Presentation to the SARS Commission

The Honourable Archie Campbell, Commissioner

by

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Check against delivery

Good morning.

Thank you for the opportunity to present to the Commission.

I am Dr. Larry Erlick, President of the Ontario Medical Association, and am here today representing the 24,000 physicians who work in this province and who were intimately involved in combating SARS. With me is Dr. Ted Boadway, Executive Director of Health Policy at the OMA and leader of the association's response to SARS.

I am also a family physician from Scarborough, the epicenter of SARS, and a member of the medical staff of the Scarborough Hospital, Grace and General Divisions.

I still have difficulty putting into words, the way the entire health care team came together and dedicated themselves to treating the afflicted and controlling the spread of this dread disease.

Today I would like to describe the attitude and approach our Association took to this crisis, point out some of the challenges we faced, what lessons have been learned, and our ideas on improvements that can be made to the system should another outbreak of an infectious or communicable disease like SARS occur in Ontario.

When SARS descended upon Toronto in mid-March, the OMA quickly became involved in the response to the disease. The OMA's role in SARS was extensive and multi-faceted.

With the health and safety of our doctors, their patients and the public in mind, the Association mobilized all of its resources to produce a coordinated response.

During my address, I will direct your attention to the following six issues.

1. The development and distribution of directives
2. The quarantine orders for physicians
3. The fit testing of masks
4. The SARS protective equipment – specifically the acquisition and distribution of protective masks for physicians
5. The role of Medical Officers of Health and
6. The OMA's involvement throughout the SARS outbreak.

On March 14th, the OMA was first contacted by the Public Health Branch of the Ministry of Health and Long-Term Care (MOHLTC) to use our communications network to distribute a document titled "*Ontario issues alert about four cases of atypical pneumonia*" to all physicians in Ontario.

The OMA distributed this document on behalf of the MOHLTC and through this e-mail and fax network we are able to reach 90% of our membership throughout the province in a matter of hours.

On March 27th, the OMA issued a press release urging full-scale vigilance during the SARS health care crisis. The following Monday, recognizing the huge impact this disease would have on our doctors and the public, we formed an internal SARS Team with senior staff from both our health policy and communications departments.

This team also initiated daily teleconferences with senior officials at the Ministry of Health and Long-Term Care as a mechanism to voice our concerns and to work in partnership to seek practical solutions.

SARS was a unique event in the life of every physician in this province and we had to quickly make decisions on how our association would respond to it.

It was immediately apparent that we were working in a void of knowledge and that only a massive cooperative and coordinated effort would help us face this public health crisis.

Our first decision was to devote every resource required to contribute to meeting this challenge. We knew that if we failed as a profession to rise to this crisis - it was our doctors and our patients that were at risk and that we would fail the people of Ontario.

However, even though the OMA had a SARS team in place and had a direct line into the Ministry of Health, it is valuable to remember that neither we as an association representing doctors, nor the Ministry of Health for the Province knew anything about this disease itself – let alone anyone else in the world for that matter.

One of the most stressful things for a doctor is to try to treat a patient with a new life-threatening disease about which little in known.

Although we know a great deal about the treatment of acute respiratory syndromes in general, no one knew how to advise us here in Ontario, in Canada, or in the world on just which tool would be most useful, or which application, or which drug or therapy would bring the most benefit to the patients afflicted with this newly emerging disease.

No one knew what the communicability was and no one knew what to advise physicians or patients on how to protect themselves. Our decision was that as useful and practical information became available, we would communicate it to physicians immediately.

To this day, the OMA continues to provide information to physicians, other healthcare workers and their associations, providing expertise, knowledge, understanding, and education about SARS, and the best way for healthcare workers to protect themselves against this and other febrile respiratory illnesses.

During the initial stages of the outbreak in Ontario, we made another decision immediately that we do not regret. We knew that in the absence of knowledge, mistakes in management or treatment would be made.

We knew that every person involved in this, whether ourselves as an Association, physicians, government, committees, hospitals, and other health care professionals, would make unavoidable mistakes and that our approach to handling these errors was critical.

