The Mushroom Syndrome:

SARS and Family Medicine

Respectfully submitted to:

Mr. Justice Archie Campbell
Chair of the Commission to Investigate the Introduction and Spread of SARS in Ontario

Contact:

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The following speech was delivered to Mr. Justice Archie Campbell, Chair of the Commission to Investigate the Introduction and Spread of SARS in Ontario on September 29, 2003:

Justice Cambell:
My name is Jan Kasperski and I am the Executive Director & CEO of the Ontario College of Family Physicians. With me today is Dr. Yoel Abells. Dr. Abells is a Toronto-based family physician, a member of the Board of the Ontario College and the Chair of Family Physicians Toronto.

We would like to begin by emphasizing that our remarks are meant to paint a picture of what it was like for family doctors during the SARS crisis. We are not here to point fingers. Indeed, everyone from Minister Clement to the members of the Provincial Operations Centre to hospital administrators, physicians, nurses and other frontline staff performed admirably, given what we knew at the time and the pressures under which we were all working. Our intent is to use the personal experiences of key physicians to illustrate the need for the recommendations that we are making. I will provide you with an overview of what it was like at "Ground Zero" during SARS I and II, and Dr. Abells will review with you activities at a higher level by reflecting on the activities of Family Physicians Toronto. Then, we will make recommendations based on the experiences of family doctors during the outbreak.

The Ontario College of Family Physicians (OCFP) was founded fifty years ago with the express purpose of establishing standards of practice for the new and emerging discipline of family medicine. We were asked to oversee the establishment of family medicine residency programs in the medical universities across Canada. Since that time, we have stayed close to our educational roots and today we are involved in the education of medical students and family medicine residents and the professional development and support of practicing family doctors.

Family Physicians Toronto (FPT) was founded two years ago by our College as a vehicle for better supporting physicians practicing in Toronto and represents over 2000 family doctors who deliver care to the people of this city. Since that time, the Toronto District Health Council, as the planning and system building organization in Toronto, has been a full partner with us in supporting the group. The membership of Family Physicians Toronto includes the Chiefs of Family Medicine from each of the Toronto hospitals and representatives from the Ontario College of Family Physicians, the Toronto District Health Council, the Ontario Medical Association, the College of Physicians & Surgeons of Ontario, the Coalition of Family Physicians and the Medical Reform Group. The OCFP is represented on FPT by Dr. Abells. Lynn Lawrie, Director of Planning at the TDHC plays a key role in supporting the group on a daily basis. You will hear later about the role she played during SARS I and II. FPT allows our family physician leaders to identify issues that affect the practice of family medicine in Toronto and, by working together, to resolve them. As you will hear, FPT played a key role during the SARS crisis.

In preparing for today, we spoke with physicians in leadership roles at the two hospitals in the epicenters of SARS I and II, those in leadership roles provincially and grass-root family physicians. One of the family physicians said that “family physicians were treated like **mushrooms** during the SARS crisis". They felt as if they were being kept in the dark and fed “manure” in terms of information and operated under an umbrella of darkness. Our two organizations had to make heroic efforts to overcome the lack of official recognition that family doctors were playing key roles during the SARS outbreak. We worked long and hard to remove

some of the blind spots in regard to the needs of family doctors. We worked together to protect our colleagues and to create needed changes. The almost exclusive focus on hospitals was a profound error resulting in loss of life that still reverberates sadly through our discipline. The fact that the work of the members of Family Physicians Toronto prevented the spread of SARS to any other doctors in the community is an enormous achievement and needs to be celebrated. Our family doctors performed heroically and we are so very proud of them. We owe it to them to complete our unfinished business by putting into practice what we learned that we must do better the next time.

So let's look at ground zero - SARS I and II.

SARS I:

The first SARS patient entered the health care system on March 7 of this year at the Grace site of The Scarborough Hospital. A week later, officials knew that over 210 people had been exposed. In spite of the fact that people could be expected to go to their family doctors in the event that they were experiencing the symptoms of SARS, no-one at the provincial or municipal levels of government thought to contact the family doctors in the area. In the early days of the SARS crisis, Telehealth, emergency department staff and the media were telling people to go see their family doctors if they had SARS-like symptoms. Yet, no-one in a position of authority thought to provide family doctors with the knowledge and skills they needed to properly assess SARS, or the policies and procedures they should follow, or the supplies and equipment they required to protect themselves, their staff, their families and, most important of all, other patients. Family doctors see patients in their offices, in hospital in-patient units, in people's homes and in long term care facilities. They deliver babies and they work as emergency doctors in hospitals throughout Ontario. The opportunities to be exposed and then to expose others are endless. There were many concerns expressed about nurses working in more than one institute, but no-one thought about the many contact points that family doctors have with patients and with various institutions in any given day. They needed information and direction to protect themselves and others. Yet, they suffered from "mushroom syndrome" throughout those early days. This is in direct contrast with the experiences of hospital administrators who state that the information was coming at them so fast and furiously that they had major problems keeping up with the flow.

