he do it by regulation?

Mr Zimmer: On a point of order, Mr Chair: I thought that the way we were going to handle this was to hear the presentations and then have a sequence of questions. If we all start jumping in with our questions, I think it's going to disintegrate. Should I hold my questions?

Mr Kormos: No, feel free.

Mr Zimmer: Well, are we going to hear the presentations and then have questions?

The Acting Chair: Mr Zimmer, as I said at the beginning of this committee, we are trying to make this committee work in an innovative way. At certain times the Chair will allow a member of the committee to ask a question where it's not in the prescribed, preordained order of the day in terms of how the committee will work. If I feel that it's a pertinent question that's not going to take us completely off the rails, I will allow for that to happen, because the spirit, hopefully, of this committee is to work on a degree of flexibility to achieve our goal of getting valuable information. So as much as Mr Kormos was basically out of order according to the old rules for the way committees work, so was I. But I thought it was just for our train of thought to continue. I thought it was permissible to ask that question.

Mr Kormos: I apologize.

The Acting Chair: OK. So do I.

Mr Kormos: It's been 16 years of being out of work.

The Acting Chair: So we both apologize, and if I could just explain myself in that fashion, we'll let Dr Basrur continue as prescribed at the beginning.

Dr Basrur: All right. If I can continue to be unorthodox, I'll take the liberty of answering questions where they are for clarification. If they are going to take us on a tangent, I'll request that that be dealt with later.

The Acting Chair: Exactly. Thank you very much for the help.

Dr Basrur: Reporting to the medical officer of health is a legal responsibility for certain prescribed entities. Again, all of these are found in different sections and verses of the act. Laboratories are the primary reporting source, so if someone has a case of syphilis, let's just say, or SARS—it's not the best example, but syphilis would be a good one—they usually have symptoms. They go to the doctor, and the doctor may treat without getting a test done. The doctor may or may not phone the public health unit to report it. They are supposed to, in law, and sometimes don't. But if they do take a swab and send it to the lab, the lab, by a matter of automatic procedure, will inform the local public health unit.

That's how we carry out our surveillance and that's how we initiate control measures. We rely on either the voluntary or the mandatory requirement to report for surveillance and control of infectious diseases. School principals, hospital administrators and operators of laboratories are the main entities that report disease to us.

In turn, there is a duty on medical officers of health to report these diseases to the Ministry of Health. Again, there's a regulation setting out what the requirements are. We are in the midst of reviewing and revising that regulation in order to learn from the SARS experience, and also to implement a better disease surveillance and case management system, which was lacking during SARS but which is now going to be, in the foreseeable future, rolled out.

It is not quite clear as yet how the chief medical officer of health in this case can and should report that information more broadly to, say, Health Canada or other authorities, and whether that can be nominal, or named, information with personal information in it or whether it must be anonymized information. So when you're looking at things that should be clearer in the future—again, I can expect you'll hear this from Justice Campbell in his interim report—that is one of those areas that would benefit from greater clarity.

The act does specify what offences are. It specifies a schedule of fines. It does note that no action or proceeding may be instituted against a person who makes a disease report if they are doing so in good faith, because it's recognized that the act is meant to protect the health of the public at large, and you don't want to be prosecuting people for trying to do their duty as either a good Samaritan or as a good member of society.

The medical officer of health has authority for a prescribed geographic area which is called the health unit. Sometimes the health unit becomes synonymous with the office and the organization. In fact, it's the territory that they serve. So the medical officer of health and the board of health for that area have full legal jurisdiction for that, but not beyond. Generally speaking, the chief MOH has authority for the entirety of the province, but usually only upon request.

Again, one of the recommendations that came out of the first Campbell interim report was that this system be flipped around such that the chief MOH had all of the authority and then delegated on a day-to-day basis to the local medical officers of health. That has a whole lot of, let's just say, pros and cons attached to it. Right now what we have are local MOHs that have day-to-day authority, and if need be, they call upon the chief for advice, assistance, more resources, fewer resources or what have you.

If there is an emergency, if the minister or the chief MOH forms an opinion on reasonable and probable grounds that a risk to health exists for any persons in Ontario, then certain additional powers can be exercised. Those are spelled out in the act as well.

Should I just keep barrelling along here?

The Acting Chair: Yes.

Dr Basrur: OK. There are a whole lot of materials in the deck that summarize the different authorities that fall under a couple of relevant sections. I won't read through them now, because I think it's better to have them come up through the questions.

The Acting Chair: Just use your own discretion as to what you think needs to be highlighted.

Dr Basur: OK. For highlights, if there is a health hazard in the community, we have what's called section 13 authority to do what it takes to get rid of that hazard or reduce its impact on people. This would be non-com-

municable: chemical spills, poor air quality—some brave medical officers of health have used it for tobacco smoke—and the like. In addition, for communicable diseases we use section 22. I'm going to refer to these numbers periodically as being germane sections of the act. Finally, for emergencies we have section 86. So 13, 22 and 86 are provisions that I live, breathe and sleep on most days.

In addition, there are a whole lot of steps that can be taken—either asking people to do certain things or asking people to stop doing certain things—so as to limit the spread of communicable diseases from one person to another. Again, these are spelled out in great detail in the act and also in the slide deck that will be coming.

One of the elements that arose during SARS was our inability to issue orders on anything but a person-by-person, one-at-a-time kind of basis. There was an instance wherein we had an entire group of people who needed to be put into quarantine on a weekend. It was physically and logistically impossible to issue orders person to person on a Saturday afternoon for 350 people who happened to live in three or four different health units all at once, each with their own MOH, their own solicitors and so on. So now there is an amendment to the act. Again, that was processed even between phases one and two of the SARS outbreak. So things can happen fast when the will is there, but also when the need is apparent, such that orders can be issued against a class of persons. In a future pandemic or other wide-scale emergency, that will be a very helpful provision so we can issue mass orders if necessary and if warranted under the circumstances.

There is an appeal mechanism through the Health Services Appeal and Review Board when an order is served, but the order takes effect at the time it's served, notwithstanding that an appeal may have been filed. Sometimes appeals take many, many weeks to be heard. When the purpose is to protect the health of person Y from person X, you can't have the wheels of justice grinding along in such a way that people get sick and die in the meantime.

I won't go into the fines and all the different legal aspects that exist here. Suffice it to say you could go page after page on what's in there.

0930

In terms of offences, generally speaking, if someone has a communicable disease and they're not behaving themselves in a way that would limit the risk to others, the medical officer of health would issue an order. If the order is breached and there is documented non-compliance of the order, then if it's virulent, you can go to a superior court justice and seek detention in a health facility to require them to be treated—to be placed in isolation against their will, so to speak. In addition, if it's not a virulent disease, you can go to Ontario Court (General Division) and seek a restraining order by a judge for a similar purpose.

Now, there are not many instances in Ontario's history where court orders have been sought against individuals who have been exposing others. But a classic example might be someone who is HIV-positive and is willingly, knowingly, deliberately exposing other people to that infection, notwithstanding that there's probably a mutual responsibility to determine whether you're protecting yourself, much less protecting other people.

As I mentioned, section 86 is a provision in which the minister or the CMOH is authorized, where they're of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, to investigate the situation and then take such actions as are considered appropriate to prevent, eliminate or decrease the risk.

You may be familiar with a situation recently—

Interjection.

Dr Basrur: Oh, thank you. It'll just distract you to look at it, so just leave it closed for now.

The Acting Chair: You remind me of my grade 6 teacher.

Dr Basrur: You may be familiar with a situation recently in a Muskoka-Parry Sound health unit where the province undertook some intervention steps to deal with a public health problem. This is a good example of two different provisions in the act whereby the province can intervene, where necessary, to protect the health of the public.

This is public information in that it was written in the newspapers—locally, at any rate. There had been a breakdown in the on-call system for after-hours response to urgent situations and emergencies, such that after working hours, there was no qualified person who was able and willing to deal with whatever the situation was. I won't get into the detail. There was a labour-management issue behind it and so forth.

Suffice to say that we had received a few complaints, not only from within the health unit, but from surrounding jurisdictions concerned that if a situation arose in that health unit that spilled across the borders to adjacent areas, it would become everybody's problem and that the only entity that could take action to deal with it would be the province. So what we did was serve notice on the board—and this is a board that did not have a full-time, permanent, qualified medical officer of health, contrary to the act. So we appointed a medical officer of health to serve that health unit and told the board that's what we were going to be doing because we needed to remedy that situation.

In addition, there had been some long-standing governance problems related to that board of health. Again, the details are beyond the scope of the committee's mandate but the province felt those were interfering with the normal operation and good management of the health unit, and took steps to do what's called an "assessment" under the act so we could diagnose what was happening at the board of health, reverse any decisions that might have been taken that were impeding the health unit's operations, and thereby eventually put it on a sound footing.

So there are procedural steps and safeguards in the act, not just for the individuals who may be afflicted with a

communicable disease, but also to deal with the organization locally that is meant to deal with these things properly. So there is a system of safeguards, if you like, that ought to kick in, if situations warrant it. Not on a daily basis, by any means; in fact, my understanding is that this is the first time section 86 has actually been implemented since the act was written. I may be wrong, but if there's another, it's probably only one other situation.

There is an additional provision within that series of sections that enables the chief MOH to take action, not just on diseases that are regulated as reportable or communicable but on any disease that is deemed infectious. "Infectious" is not a defined term, so it's literally at the professional judgment of the chief medical officer of health, and any advisers that they may have, to say, "We have a totally new entity," as we did during SARS. It didn't even have the name "SARS"; it had the name "severe atypical pneumonia from Hong Kong and Hanoi." Well, that's not much of a disease classification, but it was felt to be very serious in its manifestation. We had four possible cases in Toronto, two of which had died, so we had a 50% case fatality rate, and still a disease with no name. Something needed to be done, and the chief MOH would have had the ability to take whatever action necessary as an infectious disease, even though it hadn't actually been in the regulation at that point. The chief MOH at the time did take action to make sure that all those authorities were put in place as quickly as possible.

Again, if there's a breach of the directions that are issued by a chief MOH, the CMOH can go to court and seek an order against a board of health that is not doing its job to protect the health of the public. We've never had that instance happen in Ontario, to my knowledge, but the provision is there, if necessary.

A further matter that was identified as a missing piece during SARS was the inability to detain ill people, or people not yet ill but exposed and potentially infectious, in a safe place. So if someone had been exposed to SARS in a hospital, for example, and they needed to be put into quarantine, we could quarantine them in their home, but we could not set aside a building as "the quarantine facility." If you think about either SARS or pandemic influenza or, heaven forbid, smallpox or some such, you may want to have facilities that are designated as the place to put either ill people—conceivably, you may want to put well people there who are needing hospital care, but you want to keep the sick and the healthy separate. Or you may have people who've been exposed and you need to assess them for a certain period of time under very strict supervision, and they need to be in a defined, prescribed area with proper medical and nursing supports and all the rest of it.

The act now allows the minister to "order and occupy"—forgive the legal language—or to require that a building be given up to the minister to be used as a temporary isolation facility for up to 12 months, and that order can be extended if need be. In addition, temporary isolation facilities can be used where necessary in order to protect against the spread of communicable diseases.

Again, some of the provisions that I'm describing to you are long-standing; they've existed since 1983-84. On some of them, literally the ink has not dried because they reflect our experience in SARS last year. We suffered for the lack of those provisions, and now have them.

There are a whole variety of regulation-making authorities that are listed under the act. I won't go through those in detail.

I'll turn now, finally, to the possible enhancements to health legislation that would be helpful in the context of amendments to the Emergency Management Act.

I would like to stress that it's critical to achieve a balance between day-to-day civil rights and the normal workings of a community—businesses, livelihoods, people's ability to attend school and go to the playground and all the other facets of normal human living—but also not to wait until an emergency is upon you to try to say, "Oh my God, we need to do these three things, and we're not sure what the authorities are," or "We do have the authority to do the first two, but the third one was always seen as something we would attend to at some future date." By the time that date is upon you, I'll tell you, it feels like it's way too late to start thinking about what you need. This is the time to think about what you need and to put it in place, and perhaps to have some safeguards and checks and balances built into the legislation or into the policy framework that supports it, so that they're not used on anything but an as-needed basis.

0940

You might, in the case of the health legislation, have a series of what I call "scaleable" powers that are consistent with the day-to-day structure of the regulation of public health, not totally divorced from it, so that when you start with what seems like one case, two cases, four cases, and, "Gee, it's not just one institution, it's two institutions, and yes, there were workers who crossed over and we're not sure where a third one may have worked because we can't find that person," you want to be able to scale up but not have to invoke a new statute entirely in a non-provincial-emergency situation. You want to be able to scale up, scale back, scale up in particular geographic areas or on particular functional areas so that you've got a sensible response.

Now, it is possible to have that kind of provision built into individual statutes—the Health Protection and Promotion Act, the Nursing Homes Act, the Homes for Special Care Act, the Charitable Institutions Act, all of the rest of them. You might have it in the Ministry of Health and Long-Term Care Act. Not being a lawyer, I'm not going to try to nuance what the differences would be. All I will say is that from a public health standpoint, I need the latitude, and I know the local medical officers of health need the latitude, to say: "These are our authorities. We know what we can do on a daily basis. We know if we have an urgent situation we can ramp up this quickly, but when we hit certain parameters, we've got to escalate it to the province, because this really goes

beyond our borders; it goes beyond our competence," or, "It's multi-jurisdictional, and therefore a comprehensive response needs provincial coordination and control."

It might be the case that the chief MOH needs to have authority to make directives. I'm sure we can have a very interesting discussion, just the two of us, leaving aside the committee, about directives and who should issue them and what they should contain and what the process should be for development and approvals and so forth. During SARS, as you are aware, there were a multitude of directives issued under the authority of the two commissioners—the Commissioner of Emergency Management and the Commissioner of Public Health—and many comments back that people were unsure who was in charge because there were two signatories; there were always two people who had to be consulted. I would say that if you have a public health emergency, which means primarily that you have an infectious disease emergency for which public health is clearly the lead agency, it is wise, in my opinion, for those directives to be issued under the authority of the chief MOH. That's not to say that the chief MOH wouldn't check in with a whole lot of people: Dr Stuart—honorary doctor; lucky you—as the director of the emergency management unit; obviously with the deputy minister; with Dr Young over where he is, and so on. I'm sorry; the acronym escapes me.

The point is that someone has to be in charge; people have to know where the buck stops, where decisions are made and where they can be unmade, and who the go-to person is. For infectious diseases, I think it needs to be the chief MOH. For other emergencies, whether it's a toxic release or a radiation accident or a major flood, there may well be health implications attached to those, but it's not as clear to me that the Ministry of Health and the public health division is the lead agency for the care and control of the incident. They are absolutely going to be main supporters of the response, but not necessarily the lead. That's the distinction I would make.

We can probably have a long debate, till the end of the day, about what's a public health emergency where you might have a mixture. They talk about the spectre of, let's say, a dirty bomb. A dirty bomb might be an explosive device that contains either nuclear or radioactive material, or it may have some real or perceived infectious pathogens in it. You're going to have mixed responsibilities, mixed jurisdictions. You'd have to deal with that on a case-by-case basis, and everyone is going to have to work together extremely closely anyway.

Additional authorities that probably will be necessary before we have such things as pandemic influenza would be an ability of the chief medical officer of health to make orders regarding mass immunization of individuals or populations. Right now, from SARS we had the experience that we needed to issue an order against classes of people, but there was no vaccine. What if there had been a vaccine? I would have had to order, maybe, vaccination one at a time. I'm not sure I have the authority to order vaccination even one at a time, much less against a class of people. If we think about a vaccine-preventable disease emergency, we need to have those provisions in place so we can take action pretty quickly to protect the healthy people from becoming sick.

Similarly, there may need to be the authority to order mass decontamination, whether it's from a radiological exposure or from a chemical exposure of some sort, and some general provision that enables any other actions that are deemed necessary, reasonable and appropriate under the circumstances, to be taken, again, by a defined individual who has a lot of accountability and transparency to their work.

In my instance, I feel very strongly that the chief MOH is not just a statutory official but one whose job ought to be transparent, ought to be accountable, because it's beyond being publicly funded; it's to serve the public and protect the public's health, and the extent to which I do that job well or poorly is something that people ought to know about and make a judgment on with appropriate due process. If I say I need to have all these different authorities under my bailiwick, I think it behooves that to also be countered with checks and balances.

For example, if I invoke an authority that is substantially more than just a day-to-day, there might be a duty to report out, to the minister or through the minister to the House, however you may see fit, to ensure there is accountability for the use of that authority, so there isn't the spectre of some—I may be reasonable, but who knows about the successor to my successor? You would just want to set it out in place so it's going to be sustainable over time.

I'm glad Mr Kormos has stepped out of the room. He's probably listening on his speaker so he'll run in at any moment, because some of these are a bit interesting.

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

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

The third one is authorizing the chief medical officer of health to require any person, organization, agency or any other entity to report information to the chief such that he or she considers necessary to reduce the risk of the emergency; in other words, so that I can compel any one of you to give me any information that I see fit. I'm not sure I want that authority unfettered. It's important to think about what those checks and balances ought to be.

It is absolutely not on to say, "Yes, I'm in charge of the emergency, and I'm going to have to ask your permission," and give you a consent in triplicate, and then

you're going to see your lawyer and give me a notarized statement, and I'll do that a million times over because that's the population I have to deal with. That's not on. So what's the middle ground in between that provides protection, not just for the giver of the info but the people who will suffer for lack of that information being given?

0950

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

On that note, I'll conclude my presentation and either turn it over to Allison or be prepared for questions.