We decided that the only way to look forward to meeting tomorrow's challenge was to take today's mistakes, analyze them, find a solution, implement it, and therefore increase the effectiveness of our community's response.

That also meant not publicly criticizing those who made an error, but instead helping them fix it.

However, now it is time to highlight some of the problems that didn't get fixed, and to find solutions for them quickly, so that we will be able to deal more effectively with: SARS should it recur, other similar Febrile Respiratory Illnesses, or any other health crises for that matter which might befall us in the future.

It is in that spirit, that I would like to turn your attention to issues that we believe require analysis and repair now.

I will begin with the directives.

During the SARS outbreak in Toronto, directives for the province were set under the auspices of the Emergency Management Act (1990). The EMA was not conceived to deal with a healthcare emergency per se. Instead, the EMA is designed to deal with environmental Man-made emergencies.

Hence, with the invocation of the EMA - police, fire, Emergency Medical Services, ambulance services, and a variety of other emergency services were brought on line to deal with what was a strictly healthcare emergency.

While these resources are often invaluable, in this specific public health crisis, the lack of expertise for the 'medical emergency' at-hand slowed the process of message dissemination considerably.

The "directives" that were produced by the Provincial Operations Centre, or POC, during the height of the emergency suffered immeasurably from a lack of simple practicality. These directives did not work from a hands-on clinical perspective.

The disparity between what will function 'academically' and 'practically' during an emergency became obvious in these directives. Unfortunately, examples abound and here are a few:

- The issuing of the 'code orange' orange directive at the end of March spun the healthcare system into a province wide shut down mode. It was quite clear to all involved that this was a Greater Toronto Area based issue, and although

heightened vigilance would have been more than adequate for outside of the GTA, a province wide directive was issued – with no consideration of patient access or continuity of care.

- Directives from April referred patients to go to the emergency rooms of their local hospitals for treatment if they had or displayed any early SARS symptoms – which were similar to that of the symptoms of the common cold.

This led to the flooding of Emergency Wards throughout the GTA. Patients who poorly understood disease epidemiology and did not have SARS had lengthy waiting times to be seen and those patients who did have a very legitimate illness or injury which warranted their presentation at the emergency room were forced to wait even longer for much needed care.

- The directives which required family physicians in their community based office practices to have available an isolation room where people potentially afflicted with SARS could be kept until public health could be contacted was unworkable.

- Directives for patient transfers for the entire province that required all transfers to be routed through a single individual at the POC, 24 hours a day, seven days a week, not only delayed, but in some cases compromised patient care and safety province wide.

- The multiple directives requiring the use of an N-95 mask, which to this day have yet to be founded in evidence-based scientific literature as to their functional utility or necessity when dealing with a droplet borne disease such as SARS.

The list goes on.

However, there is no need to state all the examples for this inquiry.

The fact of the matter is, that because of the minimal input into the directives by the appropriate base of expertise, and the handling of the submitted documents by the bureaucratic powers, the messaging sent out to physicians, hospitals, and all healthcare workers alike was obscure, inconsistent, lacking in an evidence-based paradigm, incoherent at times, and completely untenable from a implementation or long-term sustainability perspective.

Physicians are inundated with huge quantities of information daily and to further provide them with anything less than accurate and concise information is not useful.
Even those of us charged with trying to make sense of them often had difficulty determining what essential changes were made to these documents.

Directives were revised on a frequent basis (multiple editions within a week of each other), yet new iterations were not numbered as we requested so that any reasonable person couldn't tell which was the latest version.

Sometimes there were different versions on the same day, so dating the directives did not help.

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

Second, when it became apparent that a mistake had been made it was difficult to get the system to find its reverse gear.

For example, the Code Orange debacle could have been prevented since the OMA identified problems immediately upon receipt of these March 30th directives. Unfortunately, they had already been widely distributed simultaneously and were not corrected for a further seven days.

This delay in corrections and lack of communications had a huge and unnecessary impact on the delivery of essential health care services to patients across the entire province as surgeries were cancelled and clinics closed increasing backlogs and waiting lists.