The Chief of Family Medicine at The Scarborough Hospital, the epicenter of SARS I, received very little guidance and advice from the Provincial Operations Centre (POC) or from Toronto Public Health to assist him in his role. But he did what he could to provide leadership for his departmental members. He sent faxes to family doctors advising them to protect themselves by wearing masks and gloves and to screen and isolate patients in their office settings. He personally gathered together as many six thousand masks following tens of requests a day from community family doctors who were unable to get any supplies in the community. He scrounged as many other supplies as he could and made them available to the members of his department. We are grateful to the administrative staff at The Scarborough Hospital for providing him with supplies from their own limited reserves when they realized that supplies were unavailable in the community. It should be noted that some of the family doctors do not have privileges at the hospital and did not have access to either the fax that gave doctors advice or the supplies**.** Of the family doctors that did receive the fax, some heeded his advice. Some did not. Some came to the hospital to get supplies. Some stayed away. In retrospect, we believe that the fear factor had not yet started to take effect. Family doctors are used to dealing with infectious diseases – Coughs and Colds, Influenza, Norwalk, Pneumonias, West Nile and so on. They had always before

"lived to tell the tale". During these early days, they simply did not realize the dangers that regular, pre-booked patients could pose, nor were they alarmed by patients who wanted to be seen on a more urgent basis with routine-sounding symptoms. Without a "General" telling them what to do and having the power to insist that they follow orders, each doctor was left to individually decide how to respond.

One of our family doctors, and the only physician in North America to die of SARS, paid the ultimate price. Our hearts go out to the family of Dr. Nestor Yanga and his partners at the Lapsley Clinic, two of whom remain disabled by SARS. We also wish to express our deepest sympathies to each family member who lost a loved one due to SARS. A patient exposed to SARS at the hospital came in for a routine visit. That visit touched off an outbreak amongst the clinic staff and their patients. One of those patients later died but not before infecting Adela Catalon, a Nurse's Aide who traveled to the Philippines and touched off a massive quarantine there that led to the WHO travel alert for Toronto. She is the fourth health care worker to die from SARS and is often forgotten in our count. She died because she volunteered to care for the mother of friend. Please remember her by paying attention to the needs of the unpaid volunteer caregivers who give so much to all of us and, in the community, provide much of the patient care.

Meanwhile, Dr. Rex Verschuren, the only physician in the Lapsley Clinic not infected with SARS struggled to keep the practice open, knowing the needs and, indeed, the fears of the patients he and his partners were serving. He did not receive any calls or visits from those in authority. To this day, he does not know if those who were exposed in his office were contacted. No one from Toronto Public Health or the Provincial Operations Centre offered the Lapsley Group advice on how to decontaminate their office. The Chief of Family Medicine at The Scarborough Hospital took on the task of trying to get locums for the clinic but found the task almost impossible. We are grateful to the OMA and the Ministry of Health and Long Term Care (MOHLTC) for working so quickly on our requests for locum support. Locums were supplied by a private firm, Med Emerg, and a number of Family Doctors who volunteered their time to work shifts at the Lapsley Clinic to see the backlog of patients. The fact that Dr. Verschuren, grieving because his partners were so critically ill, simply trucked on is just one example of the heroes in our system.

The family of Dr. Yanga's patient attended a religious retreat and his funeral. With five hundred (500) people in quarantine from these community-based exposures, the POC began to concentrate on the needs of community-based practitioners, but the actions taken were after the fact rather than proactively. We are not saying that the focus should not have been on hospitals. That was where the spread was occurring, but the Lapsley Clinic experience points out how easily this disease could have become a community-based outbreak. We were lucky this time. We may not be so lucky next time. When SARS III or MARS I or whatever they name the next new infectious disease hits, we need to ensure that community-based practitioners are better prepared.