The Acting Chair: We're going to have Allison Stuart continue with the presentation on behalf of the Ministry of Health and Long-Term Care, and then we'll have questions.

ALLISON STUART

Ms Allison Stuart: Thank you very much. As indicated previously, I am Allison Stuart. I'm the director of the emergency management unit within the Ministry of Health and I'm representing the Ministry of Health this morning before the committee. I very much appreciate the opportunity to contribute to the work the committee has undertaken.

What I'll attempt to do in the next few minutes is really focus on the environment we're working in: the operational environment, the policy environment and the legislative environment that Dr Basrur has referenced. In her presentation she talked at length about the legislative authority and powers both in place now and also ones where she's thrown out the challenge in terms of what needs to be considered within the context of the balance between individual rights and freedoms and the public good.

As you are all quite familiar now with the Emergency Management Act, having had it presented to you, I'm sure, multiple times, I'll just talk a bit about our responsibilities at the Ministry of Health under that legislation that are unique to health. Under order in council we have responsibility for human health epidemics and emergency health services. Now, I can tell you we have suggested, and people seem to be in agreement with this, that the order in council be modified slightly to read "health services in an emergency," because in health-care speak, "emergency health services" has a narrower definition than "health services in an emergency." So we could anticipate that that proposal will be coming forward.

We are required to meet the material within the Emergency Management Act, and we have, as has been indicated, additional legislative authority and responsibilities under legislation that we work with, like the Health Protection and Promotion Act, the Ministry of Health and Long-Term Care Act, as well as individual legislation that we use in the administration and delivery of health care programs and services in Ontario.

I know other presenters have talked to you about Ontario's history of emergencies and I thought it might be helpful to you to hear a little bit about what health's role would have been or could have been in those emergencies. Some of them pre-date my experience, but I can certainly speak to the sorts of things.

The first one that seems to be referenced with some regularity is Hurricane Hazel. Of course, our ambulance services would have been involved with that in terms of removing from the scene folks who were injured as a result of the hurricane. The injured needed to be cared for in hospitals and other settings. The disruptions to the sewage system and the water supply system would require monitoring through public health authorities.

We had a quite different role in the Mississauga train derailment, where the local hospital and long-term-care facility had to be evacuated and moved to other hospitals, other long-term-care facilities and other gyms and auditoriums. Once again there was an engagement in that way, but there was also the role the ambulance service played in helping to effect all that.

More recently, the ice storm in eastern Ontario: In some of the communities, the hospital became the shelter because the hospitals had generators and there was a large enough gathering space that people who were not able to stay in their homes could have a setting to stay in.

The hidden group that requires and gets health care services in Ontario is those who are in their homes. That group's ability to get services was compromised both in terms of health professionals' ability to get to them, as well as having the appropriate supplies and so on in place so as to be able to work with that. Once again, there were concerns around issues of the power supply etc, and I'll talk a little bit more about that when we talk about the power blackout.

Our most recent experiences of course include SARS, where there were major impacts on health human resources, on our ability to provide services, on wait times, not only during the emergency, not only during SARS, but after SARS, as a whole health care system had to catch up or attempt to catch up with the experiences of SARS. During that time there was the public health management of the outbreak itself, quarantine issues, contact tracing of people who may have been exposed to the virus, that sort of thing.

Then, when we were starting to think we were going to have some relief, there was the power blackout. While

it's not specifically around health care, it had very profound impacts on health. Once again, the people who are in their homes and may be on home dialysis or receiving oxygen, that sort of thing, do have emergency arrangements but they don't anticipate the extent of an emergency such as we had with that power outage. So they were certainly in difficulty.

The ability of health care workers to get out to people in homes and to their jobs in institutions, because access to gas to fire up the car and get to work—a lot of people who work in Toronto, for example, come from outside of Toronto.

Something as ordinary as the drugs people may be taking day to day which need to be kept refrigerated—you'll recall that unlike this August, last August was hot. So the ability to keep those drugs safe was an issue. We know that various agencies that did have generator power became the refrigerator for other people who needed that kind of service. Also, from a public health perspective, we had to remind the public that once your power came on, it didn't mean that the food you had in your freezer was good to go. So there were roles to be played.

The most recent experience we've had is with the Peterborough flood, where we had to evacuate a long-term-care facility. That whole facility had to move out in short order because it was at risk, not only from what everyone else was at risk for in terms of the growth of mould, the fact that there was sewage etc, but their physical structure was compromised. In addition, the local public health authorities were actively engaged in monitoring the quality of the water and how the sewage was being managed, and all health care professionals engaged in monitoring for any symptoms or signs that would indicate there were going to be disease outbreaks as a result of the exposure to untreated water.

That's just to give you a sense that in a wide range of emergencies that might not immediately be seen as being health-related, health is there and health is very involved.

Right now, within the structure of the government, our minister participates in the emergency management committee of cabinet, and our deputy minister and Dr Basrur, in her role as chief medical officer of health, participate in the strategic policy committee, which is made up of deputy ministers of primary ministries and the Commissioner Of Emergency Management. On a more operational side, ministry staff participate in the operations executive group, which is made up of assistant deputy ministers, and we also participate through liaison staff at the POC, the provincial operations centre, so that we're in constant touch with what is happening across the province.

1000

In an emergency—and of course it depends on the emergency, whose emergency it is, what flavour of emergency—we will play roles that are quite direct as well as more indirect. Depending on the kind of emergency, our CACCs—our dispatch centres for ambulance services—are routinely involved in emergencies. Our base hospital programs, both air and land, support the paramedics, the pre-hospital care, and provide them with advice in transit as they bring the patients to more definitive treatment.

We have the potential to dispatch our emergency medical assistance team—that's the EMAT, which you may have heard about and which provides support on the clinical side to hospitals and other direct service delivery—and our rapid response team, which can be sent out to a local public health unit to support that public health unit with some additional staff in an emergency.

The ministry also provides direction to and receives feedback from the broader health care system. That includes public health units, ambulance services, hospitals, long-term-care facilities, community-based services and individual practitioners. The role that we played most consistently during SARS was to provide directives on actions to be taken to respond to that particular emergency so that we had a consistent response by the health care system.

We also provide consultation and assistance through telephone lines directly to various health care providers, and play a significant role in supply management because, as we know, specialized supplies can be limited. We are continuing to do work in that area.

While the broader health care system is talking with the Ministry of Health, they are also working very actively at the local level with other local health care providers as well as with the local emergency response. One of the challenges for the local provider is to balance the telephone calls in both ears, one from the ministry and the other from the local setting.

Since our experience of last summer we've benefited from various reports: the Naylor report; the Walker panel report, which specifically recommends a review of existing emergency powers and related legislation; and the Campbell commission, which has issued an interim report setting out principles for strengthening public health and health emergency management capacity. As Dr Basrur has indicated, the Campbell commission is anticipated to release another interim report on legislation requirements.

The Ministry of Health and Long-Term Care has released Operation Health Protection, which outlines the public health renewal activities that will occur over the next five years. These include objectives and goals that will enhance Ontario's capacity to respond to health emergencies. Most of these in the Ontario health protection plan are in development, are in work, and they're not necessarily completed: the examination of the requirements that would go into the creation of a health protection and promotion agency; strengthening the role of the chief medical officer of health; strengthening the local public health units; the creation of a permanent expert committee to support prevention and management of infectious disease outbreaks—that will be formalized, I believe, in September; I think we're that far along—and to support excellence in public health through recruitment, retention and training programs; and enhance surveillance. We have surveillance activities in place on an ongoing basis for a couple of different entities,

diseases, and are looking at ways to make it easier for people to get the appropriate information to the right people and get the appropriate information back.

In emergency management, we've created the emergency management unit and we do have enhanced surge capacity, meaning that in an emergency, where you may need to provide additional resources, we have the rapid response teams I mentioned that can support the local public health units, we have EMAT, which can support the hospitals, and then within the Ministry of Health itself we have a virtual team. In an emergency, the small emergency management unit—and that's not a pitch for more resources—could not be expected on an ongoing basis to be able to manage 24/7 in an extended emergency. So we have identified, and people have self-identified, individuals who are interested in participating in the emergency management unit. They'll do their day job, but we'll provide them with additional training so that in an emergency they can be called to the unit to support the activities of it.

We have a dedicated health emergency management Web site now. We have visual recognition with the field through important health notices which are only used for important health notices; they're not for routine information. We have a communications strategy in place, and we now have a video link between the public health laboratory head office and the public health division, and that's soon to be expanded to include the emergency management unit as well.

The health pandemic influenza plan has been developed and circulated to the health care field so as to enhance local health care planning around pandemic influenza. We're also working in conjunction with the emergency management office in terms of preparing a province-wide pandemic plan that addresses all the issues of a pandemic that go far beyond health issues. We have a draft smallpox plan, and the ministry's emergency response plan is currently under review and anticipated revision.

In addition to these kinds of activities, the emergency management unit is coordinating business continuity planning across the ministry—which is common to every ministry within the government—developing the emergency readiness plan and using the health pandemic influenza plan as our model. We liaise with the broader health care sector with regard to emergency readiness. In an emergency, we provide the operational management of the emergency and we're also the lead for discussions with other provinces, territories and the federal government around health emergency planning.

In the case of an emergency, if there were an emergency declared now, we would provide, through the emergency management unit, the command/control function for the ministry, and the ministry would provide policy direction through the emergency executive management committee. This is chaired by the deputy and includes the chief medical officer of health, other assistant deputy ministers, myself and representatives from the Ministry of Labour, so that we're making sure we keep health and safety on our minds through this time.

In peacetime, when we don't have an emergency but we're doing a lot of the planning just in case, we have a health emergency management committee, which is chaired by our associate deputy minister and includes all the players described above. The Commissioner of Emergency Management also participates in that committee.

As Dr Basrur has indicated, we are looking at legislation we deal with day in and day out, with the benefit of the experience we've had over the last year, as to where there might be changes required.

We've talked about, in the health human resources area, that there may be times when we could bring in health human resources from other settings. This would require those individuals to be licensed to ply their trade in Ontario. We had great co-operation through SARS, but it could be expedited if there were actual legislation that describes how that would happen, with the appropriate checks and balances to make sure it's only used in a potential health emergency and not for other reasons.

1010

During SARS, we issued directives to provide the framework for health care providers. The legislative authority to issue those directives to health care providers and facilities was found by some to be unclear, although I think Dr Basrur has identified this morning the kinds of powers the chief medical officer of health has in those kinds of emergencies. Compliance with the directives was voluntary, and the compliance level was extremely high. But we don't know if that's the best route to take in the future, in terms of relying on people's willingness to comply, or whether we need to have a framework for that. This might happen within the provisions of the Ministry of Health and Long-Term Care Act, or we could make some changes within specific legislation. That's still really up for review. We could have it in legislation pertaining to long-term-care facilities, community care access centres, hospitals etc.

That's an overview of the ministry's involvement in emergency management and the linkages with the review you're doing at this time. Thank you for the opportunity to speak, and I look forward to the next part of the morning.

The Acting Chair: Given that we've taken up the hour, we'll go right into the expert panellists to give their introductory comments or questions—up to 10 minutes, if they want—and then we'll just go around. Then we'll have questions from everybody after that. I think that would be fair.

DONALD LOW

The Acting Chair: Could we start with Dr Donald Low, the chief microbiologist at Mount Sinai Hospital. Dr Low, thanks for being here.

Dr Donald Low: Thanks for inviting me. I'm really here more as somebody who was on the front lines working, as opposed to representing any group. So my comments will be observations that I remember, particularly from the SARS outbreak.

First of all, I'd like to support both of these reports. I think that many of the points I want to make have already been made in these reports, and I would support both of them. I think they're excellent and really touch on some of the key issues we had.

Let me just, again, put my focus on a couple of these issues that I thought were particularly important. One was critical: the identification of somebody who is really in charge. During this outbreak, that didn't happen, and I really would support that we identify who that person should be. Obviously, in medical emergencies, it should be the chief medical officer of health, and not only that that person has the authority, but also the authority to appoint individuals to assist with the investigation and managing of the outbreak.

I think what we lacked during SARS was a team of individuals who were given the responsibility and authority to carry out evaluating new treatments, trying to understand how the disease was transmitted or looking for the cause of the disease. That didn't occur. I think if it could have occurred, it would have been extremely valuable. I think that would have been facilitated by having somebody in charge with the authority to do that.

To come to the directives, our perception at the hospital level—and Janet may be able to confirm this—was that these were directives that had authority behind them and that we had to do them. I think that was the right thing. It was essential to have directives, because when you're dealing with a hospital environment, and each hospital had to deal with the directives themselves, we really had to treat them as directives; there was no question that we had to carry them out. If it weren't that way, it would have been helter-skelter, because everybody would have had an excuse why they shouldn't have to do something whereas their neighbours did. So I really think, as Allison pointed out, that these directives have to have weight behind them. They have to really have the legislation that they're coming down from above and it's the hospital's responsibility to carry them out to the best of its ability.

As Allison pointed out, it would also be nice to have the ability to bring in help from other jurisdictions. We couldn't draw from other professionals in Ontario because they were dealing with their own issues at their own hospitals and needed to be on their own base sites. But there was support from other provinces as well as a lot of support from the US to come up to help with the outbreak. I think anything which facilitates that occurring more readily in the future would be valuable legislation to have.

Really, things worked quite well because people worked together and realized how critical it was. In the future, it might not be of the same magnitude or have the same sense of urgency and it might be much more difficult to manage a similar event, so I think it is important to have legislation in place. I think the chief medical officer of health has to have this authority to manage such an outbreak, being scaled, whether it's something of the magnitude of SARS or of a smaller magnitude, such as a hepatitis A outbreak, that might occur in several jurisdictions.

As I understood during the outbreak, the chief medical officer of health really didn't have authority over other public health units. Everybody was marching to their own drum, so that there were sometimes different definitions and criteria used. At least that was my perception. It would have been better had we had somebody creating common definitions and criteria for putting people in quarantine and so on.

I have one last point to make. Sheela pointed out the new powers on her last page. I think one other power that could possibly be added or discussed is the ability to gather clinical information from individuals in different hospitals and different jurisdictions that needs to be gathered in order to manage and understand how to deal best with a crisis, whatever it is, because we often got into arguments about what was research and what was public health. We would have hospitals telling us that we couldn't have access to this information because we were carrying out research. There's this false belief that just because you publish something, it's research. In fact, it was critical during the outbreak to be able to get access to that information so we could distill it and come up with evidence that would help us better manage patient care and control the outbreak. I think that may be an additional authority which could be added to the last page of Sheela's recommendations.

ONTARIO HOSPITAL ASSOCIATION

The Acting Chair: We'll move on to Janet Beed, the chief operating officer of the Ontario Hospital Association. Janet, thanks for being here. Please proceed.

Ms Janet Beed: I have with me Barry Monaghan, the president and chief—

The Acting Chair: I thought Barry was going to give his own presentation.

Ms Beed: We've decided that I'll speak for both of us—thank you, Barry, for letting me do that. He's president and CEO of the West Park Healthcare Centre.

The Acting Chair: By the way, I should mention to the panellists that all of this is being recorded for Hansard. There's verbatim recording of all of this, which will be available to the public, to other members of the Legislature and to us. That's why I think it's important to identify yourself when you are speaking. You can get copies of this if you wish. They're also on-line.

Go ahead, Janet.

Ms Beed: I'd also like to thank the panel for inviting the OHA and its members to make contributions to your discussion as to where we need to go next. We appreciate the invitation.

As you can appreciate, hospitals were at the forefront of the SARS outbreak. We learned a great deal about emergency management, what can be done in health care with health care providers and what's needed in terms of necessary resources to respond to future health care challenges. Certainly legislative reform is integral to any future management of health care challenges.

1020

The previous speakers have captured many of the activities we've talked about, but I will summarize from a hospital context where we think emphasis needs to be placed. In preparing for this, the OHA's health emergency management subcommittee reviewed some of the key issues, and Barry and I are presenting today on what those key issues were from that collective.

When health providers are faced with an emergency situation, the goal of maintaining service to the community is paramount, but one needs to do that among a number of logistics challenges, such as supply management, which would include anything from masks, gloves and gowns, to water, fuel and electricity. Patient transportation is key, and ensuring a centralized telecommunication process and human resource management. Those are big issues to be managed, all the while paying attention to patients who are in our beds or who will need those beds.

To address these challenges it's crucial—again, I'll reinforce what others have said—that a system of coordination, providing an overarching central authority, be created. It's also clear that important legal issues need careful consideration. Things such as the suspension of particular legislative and regulatory requirements need to be considered. Immunity for health care workers and compensation for those who become ill during an outbreak are things we would suggest.

We look forward to speaking to those more as we have the discussion, but I'll just focus on a couple of issues, particularly the centralized authority. As a first priority, there's an essential need to ensure that the government have the legislative power to act as the central authority for decision-making. Everyone has spoken to it. The hospitals are saying this has to be the number one priority for us all. They then need to be able to identify the specific agency or lead person who will take the authority and execute it throughout the system, and they need to be granted the scope and powers to delineate exactly what needs to happen. This would stabilize the response and stabilize the hospital's ability to manage the situation.

The term "essential service" is also important to us. We think it's important that when determining what is an essential service, hospitals need to be designated as such. This would ensure priority to access the key things, such as water supplies and fuel, that help us run situations where we can continue to meet the needs of patients, both urgent and emergent. That was brought home during the power shortage.

Suspension of laws and regulations: During SARS it became abundantly clear to us that in some circumstances the existing legislative and regulatory requirements were an impediment to dealing with the crisis, as opposed to being enablers. This was the case with respect to transferring patients out of hospital beds to other parts of the system. If we are to respond effectively in the future, we need to address some of those that are described already.