When corrected, they were only corrected piecemeal – leaving the innocent patients of this province to bear the brunt of these errors.

Based on this experience alone, the OMA recommends that a policy machine be built that incorporates doctors with key expertise, so that settings affected by such dictates are well understood and any instructions actually make sense and are achievable.

I must say that our frustration on this front continues even today.

Further new directives have been developed by the SARS Operations Centre (SOC) and distributed for comment.
The OMA has had no formal input, despite the fact that the expertise of the OMA's Sections including those such as

Public Health, Infectious Disease, Respiratory Medicine, Critical Care Medicine, Anaesthesia, Pediatrics, Family Practice and others were offered in June when SOC was established.

The OMA had been given a schedule wherein we would receive a draft of the directives on a Friday and be expected to consult with the necessary physician groups and then have a response prepared by the following Wednesday.

As a matter of fact, our most recent set of "new normal" directives were received on a Friday, September 12th, at 3:20 pm., the second set was received at 4:10 pm the following Friday.

This makes it impossible to get the expert advice so badly needed from physician experts to make these directives workable.

This process is not acceptable.

Surely, a more effective and efficient process involving appropriate consultation and co-operation can be established to avoid further confusion should we find ourselves faced with another crisis.

A further issue of great concern to affected physicians was the concept of quarantine – particularly to physicians in the Greater Toronto Area.

Many physicians were under total quarantine, while others were under working quarantine orders.

Doctors were very willing to comply with public heath authorities in this regard, but confusion arose when the OMA and affected physicians discovered that the quarantine requirements of the Centre for Disease Control and the World Health Organization turned out to be different than those in place in Ontario.

SPECIFICALLY, THE CDC RECOMMENDS THAT
Persons who may have been exposed to SARS should be vigilant for fever (i.e. measure temperature twice daily) and respiratory symptoms over the 10 days following exposure. During this time, in the absence of both fever and respiratory symptoms, persons who may have been exposed to SARS patients need not limit their activities outside the home and should not be excluded from work, school, out-of-home child care, church or other public areas.

In fact, if different quarantine orders had been used, far fewer people would have been placed under quarantine – resulting in less of a disturbance to their working and family lives, and far less emotional and psychological strain.

The actual numbers are impossible to determine, but the anxiety amongst the general population that could have been avoided is quite palpable.

As a result, physicians sensing this discrepancy sought answers.

Our request for an explanation was simply ignored and we were told we had to take the matter on faith.

We no longer accept this on faith alone.

We still have no explanation for this discrepancy despite repeated requests.

We would like you, Justice Campbell to look into it.

During the SARS crisis, we were prepared as much as possible to follow directions and orders without question because we believed that in a crisis situation it was the only way it could work.

We demurred only when directives didn't make sense or had obvious errors.
Now that the crisis is passed, however, we are not prepared to take things on faith if they do not appear to have a solid basis in science.

In that regard, the current mask fit testing program that is being suggested by the province is completely lacking in a rational or sound foundation to be implemented, nor can it be sustained over the long term.

The cost of this program is immeasurable, requiring the fit testing every two years of approximately half a million health care workers who fall under the Registered Health Professionals Act.

The current proposed concept of mask fitting that the province is planning to implement would add a further financial burden to an already suffering system.
The ministry's proposal does not address who will cover the costs of this program, nor does it explain the scientific rationale or evidence behind this practice.

At the time when mask fit testing was first proposed, we followed the directive, but we did ask for the scientific evidence that fit testing would make a difference.

In our own comprehensive literature search, we have not found any evidence to support mask fit testing as it is being proposed in Ontario.

In fact, we have been instructed during the current planning of this massive project, not to ask for the evidence!

Without going into detail, in Europe manufacturers fit the masks against standard face types.

Healthcare workers are then supplied masks based on the manufacturers testing.

This model is clearly more effective, less time consuming, less onerous for employers, and less costly, however, it has not been accepted by the SARS Operations Centre (SOC).

We not only believe, but also demand, that if there is going to be a large public expenditure and massive dislocation of scarce resources in hospitals and practice settings that adequate scientific support and evidence must be provided.