As Emergency Departments throughout the city became inundated with respiratory problems, SARS clinics were established in three sites around the city and it was family doctors who provided the medical care in these clinics. During those early days, in spite of the fact that The Scarborough Hospital, and especially its Emergency Department, was "brought to its knees by SARS", and greatly needed relief – the planning for an off site SARS clinic in Scarborough – fell through. When that happened family doctors provided relief for the Emergency Department.

When patients kept coming in from nursing homes for suturing or fairly routine examinations of minor problems, family doctors started an emergency outreach service for the long term care facilities and provided emergency services on site in the facilities. Likewise, the Community Care Access Centres in Toronto up-staffed to provide care in patients' homes and in long term care facilities. This approach of care is what we all envision the CCACs would do on a daily basis; this is, to meet the needs of people, but lack of funding for services means that CCACs can barely meet minimum daily needs let alone fluctuations in demands. Like family doctors, they accepted these assignments without being adequately trained or equipped to protect themselves or the patients they were serving.

With media attention on the SARS clinics, many of our community-based family doctors remained relaxed. They thought that patients would go to SARS clinics and their offices would be protected from exposures. But many patients avoided these clinics and the Emergency Departments and came to see their family doctors instead. Many patients had booked appointments and others wanted to see their doctors as soon as possible. If they did have SARS-like symptoms, they were reluctant to go to the SARS clinics. They would tell us that they were concerned that, if they did not have SARS, they could get it by being exposed at the clinic, and if they did have SARS, they wanted their family doctors to look after them. Given the long-standing relationship that family doctors have with their patients, this is perfectly understandable and has to be taken into account in future planning.

When family doctors realized that patients with SARS-like symptoms were beginning to show up in their offices, they began to take precautions, but their approaches were all over the map due to lack of directions from a source of authority. Eventually, policies and procedures were released and a supply distribution system was put in place. Some of the larger clinics hired personnel to conduct SARS screening on the phone before accepting a booked appointment and security guards to screen patients prior to entering the clinic or office. Smaller offices struggled in their efforts to adequately screen their patients. Patients sometimes were reluctant to reveal their true symptoms fearing that their family doctor would not see them. So, the family doctors saw them, only to discover, after the fact, that they had SARS-like symptoms. A few of the doctors were masking all day and with every patient at that time as the potential for exposure was great.

As word got out about the Lapsley Clinic, fear amongst the family doctors was heightening. One of the Scarborough doctors reports being "scared to death". She talks about getting up each morning feeling shaky and nauseated. She would vomit and then go to the office to see her patients. She said that she was not so much frightened for herself but for her family: "What if I kill them?" Like hundreds of other doctors, nurses and other front-line staff, she got up, went to work, donned a mask and cared for her patients. At the end of the day, sick with a headache from breathing in her own carbon dioxide (CO^2) all day, she would go home, isolate herself from her family and try to sleep. As the days went by, the only meaningful thing that brightened her day was a phone call from a member of the Department of Family Medicine. The caller simply asked how she was and if she needed anything. That one act of kindness, that small effort to let her know that someone cared, helped enormously to overcome what she was feeling – on the job and in her home. Another family doctor said that her five year old daughter asked her doctor mom if she was still loved since mom no longer kissed and hugged her. The families suffered alongside the physicians and healthcare workers. While the physicians worried about their families, their families worried about them.

It is important to remember that the doctors' lounge at the hospital is the equivalent to a water cooler in an office. This is where information is exchanged. Most hospitals exchange information with their doctors by putting notes in their pigeon-holes. A major portion of the continuing medical education of our family physicians happens there as doctors discuss interesting cases and the newest treatment methodologies. And that is where medical professionals gain their sense of belonging. That was lost to them as doctors avoided the hospital like the plague. Scheduled CME events were cancelled at a significant cost to the organizers. Vital meetings were put on hold as well. Just when we needed information from one another the most, we were prohibited from getting together. In addition, we could not enjoy our families; we could not relax with our friends and neighbours or attend religious services. All of our emotional, social and spiritual support systems were replaced by feelings of fear and isolation - and those feelings went on for weeks and weeks.

In addition to the isolation that physicians felt on and off the job, they were dealing with patients who needed to see a specialist or needed diagnostic tests and a surgical procedure but the system was shut down. Family Physicians were left to care for a sicker patient population with no backup and those patients were frightened and frustrated. The emotional toil of knowing that delays might have long term negative effects on patients worried doctors tremendously. You must remember that we are family doctors. We establish relationships with our patients over the course of time and we come to care about them deeply. The helplessness we felt due to delays in care was overwhelming.