Labour issues will always be contentious, but if you have a health crisis, labour issues need to have been considered long before the crisis occurs. You can appreciate that there are many issues. What we learned from SARS is that what is needed is a process to bring together the various partners—union, management, government, ministries, associations—to address these very complex systemic and legal issues, but we need to do that long before the crisis hits. When the crisis hits, we need timely action; we don't need bringing a group together that hasn't worked together before or has only worked in distant relationships. Bringing that group together in anticipation and setting up a set of ideologies and legislative requirements will help.

An example of what we're talking about here would be the need for an expeditious ability to address the potential for work refusals. What do we do when someone refuses to work? What do we do when we broaden the definition of "essential worker"? We need to include people in the community if we are to have patients moved through the health care system, from hospital care into community care. Then there's the ability to waive some legislative requirements: hours of work and some of the other restrictions we have about where you can or cannot work.

Finally, there's immunity. Immunity for health care providers was a great concern during SARS. They wanted to know about their liability in an emergency situation, and they liked to have consideration for what legislation would be put into place for organizations and individuals who act in good will, so to speak.

Those are just brief issues we've discussed from a hospital perspective, and we look forward to further discussion of those.

The Acting Chair: Thank you very much. You were referring to Barry Monaghan. I know Barry is the person in charge of a unique hospital, West Park hospital, which has one of the few TB isolation units in Ontario. Are there others besides West Park that have special isolation units?

Mr Barry Monaghan: While you would have isolation rooms in facilities, I think the unique part of West Park's role is that it's the only facility in Ontario with a dedicated in-patient unit. From a physical facility perspective, it's designed for that.

Dr Basrur spoke to the Health Protection and Promotion Act, sections 22 and 35. We are often the folks who receive patients from across the province who require detention under section 35. Within our unit for tuberculosis, which is a locked unit, there is a sub-unit for detaining individuals who require detention over a period of time under section 35. That's part of the unique nature of the TB service. We are a provincial resource in that context.

The Acting Chair: I just wanted to bring that point to the attention of members of the committee, because it does relate to some of the issues we're dealing with.

Mr Monaghan: I can't help mentioning—I think I'm here as part of the OHA contingent and chair of the subcommittee Janet mentioned—that West Park was also the organization in the province that had the first SARS

unit established. We were the organization that received the staff members from Scarborough Hospital. We were up and running in a very short period of time.

It was because of our background and experience with tuberculosis and infectious diseases, plus the serendipitous opportunity of having space available—and the Ministry of Health representatives whom we deal with on a regular basis were aware of that—that we were able to set up the unit in about six hours and welcome those individuals for a period of approximately three weeks.

CITY OF TORONTO PUBLIC HEALTH EMERGENCY SERVICES UNIT

The Acting Chair: Our next presenter is Dr Bonnie Henry, the associate medical officer of health from the city of Toronto public health emergency services unit.

Dr Bonnie Henry: I'm really honoured to have the ability to speak to you a little bit about some of my issues around health emergency preparedness, but I'm also going to mention a few of the issues that have come up with emergency preparedness in general.

I do want to say that one of the first issues that came up when we had a conversation about West Park very early on in the SARS outbreak was, what was the authority for us to actually ask them to do this? Although it was a question, it was a very pertinent question, and it never stopped them from going full speed ahead in a really heroic effort, putting together that unit in a very short period of time.

My focus is from a local point of view. I work very closely with our police, EMS and fire services and our office of emergency management in the city of Toronto. We have a coordinated office of emergency management that involves health, but health involvement in emergencies is relatively new. It's relatively new as a player at that table in Canada and around the world. I think I'm the only person in Canada who actually has the position that I have. So we have started that process, but we need to go further.

One of the things we need to remember is that all the actual physical, hands-on management of emergencies happens at the local level. So while we absolutely need to have the authority and decision-making and a command-and-control structure at the provincial level—and I absolutely agree with that—the authority then needs to go to the local people to do what they need to do within their own local jurisdictions, because we know the quirks of our own jurisdictions.

Some of the problems we've run into, for example, are that under the Public Hospitals Act, hospitals are not necessarily required to be involved with their local emergency response organizations. That needs to be changed. There's nothing that requires them to be involved at the local level; they report to the province. That, I think, is an issue we have been trying to deal with.

The other thing we need to think about is that every emergency is chaos; that's the definition of an emergency. Whatever we can put in place ahead of time will help us minimize that chaos, but it will not eliminate it. It's not possible to do that. We need to think differently in an emergency. We need to change our thinking from our normal, sort of consensus-building way of doing things to, "I need to know who is making the ultimate decision, and I need to act on that decision." That is a very different way of thinking.

1030

I really congratulate the province for starting their emergency management unit within the Ministry of Health, because that is one-stop shopping, I think—it should be—and it should be encoded in legislation that when a provincial emergency is declared, every part of the health sector needs to be organized and managed. The command-and-control structure needs to go through a very specific part of the ministry. Part of what we ran into during SARS was that different people were getting different information from different parts of the ministry. At one time, we had a discussion that every hospital was required to fill out five different forms for five different parts of the ministry or their local public health. That's duplication of effort, and it impedes our ability to have a coordinated and rapid response to things.

I also very strongly believe that we need to have coordinated control of the public health structure. Right now, medical officers of health are very independent and the authority is in a local physician. As Dr Low mentioned, that led to inconsistencies in response. I think that authority needs to go to the chief medical officer of health. I think the legislation needs to be changed to have the chief medical officer of health independent from the political process. The way the legislation reads right now, the authority to collect information is actually with the minister. I, as a physician, am not comfortable with providing personal health information to a political person, and I think that needs to be pulled away and given to the chief medical authority.

The same thing needs to happen with Emergency Management Ontario. The Commissioner of Emergency Management needs to have independent authority to make decisions accountable to, but independent from, the political process. I think there needs to be a parallel structure. I also very strongly agree that in a health emergency we're extremely lucky to have Dr Jim Young right now as the Commissioner of Emergency Management. He understands health emergencies. But we're not always going to have somebody there who is a physician with his experience. Health emergencies need to be led by health and need to have support from emergency management. In that case, EMO plays a support role.

A few other little things that came out: We have conflicting legislation right now about who has to do what in an emergency. I think that needs to be either umbrella legislation through EMA or we need to look at the Emergency Management Act, the Public Hospitals Act and the HPPA separately to rectify some of the conflicting legislative pieces.

We need to be able to license health care professionals, but we also need to think about other profes-

sionals whom we might need in other emergencies—experts in engineering, for example—who might be licensed in different places or in different ways.

Experts who are brought in to help and advise the province—we had the Ontario SARS Scientific Advisory Committee. We need to have protection of those experts, so that if the advice they give gets changed or acted upon or not acted upon, they are not personally liable for that. There needs to be something codified in legislation that allows you to have advisers who are brought in for specific situations but doesn't make them personally liable for the advice they give the government.

I think one of the really key things we need to work on is integration of emergency management programs at the local level. Right now, everybody is required to have an emergency management program. Health is involved to varying extents in different places but is not a major player at the local level. As well, we need to integrate with our neighbours. Our emergency management organization has a very different structure than does Peel, for example, but we share a lot of common borders and a lot of common issues, and how we do things is quite different.

I think the whole issue of hospitals and other parts of the health care organization being part of our critical infrastructure is something that's not well understood by people in the emergency side of the world—the people who look after critical infrastructure even at the city level. Hospitals are a provincial entity. Do they fit into us, or is the province looking after them? Who's going to make sure they get the power back on soon? Who's going to make sure they get the trucks to fill their generators so that patients don't suffer?

We need to do a couple of little things. We need to have the ability to take over radio or TV to give important public messages. We don't have that authority right now in Ontario.

We need to look at how we can prevent people from arriving or leaving. There is a federal quarantine authority, but that is only for people arriving from outside the country. We need to work on what kind of legislative authority we need to prevent people from entering or leaving Ontario. There's nothing in the legislation in our country that allows us to detain somebody with an infectious disease who wants to leave this province.

I think we need to look at requiring people—I'm thinking of health care workers personally—to work during an emergency, and we need to deal with some of the union issues ahead of time so that there's an expectation and an understanding of what's going to happen before the next emergency comes.

There are a couple of other things and then I'll be done. I think we need to embrace the instant management system model. It's something we've been pushing in the city of Toronto for quite some time. We're very pleased that the province has now made that mandatory at a provincial level. But we need to look at integration between how, when I set up my emergency structure in the city of Toronto's public health, every hospital fits in, and then how we fit into the big picture at the provincial level. I don't think that work has been done yet.

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

I think I will leave it at that. One of the things we're concerned about is that the response has to happen first at the local level.

I have to mention funding a little bit. We have not received a single cent of funding from the federal government for emergency planning, despite an announcement a number of years ago about money being spent. The city of Toronto has spent a great deal on its own and it has had some support from the provincial government, but we need to start thinking about how to improve things at the front lines as well.

We need to think about a system where one mad cow in Alberta gets twice as much aid as the city of Toronto, which had 226 people who suffered with SARS. Thank you.

The Acting Chair: Thank you very much. Some thought-provoking comments by all. I was just thinking, talking about white powders and what could happen, we did invite Michael Crichton, the author of The Andromeda Strain and Jurassic Park, but he declined. We were given that by the 9/11 commission, which said that you have to use your imagination and think of the worst.

HEALTH PANEL

The Acting Chair: What we'll do now is begin with questions and comments from MPPs. The question or comment may be directed to one of the panel members, but if one of the panel members would like to add something or make a comment, just indicate to me and we'll certainly welcome that. We'll start with Laurel Broten, the MPP for Etobicoke–Lakeshore.

Ms Laurel C. Broten (Etobicoke-Lakeshore): Thank you for your presentations. They were all extremely helpful to us.

I wanted to raise the issue of the need for involvement, or perhaps non-involvement, of the private sector. We had a panel of individuals from the private sector yesterday. I would raise issues in terms of the laboratories and whether there's anything in particular that we

should be thinking about on that front, or the pharmaceutical industry or other suppliers, in terms of the ability to get supplies during an emergency. If folks could comment on that, whether we should be turning our minds to those issues.

Ms Beed: In the SARS experience, Barry Monaghan and I had the privilege of being on the west conference call, which was a conference call of all facilities in the west end of the city. Making certain that we could secure supplies became an issue as soon as the United States became aware of SARS. They locked up all of the supplies for masks and for some of our gloves and gowns.

We need to be certain that there's a dedicated—

The Acting Chair: Who locked those up?

1040

Ms Beed: The United States. The companies predominantly come from the United States; their production is in the United States. So what we need to be certain of is that we have guaranteed supplies. When there was some suggestion that we might have a vaccine, or that we were close to having a vaccine, and when we were discussing the impact of some of the other challenges we might face, we could not be certain that Canada would receive any dedicated resources. So I think we need to figure that out.

Ms Stuart: We certainly were engaged during SARS around distribution of equipment and supplies, and also the gathering of them, and went to all continents, other than to Antarctica, in terms of accessing supplies. There is no domestic supplier, not just in Ontario but in Canada, of some of the masks etc that are needed in some kinds of emergencies. That's an issue that is broader than this committee or this province, frankly, but it is an issue.

One of the areas where we're actively working right now is with drug stores in terms of their ability to become our supplier across the province for non-hospitals, non-long-term-care facilities, so for community agencies, individual practitioners, because they have a very sophisticated distribution system, both with IT as well as the actual distribution. They can be anywhere in the province within 24 hours, and usually less than that. We see that as a real venue and we've had fabulous co-operation from them to build this kind of contingency plan with them.

Dr Low: I think that's a very good point about the laboratories. The private laboratories in Ontario are an incredible network of not only procuring samples from patients that we would need in an investigation but also of transportation of samples. I know that some issues came up in the private laboratories that some of the specimen gatherers were afraid to go into certain institutions. I don't know if it actually occurred where they refused to, but it raises an important issue as to what their responsibilities are.

Mr Monaghan: I'd appreciate making three comments about the private sector.

First, more broadly speaking, I think the private sector has to be engaged as it relates to securing the place of health care facilities relative to access when systems are brought back up. I'll use telecommunications as an example. That dialogue needs to occur, and there needs to be an understanding of the priority that public services may receive vis-à-vis bringing telephone systems back up. Who gets access? The big cable companies, the wireless companies, the telephone companies, all of those should be part of the dialogue. So there's that broader private sector discussion that needs to occur.

The second has been touched upon, and that's the human resource piece. Within our health care system there are now a lot of private practitioners. You can include the medical profession outside of academic health science centres, where they may be engaged in a different relationship. But most physicians in the province are private practitioners, and they have relationships with hospitals. So when we think of the human resource strategies and the issues of essential workers etc, you can extend that to just about every other health care professional group: physiotherapists, occupational therapists etc. So that context needs to be thought of.

Taking that one step further, we also have to think about the network of private clinics that are in existence and are part and parcel of the health care system in Ontario. That's another piece of the equation.

Finally, and I think it's already been spoken to, is the network of lab services etc. Those are important components.

Dr Henry: Just from one other aspect that we were involved in, I do think we have to have the ability and the authority to engage not only the health sector in planning, from our point of view, but people like the funeral homes. The funeral home association was an extremely valuable partner for us in SARS. The care of people who have died from an infectious disease is very tricky, and they're very skilled at assisting us in things like that. As well, the religious groups in the community.

One group of people we've been trying to engage in planning for emergencies is the hotel and restaurant associations. Prior to SARS, they didn't feel they had any role in this and didn't think it was going to affect them at all. I think that now they are much more willing to be engaged with us. But they need to also look at how they can contribute to emergency response, not only at how it affects them. I think we need to have some bit of authority to engage that part of our community as well in planning.

Ms Broten: Thank you. Can I have one more question?

The Acting Chair: OK, and then Mr Dunlop, Mr Brownell, Mrs Sandals and Mr Zimmer.

Ms Broten: I wanted to pick up on something you said with respect to information. I'm wondering whether or not, Dr Basrur, there are technological solutions to some of these issues, in terms of the information, and whether there are any other jurisdictions we can look to for guidance that may be steps ahead of us, or not, in terms of that double-blind system, where you can have tracking of infectious diseases or other things. I'm not

sure what capacity we have in the province but I'm wondering if you had any thoughts as to other jurisdictions we might like to look at.

Dr Basrur: The province is actively in discussion with other jurisdictions, particularly Quebec and BC as provinces that are farther ahead of us in public health infrastructure from a provincial resource to support the local level. As you're aware, there is a commitment of the government to create a public health agency and to renew our infrastructure and all the rest of it. We're in discussion with those two provinces.

With regard to information collection, use, storage, disposal, the whole life cycle of information, there is a technological aspect to it. But first and foremost are legal authority, policies, protocols, safeguards, roles and responsibilities, access and privacy, and then all of those things would apply, whether you're doing paper and pencil or a very complicated computer system. Both ends of it need to be properly dealt with.

Mr Monaghan: Can I just make a comment about technology in a broad context? It should be interesting to all of us that if I send a courier package to a family member in Ottawa and it goes missing, the FedEx or Purolator or whoever can trace that and in most circumstances can tell me exactly where that package is.

In the instance of SARS and public health and the tracking that had to be done, in a perfect world I would see public health folks walking around with a hand-held device that enabled them to track people and have a database and access to that database. When it came to hospitals having to have people at the front door to meet and greet people, a couple of hospitals—and Janet, I think it was Kingston General—within a matter of about 72 hours put together a computer program and system that enabled them to do that electronically. Most of us did it by paper.

I think the overarching comment is that technology becomes a very important enabler in terms of communication, businesslike processes and keeping the flow going. I think that's an area that needs to be attended to. There may be legislative elements to that, but I think it also speaks to the nature of the investment we're prepared to make in the infrastructure.

Dr Basrur: Thank you very much, Mr Monaghan. The only caveats I would add are that the requirements that need to be in place for government agencies may be distinct from those that are non-government but broader public sector.

Second, if you're speaking of regulated health professionals collecting, using and disposing of information, there's a different duty than on those who are not regulated health professionals.

But, absolutely, I agree: The more easily we can collect and use this information for a good purpose—we're all for it.

The Acting Chair: Dr Henry.

Dr Henry: The one other caveat I wanted to bring up is the whole protection of privacy of health information. As you know, Bill 31 is going through the legislative process right now and it will in some ways severely curtail our ability to actually track and monitor certain diseases. I think we need to build our IT systems around protection of personal health information, but also somehow strike the balance between being able to use that information for the broader good and the prevention of transmission of disease. Right now that balance is a little unclear.

1050

Ms Broten: Thank you very much.

Mr Garfield Dunlop (Simcoe North): It's nice to hear all the comments. I wanted to first of all thank you for the work that was done last summer in basically two tragedies, SARS and the blackout, and for being here today to help us through this.

My question really is for Dr Henry. I was interested in your comments about your position being one of the first in the country, I believe, your role. You clearly suggest that there should be legislative changes made to help people like yourself and other, future people who will be taking over jobs similar to yours across the province and across the country.

When we were listening to the police officers etc in the last few days, we heard more about additional dollars being required for training and communications and this sort of thing. There didn't appear to be a lot of issues around new legislation. I guess in your new role, you're saying there is that. Are you saying the legislative changes that may be required should be dealt with from all aspects of provincial emergencies as well? By that, I mean police, fire, EMS, any of the organizations that would, anywhere in the province, help with the tragedy or emergency.

Dr Henry: I'm not sure I understand your question. There were certain aspects of a variety of different pieces of legislation that I think are in conflict right now about specific roles during an emergency. They either don't address it or they address it in a conflicting way. I think those need to be sorted out.