Perhaps if the scientific evidence cannot be provided to the doctors of Ontario, it could be provided to you, Justice Campbell if you would ask.

Therefore, the OMA recommends that the concept of fit testing be re-evaluated, and made to fit the needs of the system and its workers, at less cost to a healthcare system which remains under heavy strain - strains which existed long before SARS became an issue in Ontario.

Now, let me now discuss the provision of masks to physicians in community practice.

When it became apparent that physicians required masks, the OMA identified suppliers and manufacturers and offered to undertake the acquisition and distribution of masks to physicians so that it would be done quickly to protect our members and their patients.

We were specifically requested not to pursue such an activity and told that the government would undertake it for all physicians.

It took more than three weeks for this process of distributing SARS kits – which contained N-95 masks, gowns, eye protection, disinfectant hand wash, and masks for patients - to begin.

And, even then, specialists were excluded from the distribution of the protective equipment, because the decision was made to distribute these kits only to those Toronto-based community physicians who were on the government's flu vaccine distribution list.

However, the flu vaccination list does not cover all general and family practice physicians in Toronto, or the province.

This method for distribution failed physicians miserably.

There were many examples of doctors who never received SARS kits, while their colleagues in the same office did – examples of doctors on the flu list who either never received the kits or waited weeks for them. I waited almost two weeks to receive my kit.

It was not only the GP's, but their specialist colleagues, as well as all other healthcare workers who were affected by this outbreak.

Sufficient resources were not invested in the protection of healthcare workers who were or could have been exposed to this deadly disease.

As a result, thousands of physicians were left unprotected during this time.

As you know, one of my family practice colleagues in Scarborough, Dr. Nestor Yanga, made the ultimate sacrifice while caring for a patient with SARS.

It is out of respect for him and all the physicians, healthcare workers, and the public in general that I bring up this serious problem we encountered, in order to prevent it from happening again.

We recommend that stakeholders be empowered to provide their professional expertise as it relates to hospital-based care, infectious disease control and community based care. This will ensure that preparation for future infectious disease outbreaks will be designed to fit the system to which it must be applied.

We recommend that in future when there are willing partners to undertake tasks in a difficult environment, that those partners be allowed to do their part and take the burden off other people dealing with a multitude of issues.

We were disappointed and frustrated that the OMA’s willingness to take responsibility for such a massive undertaking to protect our members was dismissed.

It is one part of our dedication to being a team player that we now regret. I hope you will look at this very carefully and make recommendation for the future.

The fifth area I want to highlight is that of the role of the Medical Officers of Health in this province.

The MOHs were poorly used during the SARS outbreak. Their role, through the public health units, is very clearly defined, and includes both "health protection" *and* "health promotion", as well as an expertise in the fields of communicable diseases, disease surveillance, data gathering and analysis, and communication with hospitals and community healthcare providers.

This physician resource was not tapped into sufficiently, and the provincial Public Health Branch assumed a top-down approach by taking control over the regions through directives, while minimizing the role of the MOHs at the local/regional level.

SARS was not only a Toronto issue, but also spread across the GTA and was considered a communicable disease issue throughout Southern Ontario and the rest of the province.

The Medical Officers of Health in this province have a background in disease tracking, and long standing relationships with the infectious disease departments of their community's hospitals.

If SARS indicated one thing to the MOH's of the province, and to the public health branch itself, it was that there is insufficient capacity in the system to deal with public health emergencies.

This was highlighted in the OMA's submission to the Walkerton Inquiry, where Justice O’Connor's first recommendation, which was suggested and promoted by the OMA, was that each region be required to employ a full-time Medical Officer of Health.

To date there are vacancies for eight full-time MOH's and five associate MOH's in this province. It is not only a human health resource issue that has led to a lack of MOH's, but also a grossly underfunded public health system.

The current public health system as it exists today, has no elasticity.

Governments must make the necessary investments to restore our public health system and embrace the entire concept of the importance of the Medical Officer of Health as the physician for the health of the community.