Just as things were starting to look like we were getting things under control, the economic impact of SARS, especially in light of the WHO travel alert, dominated the media. Bowing to political pressure, the "new normal" was put into place to reassure tourists that Toronto was open for business. At The Scarborough Hospital, nurses and doctors were told to remove their masks. Staff were told that they were scaring the patients and giving the hospital – and presumably the city – a bad name.

The Chief of the Department of Family Medicine ignored this message and sent a fax out to the members of the Department telling them to keep their guard up and to keep their masks on.

Then, SARS II hit.

SARS II:

One of the Scarborough doctors who heeded the "keep your mask on" message credits that memo from her Department Chief for saving her life. Two of the first patients who died from SARS II were seen in her office prior to admission to hospital. Toronto Public Health allowed her to keep her office open because of the precautions that were in place in her office.

Meanwhile, SARS was playing havoc within the Department of Family Medicine at North York General Hospital. The surgical floor that was the site of the SARS II outbreak is next to the Department of Family Medicine. Besides the Chief of Family Medicine, the Clinic and the administrative offices of the Department of Family Medicine share six members. Three of these members were hospitalized with SARS, including the Program Director for the NYGH's Family Medicine Residency program. Three other family doctors who were in close contact with SARS patients were placed in quarantine but, thankfully, they were not infected. Everyone who had been at the hospital in the ten days prior to May 23 was placed on quarantine and allowed to do

only essential work. This included eighty-three (83) family doctors who were placed in work quarantine. The enclosed article published in the *Canadian Family Physician* journal illustrates the feelings of healthcare professionals under these circumstances.

The geographic location of the Department's clinic meant that they could not operate out of the clinic. Since the residency program is decentralized to community-based practices, the teaching program was able to continue uninterrupted; however, the illnesses of the departmental members, especially that of the Program Director and the Departmental Secretary, taxed the resources of the Department. The remaining physicians simply took on the additional workload of caring for all of the patients and teaching the residents. Hospital-based residents were not so lucky and many of them lost precious educational experiences.

Meanwhile, around them, the delay in diagnosis on 4 Surgical loomed large as a source of anger and disillusionment. Nurses were pitted against doctors, staff against administration and tensions ran high. What is admirable is that, in spite of these tensions, everyone pulled together and the North York General Hospital is a story of heroism – and a story that if told in its entirety instead of in sound bites would reveal the professionalism that is at the heart of our health care system. When asked to become a SARS Alliance Hospital, they quickly stepped up to plate. They would be first to tell you that no-one was thrilled with the idea but it was their own colleagues and co-workers who had fallen ill and they wanted to bring as many of them as possible into their own institution so that they could care for them themselves. Several family physicians and family medicine residents volunteered to act as the attending physicians on the SARS Ward. Residents helped to cover the community practices of two of these physicians so that they could devote their efforts to fighting SARS in the hospital without having to worry about their own patients. They effectively redeployed their human resources. This did not happen throughout the system. Some parts of the system were overwhelmed trying to keep up with the workload but there were others working in the system who could not carry on in their usual roles or at their usual place. We should have had better systems in place to organize the resources that we did have more effectively. You will hear talk of the need for "surge capacity". We had a very limited amount of surge power from those who could not work; we just did not know how to redeploy them effectively, and we waited too long to call on other communities, other provinces and the federal government to come to our aid. The reliance on our American colleagues should be an embarrassment to everyone across the country.

With North York General Hospital down on its knees and hospitals throughout the City just starting to ramp-up to try to catch up with the backlog of delayed care needs, The Scarborough Hospital was once again asked to go beyond the call of duty. On a Thursday in mid-May, a tent went up in the parking lot. No-one would say why. Late on the Friday afternoon, the Chief of Family Medicine**,** the Chief of the Emergency Department, nurses and others were asked to have a SARS Assessment Clinic open for business on Monday morning in that tent. The POC and their own Infectious Disease specialists were extremely helpful but everyone was left scrambling all weekend trying to find doctors to work in the "clinic", to obtain the needed supplies and to understand the conditions of employment. The tent was unable to be outfitted with water, negative pressure, toilets and dignified waiting conditions within that tight timeframe so the hospital opted to use the fracture clinic as a waiting area and to see patients in the negative pressure rooms in the Emergency Department. When Monday dawned rainy and cold, they were glad that they were inside. Healthcare in a tent may be OK for a M.A.S.H. unit, but with our world class health care system, we should be better prepared with adequate facilities for our staff and patients.