I was particularly talking about the health legislation pieces at the moment, but there are some aspects that need to go, I think, into the Emergency Management Act, as an umbrella act, that specifically say, "Under certain circumstances, these things are overridden and the authority is given to the command and control"—

Mr Dunlop: What I'm suggesting is that as Canada's largest city and the largest city, of course, in Ontario, you see the legislative requirements that would help you in the city of Toronto. But when we change the legislation, the legislation would be able to impact all municipalities or all jurisdictions here in the province. That's what I'm trying to say. You see that need, and you see that need working with police and fire, everyone that you work with. I'm assuming they are all part of your organization.

Dr Henry: I work for toronto public health, but part of my job is coordinating very closely with our police, fire, EMS, and our office of emergency management.

Mr Dunlop: Do they see a need for change?

Dr Henry: I believe they do. We've certainly had the discussions on a number of occasions. One of the things

that our relationship has fostered is the ability to understand each other's roles a bit better. For example, the Toronto Police Service was extremely helpful to us. As a matter of fact, when the outbreak happened in Toronto, the deputy police chief said, "What can we do to help?" That is, I think, a monumental change in attitude, and we are probably the only jurisdiction in Ontario where that happened. Certainly in some of our neighbouring jurisdictions, police said, "We have no role in this." Developing those relationships and understanding where each other's authority and responsibility lie makes a huge difference in allowing you to respond in a coordinated manner.

There are specific pieces of legislation, and we've discussed this: Who has the authority to detain somebody who's not actually sick but might be a hazard, but we don't know? Who has the authority if we have a section 35 order on somebody who is sick with tuberculosis but they are in their private home? Nobody has the right, right now, to go in and actually get them. We can't do that. Should we have that? I don't know. I think those are authorities that need to be looked at very closely in the legislation. I don't know if that answers your question.

Mr Dunlop: Yes, that does. If anybody else wants to add anything—

The Acting Chair: Dr Basrur wanted to comment on that.

Dr Basrur: Dr Henry's observation that hospitals and other health institutions, long-term-care facilities and others, conceivably, need to be mandated to participate on a municipal control group or in a municipal emergency preparedness context I think is a very important observation. We had always assumed that because hospitals were great big, well-funded, well-run institutions—and they are until an emergency hits—they would have all of the capacity they needed to manage their affairs, particularly when it was an infectious disease within their four walls. And that wasn't necessarily the case, because these diseases don't just stay within one institution's four walls. They can travel in and out of them on the hands of workers, patients, families etc.

The other observation is that when a health emergency or even a perceived emergency hits, it's not just limited to the health sector. It cuts a swath through the entire community, as we saw during SARS, during the power blackout and so on. No one is immune, everyone needs to be involved, and having the traditional approach of emergency equals police, fire, ambulance and maybe some utilities needs to be shifted into the future.

The third thing I would note is that Dr Henry's position is unique, probably born of the fact that right after 9/11 and the anthrax scares, the city applied for JEPP funding, the joint emergency planning program. So we got some federal and provincial money, time limited, but it was a priority for them—me at the time and them still—to ensure that we had a focus for emergency preparedness at the public health level, because it was otherwise missing. That's not to say that every single health unit in Ontario should or can have the resources to put into someone of Bonnie's expertise and calibre, but it ought to be resident in some accessible fashion.

So as we go through our moving forward from a provincial public health standpoint, we're going to be looking at how best to organize and deliver public health services across Ontario. Just to blue-sky it, it may be the case that some elements of critical skills sets—and I'm not speaking of any individuals here but just speaking of functions—may need to be deployed at a regional level in certain areas so that you might have access by local public health units to public health physicians who have greater than usual knowledge of chemical, biological or radionuclear threats, for example, or who are intimately familiar with the incident management system. So you don't have to have a Bonnie, or a quarter of a Bonnie in some of the smaller health units, but you've got access to people like her and in a similar fashion so that we can have a more coherent system across the province.

Dr Henry: Can I add one more thing? One of the difficulties we run into is that Emergency Management Ontario, as an organization, does not have health care expertise and does not understand the health sector role very well, in my experience. I think that needs to change. That is a policy part of what they do, I assume. But currently, the way they are configured, they are clearly on the side of police, fire, EMS, and sometimes not even EMS, in the way they think about emergencies. They assume that the medical officer of health is speaking for all of the health sector, and I don't think that assumption is a fair one.

Mr Brownell: Thank you for your presentations this morning. An excellent dialogue and ideas for our committee.

Dr Henry, you commented about working together, that there are common issues but there still are issues that divide, hospital to hospital, where we have to work together. I'd like to use that as a stepping stone for looking at the geographics and the size of health units, hospital jurisdictions and whatnot and issues that might hinder the delivery of emergency services. As an example, I know we have EMAT and rapid response teams, but are there throughout Ontario challenges with regard to the delivery of services in those large geographic areas? I say this because I come from a large geographic area with a public health unit—for example, Stormont-Dundas-Glengarry and Prescott-Russell. It's just huge. I lived through the ice storm. I was the brand new reeve of a new community that had not taken to emergency plans, to even put together, so we had challenges there.

1100

Are there challenges with regard to geographics and the demographics? Take, for example, massive geographic areas and health unit areas in the north, and even the First Nations concerns and whatnot. Can we get a little expansion on ideas with regard to some of the challenges there? I open it up to anyone.

Dr Henry: I guess I can start. From our point of view, there are real challenges. I think that's where we're

talking about needing a central authority, particularly during an emergency. For example, we have 22 hospital corporations in the city of Toronto. Many of them have sites outside the city of Toronto. The Rouge Valley Health System has two in Toronto and three outside of Toronto. If we are doing things differently in two different health units, that can be very difficult for a hospital.

It's the same if we look at our mental health system, our community care access centres, our district health councils, our long-term-care facilities. They are all, if you want, regionalized or organized on different geographical and jurisdictional boundaries. That can create massive difficulties in dealing with an emergency, and it's not limited to the health sector. It's similar in many other parts of our organization as well. For example, one health unit may actually involve several different municipal police services plus the OPP.

We need to think about, in an emergency, having a central command and control authority where everybody knows, "This is where the ultimate decision is made." So if I have a disagreement with my colleague in Durham region about how we're going to manage a situation, then it's incumbent on the chief medical officer of health to say, "This is the decision. This is how we're going to do it," and then it's my job to do it consistently, because in an emergency you need to have consistency. I don't think it's limited to the health sector. That's starting to be addressed under Operation Health Protection. Some of the things the Ministry of Health is doing are starting to address that.

I would also like to see at a provincial level—right now we have mutual aid agreements with our neighbours. Our police service in Toronto has mutual aid agreements with York region, Durham, Mississauga and Peel. We have agreements with some of our neighbouring health units for exchange of people in an emergency. I think that needs to be at a provincial level. There needs to be a blanket agreement and organization for an emergency that allows you to move people, and that should be the primary function of, I believe, the provincial level; that is, supporting the front-line people who are actually managing the day-to-day parts of the outbreak, and being able to coordinate the supplies, the people needed for the emergency.

Ms Beed: I think we truly experienced the diversity of our health care system in SARS when we implemented directives that we thought would assist the system in creating capacity to accommodate the SARS patients, both actual and potential. One of the directives was the elimination of all elective admissions so that you could create capacity. What this did in some hospitals was create occupancies of less than 50%, and in other hospitals it didn't touch their occupancy at all.

The diversity of the health care system and the diversity of the hospitals across the health care system exists for a reason. It exists because we've evolved such that we can meet various health care needs of a broad spectrum. In an emergency, it is a bit of a liability or a difficulty. When we do promote a centralized health authority, we recognize that the agency that they then appoint to lead the emergency has to have access to the diverse nature of the hospitals and the supports that go with it.

Mrs Liz Sandals (Guelph-Wellington): Thank you very much, all of you. You've been wonderful in saying: "Here are the issues and here are some solutions to the issues." Thank you to all of you who have given us very thoughtful presentations this morning.

I've got a whole list of questions. My head's just spinning. Can we start with the thorny issue of information collection? I hear frustration on the part of Dr Basrur and Dr Low in terms of trying to get access to information. I hear some concern on the part of the hospitals about where the information is going and who is going to have access to it. If we were going to look at an emergency authority to collect information, who should have that authority? Where should the information go? Who should have custody of it? How can it be used? How should it be retained? I think if we're actually going to look at those sorts of authorities, those would be the sorts of issues we would need to be thinking about.

Dr Basrur: Yes, it's true. It is a very large policy area, with many people who need to have an opinion expressed: everyone from the operational and program and policy folks through to the Privacy Commissioner, the Ministry of the Attorney General. You can imagine the number of legitimate voices that need to be at the table to scope out what should be thought through in a thoughtful way that still, at the end of the day, helps you actually manage the emergency.

As they say, if you have three forms in quadruplicate that have to be filled out and legal agreements reviewed to make sure the thing you signed three years ago covers off this eventuality, people will die before you've figured it out. So there has to be some balance between clarity and simplicity and reasonableness and safeguards.

It is a big area, and I would suggest if that is to be dealt with in the proposed legislation this committee is charged with drafting, it's an area worthy of its own sub-investigation just in and of itself.

The Acting Chair: By the way, we are having the manager of legal services from the Privacy Commissioner's office coming in. Mary O'Donoghue is coming in this afternoon.

Allison Stuart wanted to make a comment.

Ms Stuart: While there are issues that are specific to patients in terms of personal information about patients and how they're faring, there is other information that's required in terms of managing an emergency that doesn't have that same element of confidentiality. We're probably wise to recognize that split, otherwise you can make it more cumbersome for one group of information when it's not really required.

One of the initiatives we have underway right now is to try and develop a common data set of information that would be required in any emergency. People would know it in advance and could plan for it and so on. The difficulty is, of course, everybody agrees with the con-

cept as long as all the data they could possibly ever want is included. So we're doing some research on that right now and then we'll bring it to all the stakeholders who have to provide that information in terms of does this fit, is this doable?

The other side of it is, the Ministry of Health and Long-Term Care—I won't speak for other ministries—has been known to require a lot of routine information from the health care provider sectors.

One of the things we need to look at is, in an emergency, what do we stop requiring? What do we say no to that we'll put in abeyance for the duration of the emergency, given, we assume, limited human resources to actually compile the information.

Thirdly, how do we ensure that we streamline it so we are not—as Bonnie pointed out, we ask for the same information three times, but just slightly different, so you can't use the information provided the last time. How do we streamline it so it goes through one window and then the distribution occurs from there?

All that is underway. We're not there yet, but we've got the research underway.

1110

Dr Low: It's such an important area, and I don't know what the answer is. For example, during the early phases the CIHR—our old MRC—provided funding to do research, and we had spinoff groups. So we had different groups of individuals who were starting to do some research and then other groups of individuals. What was happening was that the same patients were getting approached by three different groups. At the end of the day, all that information is held tightly within those groups, not shared between them, and therefore we don't learn from it. So it not only slows down the gathering and processing of information but also the sharing it. It's very difficult.

We got a request yesterday from groups from China, as well as—who else was it, Bonnie; was it the Chinese group and the UK?—looking at trying to create a consortium to look at criteria for how infectious this virus is, which is very important, because how do you deal with it next time with regard to quarantine and so on? When Allison McGeer and I looked at it, we thought the best thing was, let Bonnie look after it.

Mrs Sandals: So, suffer all the insoluble problems.

Dr Low: It's going to be such a dog's breakfast dealing with the politics of gathering that information so we can participate in this exercise. We can't just wall ourselves off and not share information with the rest of the world, but this is a huge difficulty.

Ms Beed: I'd also like us to consider the impact of data that are required by the employer of the employee or of the person who is contracted to work within the institution. In the SARS situation, each day we would have a sheet up that would say, "If you have worked at the following hospitals, you cannot come in." We are not permitted to know where our employees work, in addition to our current location. In a world that contains risk or is prone to infectious diseases, I think we need to ask the Minister of Labour if there is a way we can work around that a little more effectively, both for our employees and for our physicians.

Mrs Sandals: Or at least in an emergency situation.

Ms Beed: At least in an emergency situation. When you're in an emergency situation, gathering those data—my hospital employs 12,000 people, and it sure would be handy if we had that information and maintained it in a confidential fashion for use only in an emergency situation.

Mrs Sandals: Which actually sort of segues into my next question: There have been several comments around the definition of "essential worker" and whether the definition of "essential worker" needs to be different in emergency circumstances than in normal circumstances. Is there a simple way of approaching that? I'm thinking that within health, for example, you may look at public health workers as essential during an emergency situation where normally you wouldn't. In some other sort of emergency, maybe the utility company workers—Bell Canada workers or something—suddenly become essential workers. Is there a generic way of dealing with this problem in emergency situations, rather than trying to second-guess ourselves, anticipating where the next need for essential workers will be?

There are all sorts of people here. Why don't you just go around?

Dr Henry: I'll start. I think that is an extremely important question. I think that powers need to be given to the Commissioner of Emergency Management to designate people as essential workers during a declared emergency. I also think we need to review who is considered an essential worker in everyday terms. It is inconceivable to me why our emergency medical services workers are not essential services. I can't understand why they are not designated as essential services. That is very disruptive in terms of a variety of different day-to-day aspects. So I think there are two levels and that those are authorities that should be given to the chief medical officer of health and to the Commissioner Of Emergency Management

Mr Monaghan: Bonnie has articulated one aspect of this, but you asked, is there a simple way to determine? If I need you, you're essential. I'm not being facetious. On a very practical basis, during the SARS experience, we were, as hospitals, advised to send people home who weren't essential. How do you determine that? Well, as a management team and with your clinical leadership, you sit down and say, "Who do we really need? Who do we need to have on-site?" whether it's someone at the bedside or somebody in supply management etc. So at one level, if you're needed, then you are essential. I appreciate that there has to be a more specific identification of occupational groups that must respond in an emergency, but that's not a bad acid test, to be honest.

Dr Basrur: I think the hallmark of being ready for an emergency is not knowing what's going to hit you next. So yes, the ice storm showed that there were certain kinds of people, services, supplies and equipment that

you'd never expect you'd have to draw upon at a moment's notice, like chainsaws, for example. The power outage: a very different set of circumstances. We didn't realize that we would have trouble pumping water up to the top of high-rise apartment buildings, for example. In SARS there were other situations that occurred.

I think it would be ideal to identify who best should exercise that kind of decision-making authority, whether it be the Premier, delegated by the Premier to the commissioner, the commissioner in his own right, with a reporting-out obligation, or any combination that you wish to think of, but without limiting the numbers or the scope or the types of workers or services that we may need to call upon as a province to mobilize and manage. Because when you need it, you need it yesterday, and things don't often happen quickly. They need to in an emergency.

Mrs Sandals: So there would be general agreement that some sort of emergency power to designate essential workers would be something that needs to be vested in someone.

Dr Basrur: With respect, whether it would be workers, services, supplies, supports of some sort, you can't predict what you're going to need and what the best rubric is to classify it. But have it clear as to who does make that call, what process etc, and then keeping it as fulsome as possible so that they are not constrained when they need that the most.

The Acting Chair: We're going to try to give other MPPs an opportunity, so if we have time, we'll get back to you.

Mrs Sandals: That's fine.

Mr Zimmer: We've heard a lot this morning. I think Mrs Sandals said her head was swirling, there were so many ideas and priorities around.

Earlier this morning, Dr Basrur made the hopeful comment that if there's a will and a need, things can get done quickly, and you followed that up with your most recent comment that your big challenge is not knowing what's going to hit you next. So my question is to Dr Basrur in her capacity as a medical officer, and then the same question to Ms Beed in her capacity as a hospital CEO and to Dr Low in his capacity as a disease scientist, if you will, a microbiologist.

If you looked at everything, all these ideas that are floating around the table this morning, what would your three priorities be, if you could have three priorities of things that this committee might specifically address itself to tomorrow?

Dr Basrur: Can I go last?

Mr Zimmer: She also wants to go first. I know there are probably 15 priorities, but if you had to pick three, looking at it from a chief medical officer of health's point of view rather than as a hospital head or a scientist—

Dr Basrur: I think there are a few things. One of them is the authority to issue directives. It really is surprising, after all this time, to still hear—and it's the truth—that the directives were voluntary. It's a bit like public health having mandatory guidelines enshrined in law. Well, what are they, mandatory guidelines? Voluntary directives? It's silly. If these are meant to be rules that are to be followed by all institutions to whom they apply, then there ought to be a clear authority, a person who issues them, a monitoring system and a consequence for not following them.

It's the consequence that's the hardest. At this point, I suppose you could say the directives were mandatory because the hospitals are funded by the province, but I daresay the province wasn't inclined to go and withhold West Park's funding if they didn't open a SARS unit. It just would be cutting your nose to spite your face.

1120

Mr Zimmer: So a clear authority is the one priority.

Dr Basrur: That is number one.

Mr Zimmer: Second?

Dr Basrur: Second is the roles and responsibilities amongst all three levels of government, with particular regard to the shared services agreements or mutual aid agreements across jurisdictions, in relation to people who may not be licensed to practise the profession for which they're trained, but for whom we need all hands on deck. So some sort of an expedited mechanism with supervision and so forth will be very helpful.

Mr Zimmer: Third?

Dr Basrur: The final thing would be a provincial system for a health care response in an emergency that is planned out and tested, and tested not just by the province in one room and the local municipalities doing their own thing in their own rooms and the feds doing heaven knows what, but actually integrating all of it. Because when an emergency actually hits you, especially if it's on one of the provincial borders or an international border, you can't help but say, "Yes, it may be local to Windsor, but it has international implications"—there's potential contamination of a waterway or heaven knows what the issue is—so let's practise now, before we have to run through it. Those would be my three.