This was nowhere more evident than in Parry Sound, where there was no full-time MOH in place during the Spring of 2003. As a result, a quarantine recommendation was made without adequate understanding of quarantine protocols.

This led to the unnecessary quarantine of nearly ten percent of the towns' population. This resulted in the disruption of people's lives, their jobs, the productivity of the area, and created a huge strain on an already struggling region through the necessity to track and keep surveillance records for nearly 2,000 people.

This morning, I wanted to highlight those five important areas – namely that of directives, quarantine, mask fit testing, supplies and the role of the Medical Officers of Health.
But I also want you to know how we as an Association representing Ontario's doctors went above the normal call of duty to help our members and our patients.

The OMA was compelled on many occasions to respond in other ways.

For, example, in the absence of any clinical direction for physicians, Dr. Ted Boadway, seated beside me today, developed a document for physicians on recognizing SARS. This document was distributed to our members on March 31, 2003 – days before any clinical guidelines were available from any other source.

When the POC developed screening tools for all Ontario healthcare settings, it was the OMA that translated these documents into eight different languages including: Chinese, Italian, Hindi, Spanish, French, Greek, Portuguese, and Vietnamese.

I must add too that not long after the completion and distribution of these translated materials, we received a revised screening tool from the POC and the OMA had to begin the translation process again.

While I do not believe this should have been our responsibility, I am proud that we provided this assistance to our members and their patients.

The OMA worked tirelessly with frontline physicians to solve the multi-site coverage and on-call issues that developed around the GTA that would have further brought delivery of important health care services to a grinding halt. I applaud those physicians who continued to work in extremely difficult and unique circumstances throughout this public health crisis.

The OMA staff fielded thousands of telephone calls and emails from not only physicians, but also patients, their families, other health care providers and associations who were desperately trying to gain knowledge about this disease and the implications to our healthcare system.

In conclusion, the doctors of Ontario played a critical role in fighting and treating this horrible disease.

One physician died, while many others became ill or infected members of their families or their staff.

In fact, some physicians may never fully recover.

It is very difficult to express to you today the physical and emotional strain that this disease had on the medical profession – many doctors today are still feeling the effects left by this outbreak.

Prior to this public health crisis, physicians around the province were already struggling to deal with an increased patient load due to systemic issues beyond their control.

But as critical as our role was in providing health care during this crisis, physicians also need to be much more involved in the planning and implementation process.

We were frustrated by our limited involvement in the decision making processes at an operational level during the SARS outbreak.

Justice Campbell, you have an arduous task before you and I thank you for allowing us the opportunity to present to you today.

We hope you take the following into consideration:

> We recommend that in future, any policy framework developed should involve those individuals or stakeholder groups with specific expertise in developing practical and workable policies and guidelines in their affected areas from the beginning of the process.
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> The OMA recommends that the concept of fit testing be re-evaluated, and made to fit the needs of the system and its workers, at less cost to a healthcare system which remains under heavy strain.
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> We ask that all directives should be evidence based and that the rational for decisions be transmitted to the physician community so that they can more adequately integrate it into their intellectual framework.

We recommend that stakeholders be empowered to provide their professional expertise as it relates to hospital-based care, infectious disease control and community based care. This will ensure that preparation for future infectious disease outbreaks will be designed to fit the system to which it must be applied.

And finally,

We recommend expanding the role of the Medical Officers of Health and restoring the capacity of the public health system to respond to future health care emergencies in the province.

The doctors of Ontario were committed during this crisis to find the best way to treat patients and to respect and restore the health of as many people as possible. We remain committed to this endeavor and will help to build a new response to the future.

As part of our ongoing commitment to work towards finding solutions and improving the province's response to any future public health crisis, the OMA will also be participating in the Expert Panel on SARS and Infectious Disease Control and we contributed to the National Advisory Committee on SARS and Public Health.

If needed in the future, we will do it all over again. **NO** effort will be too great. Treating patients is our professional reward and to rise to a new challenge on behalf of our patients is simply one of the most rewarding things that can happen in a professional life.

Thank you.