Tensions were high during this period. Staff and physicians learned after the fact that their hospital had been designated as a SARS Alliance Hospital. They were upset because of the lack of proper input and lack of planning and because they did not have the resources they needed to ensure the safety of their patients and staff. In spite of these feelings, they picked up the pieces and did their utmost to provide good care, but their level of trust was eroding and they began to think of themselves as "cannon fodder." The “mushroom syndrome” was very much in evidence at that time.

Physicians were reassured that they would receive adequate worker’s compensation and disability benefits if they became sick on the job. The protection they were offered was never put in writing and was later withdrawn without notification while they worked in the SARS clinics. The one question that they want us to ask on their behalf is “What are you going to do to restore our ability to trust anything that is said to us any more?” This is not “mask fatigue”, that is causing this question to be asked, but a fundamental question that this Commission and the Ministry of Health and Long Term Care will need to address.

The main question that needs to be asked is:

“How will preparations for SARS III, based on the findings of the Commission, restore the trust of our healthcare professionals at the local level and provincially?”

Let’s now look at the activities at the provincial level.

Early on in the outbreak, every hospital in the province was told to halt any elective procedures. That order was followed but resulted in an outpouring of negativity as non-affected hospitals questioned the wisdom of the decision. That slip-up led to a sense of caution at the provincial level. So, instead of getting information out, flawed and incomplete as it was, there was a sense of getting it exactly right and a sense of liability if something was not quite right. These fears slowed the process.

We understood the need to concentrate on hospitals first, especially in the eastern part of the city, but the issues and concerns of community-based family doctors should have been dealt with next; however, we had major problems getting on anyone’s radar screen. “Flags” were going up all over the city that family doctors, in particular, were confused and needed directions in order to care for their patients and to protect themselves and their staff. When the media started to direct people to SARS Clinics, Telehealth and emergency nurses were still directing patients with SARS-like symptoms to see their family doctors. At the OCFP office, I received calls from family doctors in this regard and contacted our Board Chair to activate FPT. I also called the President of the OMA, Dr. Elliott Halparin, and was reassured that policies and procedures were being developed and that the OMA was on top of things. Meanwhile, Lynn Lawrie was contacting Dr. Abells to see if Family Physicians Toronto should be looking into these concerns. It is FPT that made the difference. Dr. Abells will tell you about the activities of FPT from that point on.

Dr. Abells

Mr. Chairman:

Before I address specific SARS issues, I feel compelled to express two concerns. The first relates to what could ultimately happen to the final report and recommendations of this Commission. All too often, I have seen documents of this sort, entailing enormous input and work, shelved as a result of political agendas. Authors of the report move on to other tasks and nothing substantially is accomplished. I believe that if this is the fate of the work of this commission, the results will be tragic. Regardless of official timetables, I pray that you will continue to campaign on behalf of the recommendations made.

The second concern stems from the fact that we are in an election week. I worry that members of the media who are present here today or those on the campaign trail will use what is said today as cannon fodder against one political party or another. I am not wedded to any party right now. In fact, I am troubled by all of them. But, let it be clearly noted: no party, federal or provincial, is any less culpable for the problems we are seeing in the health care system today. I am a family physician who has, for 17 years, provided comprehensive care at a variety of levels. I work in a group practice. I am affiliated with a community-based hospital where I do emergency medicine, have done in-patient care and until just before SARS I, was Chief of the Department of Family and Community Medicine. I am also on staff at a downtown teaching hospital where I practice obstetrics and teach as a member of the faculty of the University of Toronto. Over these years, I have seen the continued erosion of our health care system at every level. For example, hospital restructuring, done without appropriate attention to the need for a community-based infrastructure, was begun by the Liberals, given texture by the NDP and given reality by the Conservatives. It has resulted in fragmented care. Moreover, our health care system has been devastated by years of chronic, deep and excessive underfunding to the hospital and the primary care/family physician sector. Staffing and physician shortages were, and continue to be, acute. What SARS did, aside from the obvious, was to bring into focus the degree to which our system is stretched. It has no 'give'. Without question, had it not been for the unbelievable response of those on the front lines and an enormous amount of luck, SARS would have been a much greater disaster.