Mr Zimmer: Ms Beed, from the hospital CEO's point of view, your three priorities?

Ms Beed: Our first would of course be the same, which is a central authority that has clearly delineated powers to execute direction, so that—

The Acting Chair: Janet, if you could speak into the mike—

Ms Beed: Clearly delineated authority that has powers to execute within its domain is our number one issue.

The number two issue for hospitals is labour: making certain that we can have preliminary discussions and understandings about how you can work with your labour market in a crisis. That would include being able to bring in staff from other provinces, being able to change hours-of-work legislation, being able to work with different regulations on who does what work. That really impeded our ability to meet the needs.

The third is that hospitals must be designated as an essential service so they are a priority for being put back up when electricity or telecommunications go down. They have to have priority over some of the other areas.

Mr Zimmer: Dr Low, as a microbiologist?

Dr Low: Yes, I think I agree with all of them. A clear authority, I think, is number one, as you've heard, and critical; and not only having a clear authority but the resources to back that up. If you don't have those resources, then you really can't take advantage of that authority. Finally, being able to draw on the expertise to support you, whether that expertise comes locally, nationally or from other countries, is critical, especially in a setting such as SARS or pandemic influenza. The problem with dealing with these outbreaks is the sustainability of them. We can handle it for a week, but we can't handle it for two, three, six weeks. We need the expertise.

Mr Zimmer: What are your three priorities?

Dr Low: I think it's the central authority, the resources to do this and the access to expertise. I think Allison Stuart pointed that out in trying to facilitate bringing in experts and giving them the temporary authority to do what they're trained to do.

Mr Zimmer: A comment from Bonnie?

Dr Henry: I guess the only other comment I would make on top of that is, in terms of legislation—I'm just thinking as a health care professional—I think it's really important to me to have an emergency management organization and a health emergency management organization that's independent from the political process.

Mr Zimmer: That's your number one priority?

Dr Henry: Yes.

Mr Zimmer: The same question to the ministry.

Ms Stuart: Well, actually, I will confess that Dr Basrur took my three priorities and used them up. So I would reinforce the brilliance of Dr Basrur's recommendations.

Mr Zimmer: Thank you, Mr Chair. I just thought it was important to get some ranking of everything we've heard this morning.

The Acting Chair: Yes, I think that's critical, because there is so much on our plate here and trying to make priorities is critical for us.

Mr Wayne Arthurs (Pickering-Ajax-Uxbridge): I want to explore something at sort of the highest level in addition to health. We've heard from a number of expert panels so far and the discussion has been absolutely fabulous. One of the issues that's always there but doesn't get the level of attention in the discussion is, who is in charge? Would it be helpful in legislation—and I don't know whether it's there; I don't believe it is—in the declaration of an emergency if it was more clearly defined?

I'll use only three categories, although there are probably others: a health emergency that might create a flow chart and a lead in the context of who is in charge; a natural disaster of some sort—natural or man-made, and I'll use the blackout as an example of something that's more natural, that might have the Commissioner of Emergency Management and EMO in charge potentially; and 9/11, which might create a different environment where it's a security issue now. Would it be helpful in the legislation if it was better defined as to the nature of the emergency such that the lead agency and the individuals who had authority in the flow chart would be better able to exercise that authority? Would that be helpful?

The second area is this issue, in part, where we talk a lot about suspension of civil liberties to one extent or another during the time of emergency and the question of the political engagement in that. The issue has been raised, by Dr Henry primarily, about whether or not the political body should really be hands-off to that, and, as part of that decision-making and authority, at what point should the responsibility default to the political body, whether it be the Premier or the Legislature, or should that authority be retained in the professionals who are designated for that purpose, whether it be in health or emergency planning or policing, as an example?

Any comments you might have on either of those two perspectives would be helpful for me.

Dr Basrur: Could I weigh in first? I would say that sometimes it is really clear-cut who is and who ought to be in charge and sometimes it's patently not obvious. Clearly, you would like to have a scheme whereby where it's clear, there's no argument, and where it's not clear, you've got some mechanism to make it clear. Because you don't know what's going to come around the corner, you can't make provision for every eventuality, in law, in statute, in regulation or otherwise. But you need some sort of process and determination of who is going to do that.

My understanding is that the Ministry of Health is the lead agency for infectious disease emergencies, which are typically called outbreaks or epidemics or even a pandemic, depending upon the scale of it. But there will be many other impacts right across the city, whether it be, "Is it safe to go on the subway system?" or "Should non-essential people stay home because we need the roads clear for the ambulances?" There's a whole host of other issues that come up even if the original hazard happens to be an agent of a communicable disease, but generally speaking, the Ministry of Health should be the one. For infectious diseases, the lead is the public health division, and the chief medical officer of health particularly.

In relation to Dr Henry's point about separating at least the public health response from the political process, as you're aware, the minister has committed to introducing legislation this fall that will give the CMOH the necessary independence to protect the health of the public and will, subject to the will of the House, reassign the authority that is currently with the minister to the chief MOH. There are a whole lot of "ifs" in terms of that legislation passing and so forth, but that would be the government's intent, to make sure that the officials who actually have to run the show have the authority they need and that there's not even a perception, much less a reality, of political interference or having to go through 10 hoops to get approval to do a press release to warn people that their health is at risk. That's just a sensible thing to do, I think.

1130

The other thing I would note is that sometimes you have an incident that waxes and wanes in terms of who ought to be the lead. I hate to use examples that are not my domain, but in the police/fire/ambulance area you might have an incident where a building collapses—first and foremost a rescue operation that one particular service takes the lead for, let's just say fire, but there's a tremendous requirement for EMS and perimeter security and so on for the police. It may be that over time, I don't know, a looting issue comes up and then the police become the lead for that. I'm just giving you some examples of where you can have more than one agency needing to be the lead as situations evolve, but the one that has foremost responsibility ought to be the lead and the others do their parts in concert with that overall response. So in the incident management system, if I or my designate is the incident commander, there would be a whole series of operational responses, public health responses and conceivably other responses as well. They would all be planned and carried out under a public health lead to the extent that infectious disease is the thing we're trying to get control over.

I don't think it's wise to try to enshrine that in legislation, because it's too much; people don't want to go and revisit it in a big hurry. Maybe regulation, maybe policy directives, guidelines or other instruments would be a more appropriate mechanism by which to try to articulate those roles and responsibilities. Frankly, every time you have an incident, you learn a lot of stuff you didn't know you didn't know in the first place. You may want to revisit how you've set out those responsibilities anyway.

The Acting Chair: I have a question much along the same lines as MPP Zimmer had. All of you here, for the most part, were involved in the front lines of an historical event, a chaotic event, that had to be managed: the SARS situation. We, the committee, are charged with looking at statutes and legislation that exist to try and ensure these statutes meet the needs of future outbreaks of something. As we keep saying, it's not if it's going to happen; it's when it's going to happen. Therefore you've been through it right there, front and centre. Just again to be very emphatic about this, we're going to come up with a piece of legislation here enhancing emergency preparedness. What do we need to do?

First of all, you mentioned directives. The directives right now are essentially voluntary. In other words, the chief medical officer of health doesn't have the authority to order a hospital to undertake A, B or C. Is that clear?

Ms Stuart: During SARS—and I think that yes, we were all involved with SARS—the power to issue directives was deemed to be part of the powers of the chief MOH under the HPPA, the Health Protection and Promotion Act. Others have challenged that, not in a negative way but in a critical way, in terms of whether that was really the intent of the act and whether some of the directives went beyond that which could reasonably be deemed to be within the purview of the chief medical officer of health.

That's why at this point providing greater clarity about the ability to issue directives before, during and after—because some of the directives we may wish to use beforehand speak to some discussions today around the need for people to be ready, the need for us to have a common approach etc. So the ability to provide that kind of thing in advance may be important, just as in the recovery period after an emergency there may be a need to have some kind of directive.

The Acting Chair: But in layman's language, those directives right now are in a grey area. They're open for dispute.

Ms Stuart: Absolutely.

The Acting Chair: So you're asking us to try to make this more definitive so there isn't the potential for questions or interpretations. You're saying you need that to get the job done.

Ms Stuart: Could I just add one more comment? When the local hospital or long-term-care facility or whatever is asking, "What's your authority?" part of that is not because they're arguing the import of doing it, but what gives them the authority to go ahead and do what we've asked them to do? It's really that they need it for their own protection as well.

The Acting Chair: Right, their own liability.

Ms Stuart: Yes. It shouldn't be seen as a criticism of the service providers. That was not the feedback we got from most people—not from all, but from most people.

The Acting Chair: I think you make a very good distinction.

Barry, did you want to comment?

Mr Monaghan: When I was travelling down here this morning, I was thinking, "What an onerous task this is." At the end of the day, what you're trying to do and will do, and should do, based on our experience with SARS and other issues outside the jurisdiction of Ontario and in the province, which we may have to deal with, is really to look at the manner in which legislation currently exists and how to better integrate it to deal with emergencies we may face in the future, and to ferret out the inconsistencies; and to call upon people like us to offer up our observations and recommendations, and pull together something that will work in this decade and beyond so that the mechanisms below the level of the legislation can be in place and so that the clarity around roles and responsibilities, the single authority—all the things we talked about—are there.

Overarching that is the challenge of recognizing what might be perceived as changes or infringements that I, as a citizen, might have to put up with if necessary in an emergency, which are temporary in nature, and recognizing that there are many challenges, not the least of which are charter challenges and privacy legislation challenges, which will have to be countenanced in the legislation so that it's not challenged before it's even declared for a month. I think that's what you've got to do.

The Acting Chair: The other question I have in the area of carrying out your duties and the people who make

up, you know, the 12,000 people in a hospital: Is there a need for some kind of enhancement of a good Samaritan provision in emergency legislation? In some cases, there would perhaps be a reluctance by someone to undertake a certain activity, given the question of whether they are liable in the long run for an act that is undertaken. As you said, if there's a directive given to a hospital, and the hospital proceeds to follow through with some directives, they feel, "Well, I could be liable, as the CEO or as the doctor in charge of a department." Would that be necessary?

Mr Monaghan: I think it's absolutely essential that it be countenanced from both an individual and an organizational perspective. There has been an example, in the SARS experience, where an organization steps forward in good faith, does its very best under very arduous circumstances at a time when there was very little knowledge of the disease, etc. After the fact—again, carrying out the duties as required by the Ministry of Labour—there was the potential for that organization to be charged under existing laws. It didn't happen and hasn't happened, but it could have happened. That whole context of operating in good faith, stepping up to the plate and not finding yourself, either as an organization or individually, at threat—there are tests of whether or not, in good faith, you've operated within the boundaries of knowledge and expertise of a circumstance at a time, and those principles can be included. But the fundamental principle you're raising in a situation such as a major crisis is a consideration that ought to be included in the legislation.

1140

Dr Henry: If I could make a comment on that, I think one of the things we learn over and over again in a crisis is that you can never do just enough. If you stop the outbreak, you've done way too much and you overreacted; if you don't stop the outbreak, you clearly didn't do enough. I don't think there's any way to legislate the ability to do things in good faith. It's a really difficult situation that we're put into. We're now dealing with at least three class-action lawsuits, none of which, thankfully, has been certified yet and all of which name the city of Toronto for doing too much. I'm actually quite proud of doing too much, the perception that we did too much. I think we did what we needed to do under very trying circumstances, and understanding that the need to protect people from lawsuits for doing what they feel is right and what is supported as right or—I'm not being very articulate—what is being done to the best of their ability and knowledge to try and control a situation that's extremely dangerous, needs to be enshrined in legislation. People who are asked by the government to help, to provide advice, whether their advice is taken or not, need to be protected from liability. I don't think the Good Samaritan Act is the same concept. I think the Good Samaritan Act is pretty good, for what it does. It protects people for different situations.

The Acting Chair: Actually, it's basically nonexistent in terms of its powers in Ontario. Anyway, I appreciate that comment.

Just one last comment before I give it to Ms Broten: I guess the other thing you keep on reinforcing is that there needs to be a definitive designation of leadership in an emergency. You feel that during the SARS outbreak, that leadership designation was not defined clearly enough in existing legislation, and it was done on an ad hoc basis, you might say. So there needs to be a formal way of designating, a process, at least, where someone, whether it's the Commissioner of Emergency Management or the chief medical officer of health, through the Premier or through cabinet or through the Lieutenant Governor in Council, is given some designated, defined authority to act. That is not in the legislation that we have before us in the province of Ontario. Am I clear there?

Dr Low: Is there also the need to have resources to go with that, though?

The Acting Chair: Or at least to allocate or to commandeer resources and do whatever is necessary to get the resources to undertake those designated duties.

Ms Broten: One of the issues that was raised before us on a previous day was the interface between human and animal disease that we're seeing. I wondered whether Dr Basrur or Ms Stuart would want to comment on a suggestion that we should have a chief veterinarian in the province who also has significant authority to act and then liaise on zoonotics or those types of interface that we're starting to see now.

Dr Basrur: I think that makes abundant sense, for the reasons that were likely provided to you previously; absolutely. It's a recommendation of the Haines commission, first of all. Second, yes, there is very much an interplay between animal health and human health, both on a case-by-case and potentially on a broader scale.

The Acting Chair: Dr Low, you wanted to comment?

Dr Low: That's a great observation. We've been involved, working with the University of Guelph in a number of examples of new zoonotic diseases. But another area that is important is the importation of animals and regulations as to what's allowed to come into the province. I learned from what we heard with monkeypox last year that at least within the United States there's really no restriction on what you can bring into the country, from what country it can come, and the potential then for disseminating it afterwards—no controls, and no way of tracking it. There are a whole bunch of issues that would be raised in this area.

Ms Broten: The other issue that was raised to us—and I think we've talked a lot about responding to situations today, but is there any difference, in your mind, in terms of the lack of authority with respect to mitigation and prevention, or would you say the same powers were necessary? Certainly in the health sector, as you respond you're mitigating and preventing all along, but at an earlier phase do you lack any authorities or powers or have any suggestions as to how we could assist even that one step earlier?

Ms Stuart: In terms of mitigation, much of the work that goes on there is work that you have to negotiate ahead of time so as to have the right plans in place,

obviously, when the emergency happens. I would anticipate that the ministry will be moving toward a position where we will be able to indicate our expectations of each organization and what those expectations are. Whether that is done through policy direction, whether we attach it to financial incentives or disincentives or whether we call it a directive, I'm not sure, but I do think we have to have the ability to establish those kinds of standards across the province so we can have a consistent response.

Ms Broten: One very quick, last question. We also heard that during SARS one of the barriers of keeping individuals safe and in their homes or under quarantine was the concern they would lose their jobs because there was no job-protected quarantine leave or what have you—I see everyone nodding. If someone just wanted to comment as to whether that was a reality you faced out on the front lines.

Dr Henry: Early on, it was a very difficult problem. Businesses were reluctant to let their people stay home. We wrote a number of very stern letters suggesting to them that the risk to their business if this person became ill in the workplace might outweigh their reluctance to let this person stay home for the period of time we prescribed. I think being able to enact emergency financial assistance to people in a crisis is extremely important, and I don't believe there was the legislative ability to do that at the time.

Ms Broten: Dr Basrur, did you have any comments?

Dr Basrur: My only comment would be that if you have a declared emergency, which is a very rare event, then, yes, there need to be extraordinary provisions put in place because of the sweeping nature of the impacts and the actions or lack of action you may be requiring of large groups of people and large numbers of employers. You can't just rely on everyone's goodwill in the face of financial and other forms of adversity.

In the absence of a declared emergency, I think it becomes somewhat more difficult. On a day-to-day basis, public health can take action to control a communicable disease threat that absolutely has real financial consequences, say for a restaurant that has to close down because a food handler spread salmonella to a number of patrons. That's just the cost of doing business. No one ever says—well, they may say it, but no one compensates them for all the meals they couldn't serve during that period of time. So there needs to be a trigger that would get into government policy that would compensate people at that level.

The Acting Chair: One question on the extension of the quarantine question we've been grappling with in this committee is, we were told there's no way of controlling someone's entry into the province of Ontario if it's a second point of entry. In other words, they've come into Vancouver and are switching. What about this whole issue of quarantine and being able to control the movement of people into the province of Ontario, especially if it's a secondary point of entry?

Dr Basrur: I'll let Bonnie go first, if you don't mind.

Dr Henry: I'll talk a little bit to that. Right now the word "quarantine" and the action of quarantine actually only applies to the powers the federal government has. In legislation in Ontario we have the ability to isolate someone; we don't actually have the ability to quarantine someone. That is just the wording used in the legislation. So we do not have any ability to prevent somebody from travelling from Manitoba to Ontario if there's an issue going on in Manitoba. I think this is something that needs to be dealt with as well at a federal level. There need to be agreements between provinces about how they're going to manage transportation of people across borders.

1150

I think the other thing we need to think about is that we do not have any authority to prevent somebody who has an infectious disease from leaving, either.

The Acting Chair: You mentioned that. We heard during SARS that there were certain people who were restricted and were given isolation orders to stay in their homes.

Dr Henry: There were orders under section 22 of the Health Protection and Promotion Act, which basically required them to do what we said they needed to do to prevent the transmission of a disease.

The Acting Chair: And what if they didn't?

Dr Henry: Then we had the potential to issue an order under section 35 in which we could detain them. We had the ability to go before a judge, but section 35 at the time said they must be detained in a hospital. That has since been changed so that we could, under section 35, require someone to stay in their home. Then we could work with our local police forces to enforce that.

Dr Basrur: Just to give an example of the scale, in the city of Toronto there were some 22,000 or 25,000 people, give or take, who were subject to quarantine in some form or fashion. Less than 30 orders were actually issued. The way I described it, it was voluntary quarantine if you agreed and mandatory if you didn't agree; we'd follow it up with an order.