Now, let me focus on Family Physicians Toronto and the role it played. I believe this will give context to the recommendations I will make at the end of my presentation. The lessons we learned can only benefit this commission. Personally, I came to SARS a little late. I was out west when the first cases occurred and had only just returned to Toronto when I received an e-mail from Lynn Lawrie of the Toronto District Health Council expressing concern regarding SARS and its potential “to get out in the community”. She wondered whether FPT might offer guidance. Speaking to other physicians, including those in my clinic, it was clear that confusion, fear and uncertainty reigned. The initial need for a hospital-based response to SARS was understandable. However, the manner in which SARS presented made us worry about the potential for a community outbreak and that once SARS was in the community, it would spread like wildfire. Apparently, initial attempts were 'unofficially' being made to develop guidelines for community-based health care workers. Moreover, the OMA had been asked to develop guidelines for community-based physicians, but were delayed in doing so. As well, rumours concerning the strategy being developed for the provision of supplies to the family physicians worried us because they were unworkable. Lynne organized the first telephone conference for that evening. It was clear from this meeting that everyone on FPT was concerned about a community outbreak and that efforts needed to be made to ensure the expeditious development of clear policies and procedures and the implementation of a strategy for the distribution of protective supplies. We developed a set of guidelines and discussed implementation plans. We also felt that the POC needed a family physician representative on its group. Over the next few

nights, we teleconferenced nightly for 2-3 hours to review where things were and what needed to be done. We approached both the OMA and the POC on a number of occasions offering to help in any manner we could. Determined to pressure both to release the policies and procedures, we were told that they were 'in the process of being developed and were to be released soon'. We succeeded in convincing the 'powers that be' to include a family physician, Dr. Phil Ellison, a member of FPT, on the SARS Scientific Advisory Committee. This recommendation was endorsed by the OMA. A week went by during which time an outbreak had occurred within a community attending a retreat, and the impact of the illnesses of the physicians at the Lapsley Clinic was being reported. Initial (well-intended) guidelines from the OMA had been distributed but these were ambiguous, lacked ministry-supported 'teeth' and provided no centralized system for the provision of protective supplies. Physicians were more or less left to resource equipment on their own. Ill patients were all at once being told to stay home, visit their family physician's office, go to the emergency department or attend a SARS unit. We were desperately concerned. On the evening of April 15, 2003, I received a call from the chair of the SARS Scientific Advisory Committee of the POC asking us to meet with them the following morning to express our worries and offer our input. Drs. Phillip Berger, David White and I met with the SAC. We advised them that we understood the initial need to focus on hospitals. Using the analogy of 'war', it made sense to concentrate on the hot spots first and then engage the second wave. This second wave needed to be community-based and community-responsive. We described our concerns emphasizing the need for Ministry authorized, clear and unambiguous SARS protection procedures, as well as Ministry-produced signage for our offices. We suggested using the ministry's centrally-based vaccine distribution system to provide immediate protective supplies. Most important, we recommended the establishment of a Family Physician/Community Advisory Committee (FPCAC) sensitive and responsive to the needs of community-based health care workers. All of our recommendations were well received. That morning, we developed a set of policies and procedures, defined the minimum needed supplies and established the aforementioned strategy for supply distribution. A commitment was made to establish the FPCAC. We were ecstatic; but, frankly, the politics of trying to be heard was draining, compounding the increasing fatigue we were all experiencing trying to provide care to our patients during these difficult times. We had expended a great deal of energy to ensure that family doctors (our friends & colleagues), received the support they needed.

Unfortunately, much of our contentment was short lived. For a variety of reasons, essentially political, the final draft of the directives took nearly a week to be approved and distributed. They were not Ministry-directed. No signage was provided. As it turned out, when the equipment kits were delivered, the distribution system was limited to Toronto. For the following three weeks we lobbied for a wider distribution of supplies to include, minimally, the GTA. Yet, despite assurances that this would occur, the supplies were never forthcoming. Finally, the requested advisory committee was never established. As Chair of FPT, these failures continue to weigh heavily upon me. This is why I asked for the opportunity to present here today.

As Jan already stated, with respect to the events specifically surrounding SARS, our intent is not to point fingers. Everyone tried to help. We all made mistakes, but we all tried our best. As one author wrote in an article on SARS in *Toronto Life*, “We can continue to shift blame from level to level but this will accomplish nothing”. Clearly, we have become complacent. As we prepare for SARS III or whatever new and potentially devastating disease is around the corner, there is a feeling that nothing has changed. While a fair amount of work is being undertaken including preparation of new community guidelines behind the scenes, family doctors have been left to feel

that there is no comprehensive plan for next time – a plan that will allow us to be both proactive and reactive.

SARS hospitals such as the Scarborough Hospital and the North York General Hospital are facing large deficits. They have invested in negative pressure rooms and will need to establish appropriately designed SARS assessment units. On the one hand they are being told to be SARS ready. On the other hand, they are being restricted to 3% increases in their budgets and being told to make whatever cuts are necessary to hospital operations to stay within 3%. This level of cost containment, and the paralyzing impact it will have on implementing infection control readiness, both in the hospital and the community, will prove irresponsible and deadly if we confront a SARS III. This is particularly true in the context of vulnerable populations, such as the community served by The Scarborough Hospital. Scarborough is one of the most ethno-racially diverse communities in Canada. Scarborough is also characterized by many of the worst disparities and inequities across the determinants of health. These include child poverty, environmental pollution, homelessness, overcrowding, lack of education, cultural and refugee barriers to accessing health care, and unemployment. All these will give SARS III a "leg up", providing it with additional vectors of spread. North York General Hospital faces similar challenges. Fiscal restraints are hampering the planning efforts of these hospitals and their health care providers to protect the health of the public in the event of another epidemic. Now is the time to facilitate their initiatives with reasonable financial and staffing resources. Both hospitals are investing heavily in infection control. Their deficit recovery plans will need to cut deeper in order to accommodate these new expenditures. Of all the hospitals in the province, these two should be given the support they need to become what our American colleagues call "magnet hospitals". We urge you to recommend adequate funding for them to facilitate their recovery to full service and their chance to take their former proud place as community-based hospitals.

As for the grand plan, here is what we need:

1.0 Leadership:

We need to strengthen our leadership capabilities by:

1.1 **Establishing a Permanent Central Coordinating Agency**:

We need to establish a permanent agency to co-ordinate all healthcare system activities in preparation for another crisis and to oversee activities during a crisis. The agency needs to be properly resourced so that it has up-to-date information and the human resources necessary to maintain system vigilance and fast "ramp-up" capacity in the event of an outbreak or other major emerging situations. Physicians who have practical, hands-on-experience in the hospitals and in the community need to be included as agency members. We need family doctors at the table who understand our unique and varied practice environments. The enormous amount of volunteered time accorded by many during SARS I and II cannot be continuously expected. Appropriate remuneration for the time commitment of these valued people must be available.

1.2 **Proactive Planning for Decision Making and Communications:**

For the first few weeks, SARS outwitted us and managed to stay a few steps ahead of us. Our pre-existing, bureaucratic patterns of health care decision-making were impediments to beating the virus. Our communication system was

too slow and essential information did not get to the right people quickly enough and with sufficient authority to prevent the virus from getting a leg-up. Communications were insensitive and ineffective, and proved to be downright deadly. The old ways of planning how to respond to a crisis in the midst of the crisis must end. Communications about what must be done needs to be done fast and accurately. Before SARS III or any other crisis occurs, we need to develop:

1. a prearranged set of clearly defined protocols for how decisions are made and how information will be disseminated
2. a prearranged infection control protocol and a plan for the distribution of supplies to make those protocols a reality
3. a prearranged plan for communication that documents who will be responsible for communications within each sector and between sectors
4. a prearranged plan for the redeployment of health human resources to adequately cover the "hot spots", including plans for when and how to acquire assistance from other communities, provinces and the Federal Government.

1.3 **Identifying a "General":**

During SARS I and II, the health care system received excellent leadership from Dr. Young, Dr. D'Cunha, Dr. Basrur, Dr. Low and many unsung heroes like Dr. Brian Schwartz, who was the original head of the SARS Scientific Advisory Committee, but no-one issued "orders" to community-based physicians. No-one said: "This is what you must do and you will do it - and now". Drs. Young and D'Cunha did this for the hospital sector, but the community was left out. Having reflected on our needs in the community, we know that we need to have **a respected family physician take on the role of "General" in the community**. That physician must understand all facets of our healthcare system – silo-by-silo. He or she must understand hospital-based practices but above all, must understand the complexities of community-based practices. S/he must be given the authority to issue directives that are mandatory and to direct how policies and procedures are to be implemented. This will sound draconian to physicians at first but it is what is needed. Those orders need to include a directive to use "maximum protection" at the first sign of an outbreak, which will be cost-effective in the long run. The up-front costs of protection will be worth the investment if we minimize damage in the long run.