We used the word "quarantine" because it was widely understood as being—

The Acting Chair: But it technically was not.

Dr Basrur: No. It was an order to isolate yourself or to conduct yourself in such a way as not to expose another person. That would be the legal language under the act.

The related question is border screening. Should we be trying to keep sick people or potentially sick people out and, by extension, should we be trying to keep sick people here so we're not exporting them? It ties in with that WHO travel advisory and so on. They slapped the travel advisory on Ontario because they thought we were exporting cases and then lifted it because we put border screening in against people coming into the country. It did not make a ton of sense. So I think there are a number of things that need to be thought through in terms of the logic: What would make sense in an ideal world? What is realistically practical when you consider the many, many thousands of business, visitor and family travellers across

interprovincial as well as international borders? What is the cost benefit of even trying to put those measures in place relative to the risks, where they're occurring and what other collateral damage you're going to be creating?

Dr Low: Maybe it's time we clarified these terms in the legislation. Isolation is very different from quarantine and if we're using these terms interchangeably, it's not right.

The Acting Chair: Yes, it's the first time I think we've been made aware of the difference in terms and I'm sure the general public—

Dr Basrur: Quarantine is basically taking a healthy person and asking them to stay put. They may have been exposed, not yet sick, still healthy but exposed, and therefore a potential risk to others. Isolation is someone who is already sick. You keep them in a place so they can't expose more people.

The Acting Chair: That's what happened at West Park hospital, for instance. But that's done through federal jurisdiction.

Dr Basrur: West Park was for sick people who needed treatment and Scarborough Grace was closed down. Some of those workers had become ill, they needed a place to be cared for and West Park generously opened up a wing of their hospital and looked after them.

Mrs Sandals: Can we just clarify then? The current legislation allows you to issue an isolation order for someone who is already sick, and previously that would actually involve moving them to an isolation unit in a hospital. It's now been extended so you can isolate a person who is already sick at home?

Dr Henry: No. Can I explain that?

Interjection: Yes, go ahead.

Dr Henry: It's not an isolation order. We can issue an order under section 22 when we have reasonable and probable grounds to believe that somebody may be a carrier or may be infected with an agent of a communicable disease, which means we can direct them to do what we need them to do to prevent them from transmitting that disease. So it's not a blanket isolation order.

Mrs Sandals: So the isolation order could then apply to someone who has been exposed but is not necessarily showing symptoms?

Dr Henry: Exactly, who's not yet ill.

The second level of that is if they don't do what we ask them to do under section 22. So there's a person who's not behaving with quarantine. They're leaving their house, they're having contact with others, and we're very concerned that they were exposed and they might get sick and pass this on to other people. We can apply under section 35 to have them detained for treatment, for example, in a place like West Park.

What the legislation did not allow us to do prior to the change was to have that second level. So somebody disobeyed the order to stay in their home. It specifically said "had to be treated in a hospital" or "had to be isolated in a hospital." The term "quarantine" just doesn't appear in any of our legislative wording in Ontario. There's a Quarantine Act that is a federal act that only applies—the word only applies to people coming into the country. Does that clarify things a little?

Mrs Sandals: Yes, except what I'm trying to get a handle on is, what's the missing power?

Dr Basrur, you talked about mass quarantine as an issue. I'm sorry, I haven't looked really carefully at your notes. Is it delineated here very clearly what would be a desirable quarantine sort of power from your point of view, or is that something you can give us? Obviously there's a fair bit of confusion around what one can currently do and what, in an ideal world, you would like to be able to do.

Dr Basrur: It's probably worthwhile, in the interest of time, for the three of us to just make sure we're all on the same page insofar as these terms are concerned and their definitions, to state what the power is that currently exists and what would be ideal.

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

Mrs Sandals: It would be really helpful if you could get on the same page and write that done.

The Acting Chair: Yes. I think that would be very beneficial. I know, given your schedules and so forth—but if you could perhaps collaborate on that, because I know our researcher is also trying to sort this out. If that could be forwarded to the clerk, maybe on some short memo, something you could help sign off on so that we have a better general understanding of this contentious sort of interpretation, that would be helpful to us. Research, as I said, is also looking for this kind of advice.

It's about time for us to recess. Again, on behalf of the committee members and all the members of the Legislature I'd like to thank all of you individually for not only appearing here today—I think you've been absolutely wonderful in the contribution you've made to our deliberations as we grapple with this task, which seems to be more ominous every day—but we have a charge here to come forth with legislation by November 1 and we hope to have your input on an ongoing basis. This will go before the House and then for second reading debate and for more public hearings like this perhaps even after that point. So we have a pretty tight time frame, but we look forward to your input as this develops.

Again, we hope to have somewhat of a focus on the calendar, that it's not going to go on forever. But I would like to thank you for your contributions today and also for the work all of you did for the people of Ontario, whether it be at the West Park hospital or front-line work by Dr Low, Dr Basrur, all the hospitals or Toronto public health. I think it's a real testament to the dedication the

men and women in the health area have, to the leadership you showed above and beyond the call of duty, and making it work as you went along. Like someone said in a brief we read, you sort of had to build the boat in the middle of the ocean, in the middle of the storm. So we're trying to perhaps do something in dry dock here that might help in the future.

I want to thank you on behalf of all the committee for the wonderful work you did that helped so many people to get us through those trying days and weeks. Again, thank you very much for being here today. I know how busy you all are.

We're recessed until 2:30 pm.

The committee recessed from 1159 to 1430.

The Acting Chair: We'll bring the committee on justice policy to order.

We have a couple of announcements to make. First of all there are some pages missing from the shoulder-high stack of binders that you received. This is one of 50,000 pages that was not included; I don't know how they ever found it. Is there another one, Mr Clerk, besides this one? Mr Kormos was looking for this one. He'll be happy to know that it's here. You can add this to the stack.

Last week I think Dr Young was at a conference in Montreal, or he was in Quebec anyway. I've asked for a list of all conferences relating to emergency preparedness to be made available to the members. I've received a list of these conferences—there's a Red Cross conference, for instance, here in October and there are some in other places—just for the information of the committee. Those will be available to you before the end of the afternoon.

Tomorrow the committee will reconvene at 10 am.

LEGAL PANEL

The Acting Chair: This afternoon we have a number of expert panel deputations in regard to the area of legal matters. With us today we have Mary O'Donoghue, manager of legal services, Information and Privacy Commissioner. Welcome, Mary. Thank you for coming. We also have, from the Coalition of Muslim Organizations of Canada, Irfan Syed. Thank you for being here, Mr Syed. We appreciate it. We also have the Criminal Lawyers' Association—they're not here.

We'll allow each presenter to make opening remarks, 10, 15 minutes or so, and I think what we should do is maybe then proceed with the next presenter with the same 10, 15 minutes. Then we'll have questions or comments from the MPPs on the committee. Also, if you want to either ask us questions or ask each other questions, you can. It's pretty open-ended in that regard. As you know, this committee is seized with reviewing Ontario's emergency management statutes. We're doing an overview of those statutes to see whether there are gaps or areas that we can improve upon for potential legislation. Also, we will be writing a report.

Ms Broten: I think it might be helpful, given that I'm not sure the two presentations will be that similar in their focus, if we had an opportunity to ask questions immediately following the presentation of the first witness.

The Chair: Yes. If you so wish, that's fine.

INFORMATION AND PRIVACY COMMISSIONER

The Chair: We'll begin with Mary O'Donoghue of the Information and Privacy Commissioner's office. You're the manager of the legal services branch. If you could proceed, Mary.

Ms Mary O'Donoghue: Mr Chair, I'm assuming you would like us to address issues of when personal information, including personal health information, can be disclosed, used, shared or collected in emergency situations for the purposes of public health and safety. That's what I thought I would address this afternoon.

I would also like to note that I have some colleagues here this afternoon: John Swaigen, legal counsel; Judith Goldstein, legal counsel; and Colin Bhattacharjee, policy development office. They are more expert even than I am.

I appreciate this opportunity to address the committee.

I'm going to address first the public sector privacy protection act, the Freedom of Information and Protection of Privacy Act and the municipal one, which I will do together, and the new Personal Health Information Protection Act, which will come into force on November 1 of this year.

When I speak about the freedom of information act I'm going to call if FIPPA, because it's just too long. It applies to all provincial ministries and agencies, and then the municipal one applies to municipal bodies such as municipal councils, school boards, fire stations, public libraries, boards of health, district health councils, a wide variety of places, and any number of those may have information that should be shared in the course of an emergency for the protection and the prevention of health disasters, if you like.

I'm going to start with FIPPA, the freedom of information act. Section 11 of that statute requires the head of any public sector institution to disclose personal information where there is a grave public health or safety hazard. It does not require the consent of the person and it doesn't require that there be any kind of request for the information, but they must disclose this.

Section 42 of FIPPA is the one that governs disclosure of personal information by public institutions absent a request. Now, in all situations you can disclose personal information, including personal health information, with the consent of that person, but the consent is not the only circumstance when you can do it. You can also disclose it in compelling circumstances affecting the health or safety of an individual if it's not an unjustified invasion of privacy, taking into account whether access to the information may promote public health or safety. Where there is a request for information, you can also disclose it for research purposes; for instance, if you had an emergency research thing. It's a little more difficult under that

section, 21(1)(e), because there are certain conditions that have to be in place.

If it's collected for a specific purpose—for instance, if you needed to do emergency research and it was collected for that specific purpose—then it can be disclosed for that purpose or for a consistent purpose under section 42. It can also be disclosed where another act requires this, federal or provincial, or an agreement or arrangement under those acts. It talks about an agreement or an arrangement under a statute; that would include an order or anything of that kind. So, as you can see, there are a number of situations where it can be disclosed; also if there is a request for information. Without the consent for the information, there is a public interest override in section 23 which says that almost none of the exemptions that might apply to that information will apply where there is a compelling public interest in disclosure that clearly outweighs the purpose of the exemption from disclosure. So that's another area where you can disclose sensitive personal information. That would not include personal health information, however; it would include personal information where the institution that's holding it is also a health information custodian under the Personal Health Information Protection Act. I'll come back to that.

District health councils would be covered by the same rules that I just mentioned. The medical officer of health would be covered by those rules, and all other provincial institutions that have in their custody or control information that should be disclosed where there is an emergency and it involves public health or safety.

Schools and school boards can disclose, because again they are institutions under the public sector acts, and the Education Act permits disclosure to the Minister of Education and to others prescribed by regulation where it's collected to ensure the safety of pupils. Again, you can see that that might have some emergency application. The Health Protection and Promotion Act says that a school principal must report a student who may have a communicable disease to the medical officer of health.

These are all other statutes that would fall under the freedom-of-information exception which says that you can disclose to comply with another statute. That's why I'm referring to them.

When you deal with health information custodians under the new Personal Health Information Protection Act, most of them are not public sector bodies and they have no barrier to disclosure under FIPPA, the public sector acts, but the new act will apply to them. They can disclose, with the consent of the individual, personal health information to anyone.

1440

Without consent, they can disclose—I'm now talking about private sector health information custodians—to the chief medical officer of health or a medical officer of health for a purpose under the Health Protection and Promotion Act, and that would again be a public health reason. So that would be: "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." So, again, you can see how this might have application in a health emergency.

They can disclose to a similar authority, to the medical officer of health, under the laws of any Canadian or foreign jurisdiction for a similar purpose—again, for health protection and prevention. And to anyone—so this is, say, your doctor or a hospital—they can disclose personal health information where it's believed necessary to reduce a significant risk of bodily harm to an individual or a group.

Then there are other areas that may not have so much application to an emergency, but they may: to a health care facility to help it determine appropriate health care, and that might include the types of precautions they might take; where it's permitted or required by a law or a treaty; to a researcher—again, they would be under conditions, and I think that might be more difficult to achieve in an emergency situation, but not impossible; to prescribed entities—so they would be set out in regulations; for planning and management of health systems—and there are some conditions there; and, on the request of the Minister of Health, it can be sent to a health data institute for analysis or delivery of health services—again, subject to some conditions.

The Ministry of Health is both an institution under FIPPA and has the section 11 requirements for disclosure of personal information where there is a grave health, safety or environmental hazard, but is also a health information custodian under the Personal Health Information Protection Act, and so then would fall under those rules for those purposes with respect to personal health information.

Ambulance operators are another group of actors who may disclose information without consent. They can share personal information with each other for the purposes of exercising their powers or carrying out their duties under the Ambulance Act. Again, if an ambulance is owned or operated by an institution—say a municipality under MFIPPA—they can make the same sorts of disclosures as other public institutions.

Police departments, under the public sector acts, are also institutions under MFIPPA generally; the OPP under FIPPA. Despite any other act, a chief of police or designate may disclose personal information or personal health information in accordance with regulations for the protection of the public or the enforcement of any federal or provincial act.

I had mentioned that school principals, school boards and the Minister of Education may collect specific personal information and personal health information to ensure the safety of pupils. Again, school boards may collect personal information and personal health information specified by regulation to ensure pupil safety when this is ordered by the Minister of Education.

So you can see, quite a number of situations have been envisaged by these acts.

What I have been talking about is disclosing and using information for specific purposes. When you talk about,

"Can they collect this information for these purposes?", all institutions under FIPPA—and that would include health information custodians that are institutions under FIPPA as well—can collect without consent for any purpose related to their statutory functions. Generally, institutions may collect where it's necessary for a lawfully authorized activity, if it's expressly authorized by statute or for law enforcement. So those are fairly broad permissions for collection.

You can always collect with consent and without consent. I had mentioned that you can collect for a lawfully authorized purpose or with express statutory authority but, where the information can be disclosed by an institution, it can also be collected for that purpose by an institution. Furthermore, if it somehow doesn't fit, if it was collected for a different purpose or disclosed for a different purpose, if it was otherwise, then, directly from the individual, you can collect it with the authorization of the Information and Privacy Commissioner.

So if I get to the Personal Health Information Protection Act, a health information custodian can collect with consent. You can collect it where it's needed for a lawful purpose, or without consent if the medical officer of health, for instance, or a health board is carrying out duties under the Health Protection and Promotion Act. They can collect it without consent, again, for research purposes from people who are not health information custodians. Again, there are statutory conditions and it may be that they are not all applicable in an emergency situation for practical reasons, but that's not to say that it would be impossible. Again, you can collect where it's permitted or required by law or treaty, agreement or arrangement. You can also collect indirectly if that's permitted or required by law.

I had mentioned district health councils and boards of health. They, again, have the same powers that I mentioned with respect to the medical officer of health under FIPPA. As I mentioned earlier, all health information custodians who are private sector have no barriers to collection under FIPPA or MFIPPA, but they would look to the requirements under the Personal Health Information Protection Act.

The medical officer of health may directly or indirectly collect personal information for the purposes of the Health Protection and Promotion Act or to administer a prescribed public health program or service. He may receive reports identifying individuals suspected of having communicable diseases collected from physicians, dentists, nurses, pharmacists, optometrists, drugless practitioners, etc; so anywhere in the health system where they feel that this information may reside that they need for the purposes of carrying out their duties under the Health Protection and Promotion Act.

I've run through these, and I'm hoping it's not too confusing, but I want to give you a sense that some of these issues have been addressed in the statutes. I'm really concentrating on the public sector, FIPPA and MFIPPA, and the Personal Health Information Protection Act, but I wanted to show you these other statutes to show that, where FIPPA and the health act permit you to collect under the law, these other laws exist to show that the information can be collected, used and disclosed for public health purposes.

I think I'll stop there.

The Acting Chair: OK. Thank you very much. We'll have questions, starting with Ms Broten.

Ms Broten: One of the things we heard when we had our health panel this morning was that a lot of rules with respect to collecting and using information in the regular course are fine, but it is simply not possible during a provincial emergency. This committee is obviously responsible for balancing the interests of the ordinary course and the rules of protection that we have with respect to personal information, and the balance between civil liberties and personal rights versus responsibility on the province to deal with it in the face of a provincial emergency. Some of the recommendations in some other jurisdictions already have this ability to request information from private sources, to basically demand that we need access to this information. I'm wondering if you could give us a snapshot of some of the considerations we should have as we put forward new legislation, and also if you have any knowledge of the examination of these issues when other jurisdictions tackled pretty much the same issue we're faced with today.

1450

Ms O'Donoghue: I would have to say that this is entirely outside of my area of expertise. We administer the act as it comes to us on a day-to-day basis. I would have to tell you that in situations where you're out of the ordinary run of business, it tends not to come to us. So I can't really comment on where there may be shortfalls.

I really wanted to show the committee that there are areas where these things have been addressed and there are ways of getting the information out. I wouldn't be able to point out the gaps that would prevent in a real emergency. Again, I look at the Health Protection and Promotion Act and it permits all sorts of disclosures. You don't need a request, you don't need consent and you don't need a lengthy process, you just do it, particularly where there are other statutes that provide for this. So it hasn't come to us that there are huge gaps there, but you may have heard more than we would in this situation.

Ms Broten: Do you coordinate with other provinces or the federal information and privacy commissioner's office?

Ms O'Donoghue: We certainly consult with them regularly, yes.

Ms Broten: Are you aware of any information and privacy challenges with respect to any of the newer legislation in other provinces or the new federal legislation?

Ms O'Donoghue: They're all new, so they're subject to interpretation. They get interpreted when somebody makes a complaint, and there haven't been that many complaints. This act, the Personal Health Information Protection Act, isn't even in force yet. Often you become aware of the gaps as things go on but it takes some time.

I am aware that there have been situations where people felt that the privacy act would prevent disclosure

where it was needed. There was a case recently in British Columbia, a very tragic case, where a student was seeing a physician or some health care provider who felt that this student was suicidal, but also felt they could not contact the family because they were prevented by the BC privacy act. They did not, and the student did in fact kill herself. It was a really tragic case. But the BC privacy commissioner was able to show that that kind of disclosure was permitted, and we have exactly the same provision in our act for that kind of disclosure. I think sometimes there are misconceptions as to what can be disclosed and what can be disclosed in a hurry.

Ms Broten: One of the challenges, perhaps, that our committee might face is a misunderstanding in the broader community about what is already protected as we put forward clear indications of information that will be attainable by the actor of the state, whoever this person might be. For clarity's sake, it's not necessarily the extension of further disclosure powers. It might just be a clarification of powers that already exist.

Ms O'Donoghue: I think that might be true, and also education. It's not just education of the general public but it's clearly education of actors in the health field. They were under the impression that they couldn't disclose but in fact there was a provision.

Ms Broten: Thank you.

The Acting Chair: Mr Dunlop?

Mr Dunlop: I have no questions.

The Acting Chair: Ms Sandals.

Mrs Sandals: I think I heard you say you can disclose information without consent if it's required for the protection of the individual's health and safety.

Ms O'Donoghue: Yes.

Mrs Sandals: What if the issue is not that person's health and safety but some other person's health and safety?

Ms O'Donoghue: Actually, that can still—let me just find it.

Mrs Sandals: So the information and the person don't necessarily have to be—

Ms O'Donoghue: "Disclosures related to risks"—this is personal health information—"...may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of ... bodily harm to a person or group of persons."

Let me give you an example. Suppose the physician sees somebody and says that this person has a fairly serious communicable disease. This may harm not only their family, but the school the kid has been attending etc. I think this would be covered under the "group of persons." He may disclose this and send all those kids off to see their doctors.

Mrs Sandals: So a communicable disease would sort of come under the definition of "bodily harm."

Ms O'Donoghue: I think so. In other areas of law you hear about somebody who's really crazy and wants to go out and harm people. Again, I think this would probably fit in. If you felt there was a really serious threat of imminent harm to somebody's family or whatever, who has been threatened by this patient, yes, you could disclose it.

Mrs Sandals: Given the discussion you were having with Ms Broten, and certainly as a non-lawyer—I used to be on a school board, so I've been on the receiving end of this before. Being somewhat familiar with it, I would certainly not have been able to go through the minutiae of when you can and can't disclose. I always took it as, "Don't disclose."

Ms O'Donoghue: Right, and I think this is where we need more education.

Mrs Sandals: So the fallback position is, never disclose. There would have been one person in the organization who figured out the ins and outs—the exceptions to that—but certainly I would have taken it as, "Don't disclose."

Do we have a problem in an emergency situation that the normal operation of all these laws around what you can and can't disclose, and to whom, is sufficiently complicated that in an emergency situation you need some clearer rules about emergencies?

Ms O'Donoghue: I think I'd go back to when we were talking about not just the Personal Health Information Protection Act but the general act that applies to all the public sector—and we'll go back to public sector institutions, including school boards, schools, ministries or whatever. It says that you can disclose in compelling circumstances affecting the health and safety of an individual, and it need not necessarily be the individual whose personal information—it says "an individual." Then you'd have to do a notification afterwards, but it doesn't say you must hold a hearing. There aren't presteps that would stop you from taking immediate, although you would like it to be considered, action.

Mrs Sandals: So your sense is that, at least within health emergency situations, the authority is there to disclose. I'm trying to think of an example, but I'm trying to think of some other sort of emergency where there might be a requirement for the disclosure of some other sort of information, because personal information isn't always health-related.

Ms O'Donoghue: That's right. If you look again at section 11 of FIPPA, it permits you to disclose, for instance, if "the head has reasonable and probable grounds to believe that it is in the public interest to do so and that the record reveals a grave environmental, health or safety..."—so health is only one of the issues, but public safety can be one, or an environmental thing.

Mrs Sandals: So safety would get into perhaps—which maybe leads us to another question: the rules of courts and such things. At any rate, just generic safety is within the—

Ms O'Donoghue: It's not qualified. It doesn't say a particular kind of safety. It just says that the public interest requires it, and it's a grave threat to safety. So it's not something minor.

1500

Mrs Sandals: Something which is perhaps right out of your field because it's not FIPPA or MFIPPA, but one of

the things that has been suggested to us is around hazardous materials and that sort of thing, where the information required to deal with a potential emergency situation is in the hands of a private corporation because they own the hazardous materials. Is there anything that requires that disclosure, or does that fall under your purview at all?

Ms O'Donoghue: The only place I can think of that it would fall under is, again, section 11, where it requires the minister to disclose information where there is a grave environmental hazard. But it would require the minister to have custody or control over that information in the first place. None of these acts would address your going and getting the information from that company.

Mrs Sandals: So the hole in all of this, then, may not be so much the disclosure of the information, if it's either resident within the health sector or resident within a public body. The issue may be around the authority to collect the information in the first place.

Ms O'Donoghue: I don't think it's really a collection issue, in the sense that under our act you can collect it for a lawfully authorized purpose or where you're expressly permitted by law. You'd be in more of a seizure situation, and I think that would be somewhere else.

Mrs Sandals: OK. So maybe what we need to sort out is the seizure of the information in emergency circumstances, which may be where we at least need to crack down.

Ms O'Donoghue: There may be powers somewhere else that I don't know about.

Mrs Sandals: But the disclosure is there. It's whether or not we have access to the information in an emergency situation in the first place.

Ms O'Donoghue: Right.

The Acting Chair: There were a couple of issues raised by our deputants. One was by EMS Toronto. They raised the issue of an emergency services person, an ambulance driver, taking a SARS patient from one hospital to another, which they did, and never being told that person had SARS. They felt they should have the right to know that information and they should have been informed that they were carrying a person with an infectious disease, yet they were not given that information. As you know, jail guards, for instance, who transfer people from the Don Jail to the west detention centre, are not told they could be transferring an HIV-positive inmate. I know in that case they can't get that information.

Ms O'Donoghue: I've been referred to section 76 of the Personal Health Information Protection Act—I'm looking at the wrong one; bear with me for a moment. Oh yes, subsection 19(2) of the Ambulance Act: "The persons named in the following paragraphs may disclose to each other personal health information about an individual without ... consent where the disclosure is reasonably necessary for purposes relating to the discharge or exercise by the recipient of ... information of their duties or powers under ... the regulations," and then you have the minister and an operator, presumably of the ambulance service, the minister and a medical director, the minister and one of an upper-tier municipality and a delivery agent, and these are sort of sharing. So it has actually been addressed in this personal health information act.

The Acting Chair: But I'm saying that in real life, no one has the obligation to tell that front-line health provider in an emergency that he or she could be in danger.

Ms O'Donoghue: This act does not impose requirements to disclose on patients. It doesn't. That's not really what it's there to do. But the medical officer of health may collect information about communicable diseases etc.

Interjection.

Ms O'Donoghue: Yes, an ambulance person can disclose, but I think what Mr Colle is talking about is, is there an obligation on the patient to disclose to the ambulance person?

The Acting Chair: The patient or the hospital that discharged the person or the organization that's moving a patient from hospital A to hospital B.

Ms O'Donoghue: Yes, a hospital may disclose that to the ambulance driver under section 40.

The Acting Chair: But it seems the hospitals we had here today are wondering whether they have the right to disclose private information to a second party.

Ms O'Donoghue: This is for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons. You can imagine that ambulance drivers would fall under that, because they would be at risk if they weren't taking the precautions that you would take with somebody with SARS.

The Acting Chair: Exactly.

Ms O'Donoghue: It says "may disclose"; it doesn't say "must."

The Acting Chair: This is where I guess they feel that they are vulnerable, especially in an infectious disease situation. There doesn't seem to be a protocol that they feel comfortable with, and they could be spreading the disease, in fact, because they haven't been made aware of the fact that the patient they're transporting is carrying a transmittable disease.

Ms O'Donoghue: Well, part of the problem has been addressed.

The Acting Chair: I'm just saying, what if we put in legislation that an emergency front-line person had the right to ask for and to receive that information of whether or not they were vulnerable in that they were transporting someone with a transmittable disease?

Ms O'Donoghue: It seems to me that a hospital, for its own risk analysis and risk protection, should put something in place that deals with the consideration of when you disclose and to whom. These things are foreseeable.

The Acting Chair: The hospital is saying they can't do that.

Ms O'Donoghue: In fact, section 40 does permit them to make disclosure for eliminating risk.

The Acting Chair: Those are the things we'll have to iron out, but we'll certainly pass that on to the hospitals and the EMS presenters.

We also had an indication from Dr Basrur and Dr Low that one of the concerns they had after their SARS experience was their ability to gather and acquire information from hospitals. They feel there was a real barrier, and there is a barrier, to them acquiring data on patients who have been in hospital. For example, in the situation with SARS, they had a real difficulty acquiring information.

Ms O'Donoghue: Yes. Again, people are beginning to work with this act, and I think it makes it quite clear that you can and it does permit disclosure by hospitals. So I don't think hospitals will be able to say any more, "We're not able to give you that." In fact, what this does is it clarifies a lot of those rules that were perhaps a little more inchoate before.

The Acting Chair: It would be interesting to have you here at the same time as Dr Basrur and Dr Low—

Ms O'Donoghue: Oh, please not.

The Acting Chair: —just to try and figure this out. We're here as laypeople trying to understand this very complex area. But I can understand that. Anyway, those were some of the issues raised before us.

Ms O'Donoghue: I think they're good issues.

The Acting Chair: OK. Thank you for that attempt at clarification.

Next is Mr Zimmer.

Mr Zimmer: It seems to me one of the problems with confronting emergencies and the whole question of privacy information and indeed the whole privacy legislation and various other non-emergency activities of governments and agencies is that there is a plethora of privacy protocols for hospitals, school boards, police departments, legislative bodies. They're all over the place and these bodies have their own interpretations and their own protocols.

When an emergency arises, or even something short of an emergency when one is trying to get a piece of information, you find that you run into these various local protocols or interpretations of privacy legislation by hospitals, school boards, police, all manner of institutions—the forestry people—and nobody seems to be able to get a quick response. One of the responses you get is a generic response: "I think there may be privacy concerns here." You hear these magic words, "there may," "I think," and the bell goes off that there may be privacy concerns. Then everybody runs for cover and often it's days or weeks, or sometimes you never do get it sorted out.

1510

So my question to you is, particularly in the context of a crisis situation, what recommendations or what thoughts would you have where we could bring some clarity or order or simplicity to this whole issue of dealing with the response from somebody, "Well, I think there may a privacy concern here," when you've got to move quickly on the issue?

Ms O'Donoghue: I'm going to first address real emergency situations where there is a serious risk to a number of people. I think these situations are foreseeable, and therefore the protocols ought to be put in place long before there's an emergency. That requires looking at the statute and looking at what is permitted, and under what circumstances, and making sure that your front-line people are trained and kept up to date on that. That would be my first recommendation, because, again, I don't see that you have to go beyond this statute to find the answer.

In terms of situations that are not so much an emergency, it does require that there be a compelling interest in the disclosure. There are privacy issues, and that's why this statute was written. It wasn't just written to codify disclosures; it was written in contemplation of the privacy of patients. I hear your issue about different people having different interpretations, but at least you'll be able to get some kind of answer if the big institutions like the hospitals, especially, have sat down and done the planning and got their protocols in place for foreseeable situations.

Mr Zimmer: I take your point when you say the answer to whether there's a privacy concern is ultimately in the legislation, but the difficulty is that in an emergency, or just in any situation with a very tight time frame, when someone raises that there may be privacy concerns, it's a very spooky concept, and things just grind to a halt. I think we've got to figure out some way—

Ms O'Donoghue: That's why I'm saying that you've got to do this long before there's an emergency. As I say, these are foreseeable situations. You really have to have this stuff in place and your front-line staff trained as to the fact that, "Yes, you can respond in an emergency, and this is how."

Mr Zimmer: Is it your sense that in fact that sort of clarity or training or awareness is lacking right now?

Ms O'Donoghue: I really couldn't answer that. I know that lots of work is being done, and I do know that various actors in the health sector have operated under their own protocols. But this really is now a code which didn't exist before.

Mr Zimmer: My last question, and this may be a bit unfair: Is it your view that in an emergency situation the need for information should trump privacy concerns?

Ms O'Donoghue: Sometimes it does in the statute.

Mr Zimmer: And is it your view that, other than sometimes, as a matter of principle an emergency threat or concern should in all cases trump a privacy concern?

Ms O'Donoghue: It depends on the emergency, I'd have to say, in my lawyerly fashion.

Mr Zimmer: Well, an emergency that was threatening life, limb, or the public health.

Ms O'Donoghue: If it's life or limb—this talks about a "compelling" interest. Not all emergencies are compelling, because in fact they may be an emergency for 10 minutes and then dissipate.

Mr Zimmer: Perhaps what we need is a definition of when an emergency is such that it would trump a privacy concern.

Ms O'Donoghue: Again, I would refer you back to the statute and to the wording of what is "compelling."

Mr Zimmer: Thank you, Mr Chair.

The Acting Chair: Just one question, and then to Ms Broten. You mentioned that now people have this code. Are you talking about the legislation?

Ms O'Donoghue: I'm talking about the legislation, yes.

The Acting Chair: And when was that brought about?

Ms O'Donoghue: It was introduced on December 17, 2003, and it will take effect on November 1, 2004. So people are preparing for it now.

The Acting Chair: OK, thanks. Those dates are very helpful.

Ms Broten: I just have a question with respect to the non-health sector, if we could look at that for a minute. Certainly you've clarified for us the difference with respect to information that is in the possession of a government body or agency, as opposed to going out and demanding it. But, for example, if an arm of government had information with respect to some kind of product we would need to potentially ration—diesel fuel, as an example—and through consumer and business affairs or some arm we knew what companies had so much fuel and we wanted one arm of the government to say to the other, "Disclose that information to us because we are going to put in place a rationing scheme of how this is going to operate," would one arm be caught by FIPPA in response to the other?

Ms O'Donoghue: First of all, government institutions can disclose information; we're not talking about personal information. FIPPA and MFIPPA don't place barriers to disclosure from one ministry to another. That's the first thing. If it were held outside of government, these statutes don't address the compulsion of the production of information to government. That would fall under other statutes.

Ms Broten: What about one level of government to another, federal to provincial?

Ms O'Donoghue: Federal to provincial, there are arrangements there. Again, section 42 permits disclosure, for instance, to other law enforcement agencies in Canada and it permits disclosure for the purposes of complying with another statute. It could be a statute of the Parliament rather than a statute of this Legislature here. You can also do it under treaties or under arrangements under those statutes.

Ms Broten: What about commercially sensitive information, business information that is not personal but would be viewed as being commercially sensitive to the business operator?

Ms O'Donoghue: Again, if it related to a public health, safety or environmental risk and the public interest required the disclosure of that information, then I refer you back to section 11. It doesn't have to be personal information. It can be disclosed. The public interest would trump.

The Acting Chair: Thank you very much, Ms O'Donoghue, for an excellent presentation and helpful interpretation of some of these new statutes and how they impact on emergency management. It's a very complex area, we're finding, and we appreciate your help in guiding us through that.

Ms O'Donoghue: Thank you for inviting us.

COALITION OF MUSLIM ORGANIZATIONS OF CANADA

The Acting Chair: Next, from the Coalition of Muslim Organizations of Canada, is Irfan Syed. Mr Syed, you would like to begin with a presentation, and then we can ask questions. You can begin right now. Thank you for waiting.

Mr Irfan Syed: Thank you, Mr Chair. Good afternoon, ladies and gentlemen. Just a brief background: My name is Irfan Syed. I'm actually the current chair of the Muslim lawyers' association and we're a member of the coalition of Muslim organizations. Because our expertise happens to be the legal area, we often get called on to speak on behalf of the organization on legislative matters.

The coalition is an umbrella organization consisting of most of the major Muslim organizations in the greater Toronto area. We have participated primarily at the federal legislative hearings, most notably the House and Senate committee hearings on Bill C-36 and Bill C-17, the short titles being the Anti-terrorism Act and the Public Safety Act.

I'm just going to mention two perspectives for us. In emergency situations in general, like all Canadians and Ontarians, our community wants to make sure there are plans and procedures in place to prevent, mitigate and respond to emergencies effectively. As a result, of course, we want to make sure that municipalities and government agencies are prepared, that they do respond effectively and that there is good oversight, at both the preparation level and the implementation or response level.

1520

Speaking more from our particular community perspective, there could conceivably be certain types of emergency situations that arise which may have a differential impact, especially in terms of the post-emergency situation or the fallout or backlash. In this regard, of course, we refer to the environment after 9/11. Some of that environment entailed suspicion, profiling, and discrimination, almost all of which was unwarranted.

Because of the short timeframe that we had of notice of this hearing, we haven't prepared detailed submissions for you, but I would like to draw to your attention that our interest is that some focus be given to the oversight mechanisms in place to prevent unintended, or perhaps even intended, consequences that would be unjust, if not an abuse of power.

The reason I weigh some of this is because, among our experiences—and I dealt personally with investigative agencies, RCMP and CSIS investigators, as well as discussions with politicians and judges. Perhaps as individuals or as a group, but just based on their experiences and

their particular training, they may have certain preconceptions or notions that may lead them to make inaccurate judgments, not with a bad animus or evil intent, but just that they don't know how to do certain types of assessment, especially in terms of risk. Because of errors in that risk assessment, vulnerable members of the Muslim community could be unfairly targeted and affected.

What would we be interested in saying or where can we participate? In the Emergency Management Act, I look at section 2.1(3), where we look at the hazard and risk assessment itself, and infrastructure identification. Similar to the risk management that's conducted by other levels of government and agencies, there should be an opportunity for public participation, to say, "OK, you may have done your own internal assessment but here's what we think are probably hazards and risks." At the same time, we should bring to your attention what are not hazards and risks so that the screening mechanism you're using is not overly broad.

Another area related to this is the following subsection, subsection (4), where I guess if an assessment has been made, perhaps an emergency program established and a plan, both the preparation and response, it may be based on certain information. Our concern is that some of that information may not be made public. So it may be difficult to evaluate both the aspects of the plan or program that are made public and aspects that may not be made public. The concern here, of course, is that information that's perhaps provided, especially by foreign governments or their intelligence or defence agencies—or perhaps even Canadian agencies that have collected information and, again, have been subject to certain biases in perspective that could impact the way emergency plans are implemented.

We can get into what kind of specific scenarios I might have in mind a little later on, perhaps in the questions, but again, as I said, the concern arises that in our more recent experiences in the last few years with RCMP, CSIS, politicians and judges, based on the questions they ask, we really don't think they have a good understanding of the Muslim community. Related to that, of course, is the opposition the Muslim community faces every time a new mosque is going to be built, and if we ever have to go to municipal hearings for rezoning. You hear the comments from the public, and it's quite alarming and shocking. There's no reason not to believe the same viewpoints are not held by people in government, law enforcement and other agencies.

Where we have certain points of control to prevent unintended consequences or possible abuses, I noticed that, at least in this particular statute, the Solicitor General is responsible for the administration of the act. Without disparaging anybody, the federal Solicitor General position has been filled by people in the past who have not inspired a lot of confidence either.

The other person is the chief of emergency management for Ontario. Again, what are the qualifications for that job? Is it going to be a political appointment? What kind of training will they have? What will they be required to become apprised of?

Related to this, of course, are the provisions of section 11, where we talk about the protection from personal liability "instituted against a member of council, an employee of a municipality, a minister ... for doing any act or neglecting to do any act in good faith." This again is where our concern is. It may very well be that individuals may act in good faith but because of their particular experience, their background or the information they have, they may act in a way that, in hindsight, may be found to be inappropriate. What are we going to do proactively to make sure that these individuals involved in both oversight and implementation are sufficiently informed of the matters that they should be? For lack of a good analogy, we talk about diversity or sensitivity training that takes place in many agencies. Is that something that should be called for here? Perhaps.

Those are my introductory remarks. I hope we can take the discussion further with the questions.

The Acting Chair: Mr Syed, if you wish to forward on to us more information when you have more time, feel free to do so. We would welcome that.

Mr Syed: I will see if we can manage that. In fact, many of the concerns are similar to our submissions under the Public Safety Act. This is under the authority of the Minister of Transport where they can make emergency measures dealing with, for example, airports. Part of the concern we had there is that some of the emergency measures that could be implemented don't have to be disclosed to the public, so there could be mechanisms or measures that are being put in place and the public doesn't know what's happening. So if individuals are affected—for example, they're subjected to additional screening or prevented from boarding—you don't know what criteria that's been based on.

Similarly, the concern is that under these types of emergency statutes in Ontario, might there be provisions where something is implemented—it could be something as simple as saying, "People of Arab or Muslim descent are prevented from approaching any municipal infrastructure facilities"—and that type of order or provision may not be made public?

The Acting Chair: That's why I think you made an important point. One of the things we're doing as a committee is looking for oversight mechanisms to ensure that there is accountability and transparency that can safeguard people's civil rights. I think the key is to try to come up with the kind of oversight mechanism that will enable the emergency front-line workers to protect the public interest, but at the same time, in their protection of the public interest, there is still accountability to the public, and ensuring that they're not overstepping their bounds in terms of civil liberties or charter rights. We're also grappling with that. Certainly down the road, we'd like to get more input from people like you about these mechanisms, which I think are important.

Mr Syed: We look forward to it.

The Acting Chair: Questions?

1530

Ms Broten: I was wondering whether you or your organization are a member of the multicultural panel the federal government has put in place as part of the community safety arm of government that they've established.

Mr Syed: I think you're referring to the multicultural round table that's part of the national security policy. This is just now being implemented, and I think they're taking recommendations on who would participate in the round table. We do want to participate, but it should be meaningful participation. In fact, COMO was invited to meet with Minister Anne McLellan a week before the announcement of a national security policy. It was sort of just a quick dinner—"We're here; we're interested in hearing your thoughts"—no notice that the policy was going to be announced the following week. There was serious disappointment in that, because the communities to some extent felt they were used. They were brought in the week before for a photo op, the announcement that consultations occurred and a week later the policy was announced. For people who observe these things more carefully, we don't have confidence that the round table is going to be a meaningful participation.

Ms Broten: OK. That's helpful to know.

One of the things we're looking at is the whole implementation of checks and balances, and I think it's important to remember that what we are talking about would be a provincial emergency—an extraordinary occurrence in the province, not an everyday type of occurrence. But certainly there are issues, and I raised these with Dr Young, as to the delegated authority you would see. Whether the orders would be made by the Premier or Dr Young or whomever that might be, they are not the actors on the ground enforcing all those mechanisms. How do we establish sufficient checks and balances, accountability etc, as the Chair has said?

One of the mechanisms that some other pieces of legislation have are 15-, 30- or 45-day callbacks on various orders or directives that have been made and a calling to account to the Legislature. You're nodding, so I think you're familiar with that type of accountability mechanism. Is that something that meets with the desires you've put forward, or are you thinking of a type of accountability separate from the political body and the government itself?

Mr Syed: I would suggest both. Again, the Public Safety Act contains that, where emergency measures are implemented and there is a review period. I can't remember the exact time frames. I think they vary from a minimum of 14 days to 45 days, subject to review. But again, that's not subject to public disclosure, so there may be a review in council at the cabinet level. That's one aspect of it. Of course, when measures have been implemented for a certain period of time, especially for a lengthy period of time—30 days—damage could be done to individual civil rights, some of which could be irreparable.

What I'm suggesting is, yes, have that mechanism, but also have the mechanisms in place beforehand so that as the measures are being planned and implemented, there could be somebody to provide sober second thought and say: "Wait a minute. Is this really achieving our objectives, or is it overly broad?"

There are two aspects to it. If emergency measures are implemented and it's publicly known what the measures are, especially if they restrict individual civil liberties, then it's possible that those could be subject to judicial review. But if those measures are not made public and you just have a suspicion—and then of course the anecdotal stories have to pile up before you see a pattern—by that time it might be too late. That's where my concern is: timing.

Going back to the experience after 9/11, a number of allegations were made against individual Canadians, both within Canada and outside of Canada. Their reputations were damaged and their businesses basically shut down. While they were exonerated months later, they were never able to go back and regain their lives or their livelihood the way they were before.

Ms Broten: OK, just one last question. Certainly taking guidance from you with respect to perhaps the federal government not having established things in a perfect manner, are there other jurisdictions that have done a better job as they struggle with many of the same issues, worldwide and certainly in North America? Are there any jurisdictions you can think of which have established a model that has the appropriate checks and balances in place that we might look to?

Mr Syed: Probably not. In fact, with our review of Bill C-36 and Bill C-17, the jurisdictions we did look at were the United States, the British model, and I think to some extent the Australian model. While the British model had some things in it that I think we had reference on—they don't come immediately to mind—the Canadian model was the best at that time.

The deficiencies lie at the participation level. Some of it is the fault of the community itself, because it is a relatively new community and perhaps hasn't participated at certain levels as it should. But up until recently, there were no politicians from our community, very few involved in the law enforcement area and intelligence and security. So some of it is up to the communities themselves to participate more. In fact, as I said, this organization was formed very soon after 9/11 and decided, "Look, we have to have a voice and a viewpoint, so we have to participate."

But in other areas it takes some time. There are no Muslim judges in Canada at the federal or provincial level, so when a federal judge is evaluating secret evidence provided primarily from foreign jurisdictions, what type of briefings are they going to be looking at, especially when that material can't be disclosed to the defendant's lawyers? I think, similarly, what I'm suggesting and what we've suggested in other venues and forums at the federal level is, for example, that when there is sensitive information that you think might affect a particular community, perhaps you should have representation from that community, individuals who may

have the proper security clearance to review that information and provide their input. I think that would go a great way in preventing problems later.

I'll cite an example. I was fortunate to meet with a forum of judges about a month ago on a different matter, and they were thinking of a certain issue that concerned them all. They were looking at a means to address it. They were looking at inviting representatives to speak to them about it, and among the group they wanted to invite were representatives from the Muslim community. They suggested some names whom they thought were representatives or perhaps leaders of the community. What was shocking to me and what I explained to them afterward was that the people they thought were representative were in fact not representative; they were far outside the mainstream. In fact, if those people had been invited and had given representations, that whole event, in the Muslim community's eyes, would have been undermined; it wouldn't have been considered legitimate. So that's an example.

On the one hand, the communities have to participate and say, "Look, we're here," say who we are, what we believe, what we do. On the other side, government or agencies have to be informed: What is the community makeup? Who does what? What do they believe? What is their position on something, what's their stand?

This ties in to the risk assessment. Let's face it: Allegations are out there saying that if you fit this particular profile, you're the one we have to look out for; you're the risk. Is that true? If you're only hearing from one side, probably. That's going to affect your decision-making.

Ms Broten: We certainly appreciate your taking the time to come and talk to us at this very early stage of our process as we are looking at what type of legislation we would want to draft. It's an issue that we're very cognizant of in terms of balancing the powers we may seek on behalf of the government in the context of an emergency and civil liberties.

1540

We invited a number of groups to come and make representations to us today: the law society, the Criminal Lawyers' Association, the Canadian Association of Black Lawyers, the legal clinics, the Canadian Arab Federation, ARCH, the civil liberties association and the Ontario Bar Association. We haven't had a large take-up to come before us at this time when we're very early on in the process. Perhaps most groups are used to coming in and making deputations after there is a piece of legislation out in consultation. But we really wanted the groups to come forward and speak to us at an early stage so we could get some advice and some thoughts and things to think about as we are moving through this process. So thank you very much.

Mr Syed: You're welcome. I think you're aware that the CBA conference in Winnipeg just wrapped up, so a number of people are just flying back today; I think the earlier presenter just arrived too.

Mrs Sandals: Just briefly, I want to make sure I'm understanding where your major concern would be. If we're talking about emergency powers, and this is very definitely in the case where a provincial emergency has been declared and we're looking at things that would be very public orders—evacuation, quarantine, rationing, those sorts of things—those are things that are quite public by their nature and which apply to the general public. Those are things where you would not react any differently than anybody else reacting to that sort of situation. Where you would want us to be particularly sensitive is in the case where something has an effect that may not be entirely public. In some sort of emergency power which is not necessarily terribly public or which may have some differential application, that is where you would want us to be particularly careful about checks and balances?

Mr Syed: Absolutely, and in addition, even with the public orders, the mechanisms that are available—for example, judicial review or internal review—to set short time frames. I'm assuming that in an emergency, an oversight committee can meet fairly quickly, if they're not too widely dispersed. So is it something you should consider, that once the emergency is enacted, the committee meets to review the orders within 48 hours? Or should it be a week? I think that has to be part of it before the public gets involved.

If I can give an interesting example, because it happened today, I was in fact at a client's earlier today, and this particular client is a charity. Most of its funds and operations are overseas. It has been subject to a CCRA review, which raised some concerns that I'm helping them address.

Interestingly enough, while I was there, they received a second visit from the OPP. It was curious, because they were from a particular investigative branch and they didn't come to ask any questions. They just came to introduce themselves, for the second time. Curious. But it became obvious that they were there basically to tell them, "Look, we're here keeping an eye on you."

How do I get to the bottom of that? It seems to be it implied intimidation or a threat, because in fact we saw that before. We talk about Bill C-36 and its oversight mechanisms. The Solicitor General is required to provide an annual report to Parliament on the use of certain special provisions: investigative hearings and preventive detentions. The Solicitor General was able to come back in previous years to say, "We haven't used these powers." OK, that's interesting, but for people who have heard the anecdotes on the ground, you'll find out that CSIS and RCMP investigators have always threatened to use these powers if people didn't co-operate. So in the Solicitor General's reports there is never any mention of how many investigations were done, how many investigations resulted in nothing being found for further investigation, how many times the powers were ever threatened to be used. I think that's often an aspect of it that goes under-reported, if at all, and is hidden because it is a stick. Similarly, it's possible that it could be there in provincial legislation as well.

Mrs Sandals: Thank you.

The Acting Chair: If I could just comment: You mentioned the fact that no matter what the laws are or who is making the laws, if there isn't a good cross-section of representation from all communities, laws are always possibly going to have gaps in them. That's one of the points you made. It's interesting that two people I know with strong ties to your community who were elected federally—Wajid Khan and Yasmin Ratansi—hopefully will be helpful as they go through their ongoing processes in Ottawa.

I think I speak on behalf of all of the committee. As Ms Broten said, we are trying to reach out to as many people and organizations as possible very early on because we have not predetermined our checks or balances. We're trying to find the best way of essentially protecting people in case of a flood, a blackout, an infectious disease or whatever it may be. That's our intention and goal. In achieving that goal, we don't want to infringe on anybody's civil liberties, rights or traditions. That's why we want to make sure we cover those bases before we go ahead, because we don't want that to detract from the front-line people protecting all members of the public. That's why very early on we're reaching out to all organizations and individuals in saying, how can we best ensure that those are safeguarded as we proceed toward our objective of protecting the public in case of a disaster or some kind of emergency situation?

That's our intent and that's why, as I said, we're more than open to advice and concerns that are brought forward early. We certainly will weigh those very heavily because, again, in trying to achieve one good, we don't want to infringe on hard-gained rights of all Ontarians. I think that's our objective.

Mr Syed: I very much appreciate that. The committee is probably already aware that in the emergency types of statutes and situations where there is a lot of inter-governmental co-operation—or at least we expect it to be more so in the future than in the past—the oversight gets blurred as to who is watching whom doing what.

It ties in to some extent with the federal legislation, Bill C-36, where it refers to the powers of peace officers. What's happening now, post-9/11, is that there are mostly RCMP and CSIS officers who are on the ground. Because their numbers are fewer and they're not as integrated in local municipalities, they are training more either OPP or local police officers. So the issue is, where is the oversight? Are they taking direction locally? Is it being cleared locally for the investigations or is it being directed internally, within those agencies?

It might not be directly within the purview of this committee but it's something to consider: In an emergency, who is going to be taking charge of what? Will the federal and provincial governments be working together or will you be taking your directions from the federal government? Whose statutes or emergency plans will take precedence?

The Acting Chair: That has been raised many times before this committee. It's a very real question and that's what we're trying to grapple with. That type of jurisdictional greyness really hinders protecting the public interests in both ways.

On behalf of the committee, thank you very much for taking time to be with us. As MPP Broten said, we've had difficulty getting people who are associated with legal activities or the legal profession to appear. There will be more time in the future to consult and get other organizations and groups to come before us.

Again, feel free to forward any other information. As this proceeds in our report writing and our legislative writing stage, we'd be more than happy to get your valued input. Thank you for taking time.

Mr Syed: You're welcome.

Ms Broten: I was wondering, before we adjourn today, Chair, if we could just go through the schedule for the next couple of days and perhaps into next week, if there were additional groups to be invited or suggestions that members wanted to make in the week to come.

The Acting Chair: Sure. I guess we can adjourn for now. Then, if you want to stay around, we'll look over the schedule for the next week or so.

The committee stands adjourned until 10 am tomorrow, same room.

The committee adjourned at 1556.

CONTENTS

Wednesday 18 August 2004

Emergency Management Statutes Review: Health Panel JP-137

Dr Sheela Basrur JP-137

Ms Allison Stuart JP-143

Dr Donald Low JP-145

Ontario Hospital Association JP-146
  Ms Janet Beed
  Mr Barry Monaghan

City of Toronto public health emergency services unit JP-148
  Dr Bonnie Henry

Information and Privacy Commissioner JP-161
  Ms Mary O'Donoghue

Coalition of Muslim Organizations of Canada JP-167
  Mr Irfan Syed

STANDING COMMITTEE ON JUSTICE POLICY

Chair / Président
Mr David Orazietti (Sault Ste Marie L)

Vice-Chair / Vice-Président
Mr Bob Delaney (Mississauga West / Mississauga-Ouest L)

Mr Michael A. Brown (Algoma-Manitoulin L)
Mr Jim Brownell (Stormont-Dundas-Charlottenburgh L)
Mr Bob Delaney (Mississauga West / Mississauga-Ouest L)
Mr Kevin Daniel Flynn (Oakville L)
Mr Tim Hudak (Erie-Lincoln PC)
Mr Frank Klees (Oak Ridges PC)
Mr Peter Kormos (Niagara Centre / Niagara-Centre ND)
Mr David Orazietti (Sault Ste Marie L)
Mr Mario G. Racco (Thornhill L)

Substitutions / Membres remplaçants
Mr Wayne Arthurs (Pickering-Ajax-Uxbridge L)
Ms Laurel C. Broten (Etobicoke-Lakeshore L)
Mr Mike Colle (Eglinton-Lawrence L)
Mr Garfield Dunlop (Simcoe North / Simcoe-Nord PC)
Mrs Liz Sandals (Guelph-Wellington L)
Mr David Zimmer (Willowdale L)

Clerk / Greffier
Mr Katch Koch

Staff / Personnel
Mr Albert Nigro, legislative counsel
Ms Margaret Drent, research officer
Research and Information Services