1.4 **Leaderships Connect:**

We need to ensure that each region of the province has the capacity to bring together leaders who can oversee operations in their region. We were fortunate to have had Family Physicians Toronto in place prior to the outbreak of SARS, but we do not have similar structures in place in many parts of the province. The OCFP and District Health Councils should be directed **to launch organizations similar to Family Physicians Toronto around the province** to connect the family physician leaders to one another to forge the decision-making and communication pathways that will stop the "mushroom syndrome" that family physicians experienced during SARS I and II from occurring in the future.

While we need a better organized system at the provincial level, the approaches to

decision-making and communication taken by the Central Coordinating Agency needs to be supported and reinforced at the regional and local levels. We need **local and regional planning throughout the province.** The leadership from Hospitals, CCACs, Public Health Departments and District Health Councils need to be supported to work with their local Chiefs of Family Medicine organization to plan for a complete health system response in preparation for next crisis.

2.0 System Redesign

2.1 Investing in Health Human Resources:

As stated before, SARS I and II demonstrated the depth of the health human resource crisis that we are facing in this province. Physician, nursing and other staff shortages are so acute that there is no reserve capacity to handle a crisis like SARS or any other crisis. We were struggling to provide care before SARS. In the hospital sector, "cost containment" had left the system facing a major crisis. During the crisis, hundreds of health care personnel were lost to SARS. There are no extra nurses or doctors to replace these hospital-based personnel who were infected with SARS, many of whom are still too ill or devastated to return to work. During the outbreak, there were no replacements to be found to replace our highly trained ICU and Emergency Nurses who contacted SARS. Private centralized agencies were not able to supply nurses with the level of expertise to function in these vital and highly specialized settings. Trying to maintain services for patients was a challenge. The continuing struggle to ramp up these services to the "new normal" level of care in the absence of so many of our healthcare professionals is proving to be every bit as difficult as handling the initial crisis. If we do not invest in our health care human resource capacity and plan for what has been referred to as "surge capacity", we might as well simply give up and go home. The health care system is not bricks and mortar. It is people helping people. Post SARS I and II, they are tired and they are demoralized and they are asking that they never be put into such an overstretched situation again. Pre-SARS health care delivery partners will no longer suffice. We need **a major investment in health human resources, and we need those people to know what to do.** We not only need infection control protocols, rapid and accurate decision-making and speedy communication systems, we need them in place ahead of time. The role that each sector will play before, during and after a crisis needs to carefully worked-out in advance. Health care personnel need to assigned and know their jobs well in advance. We trust them to do their jobs on a daily basis but in a crisis they need to be clearly directed and effectively guided. We must ensure that they have the appropriate authority, resources and communication loops at their disposal the instance another SARS or any other crisis occurs if we are to win these battles in the future. Patients trust their health care providers to deliver the best care possible. Health care providers need to know that appropriate strategies are in place to ensure that their welfare and that of their families is protected, as well.

2.2 Strengthen and Integrate Primary Care and Public Health

Both primary care and public health departments have been devastated by years of deep and chronic underfunding. The acute shortage of family doctors and

public health staff have left the community vulnerable. The community response to outbreaks would be enhanced if these two sectors worked more effectively together. **Effective planning and co-ordination at the provincial level is needed to facilitate better integration at the local level.** Family doctors are in key positions to provide the majority of care for patients on a daily basis, to recognize emerging illness trends as they are emerging and to provide care during a crisis.

1. Investments are needed to **strengthen our primary system** to better support the daily care of patients and to address the needs of "orphaned" patients, (that is patients without a family doctor). We need more family doctors. Efforts need to be made to make family medicine attractive to medical students and the infrastructure of primary care needs to be strengthened to attract family medicine residents to comprehensive family practices. Primary Care Networks, Family Health Networks & Groups, Community Health Centres, Community Service Contracts and Northern Alternative Payment Plans are helping us to do so, but urban models such as North York General Hospitals' "Networks of Networks" needs to be explored as well. We need to ensure that family doctors are able to provide comprehensive, multi-level outpatient and inpatient care at all times, but especially during an outbreak.
2. We need to enhance our communications on a daily basis with family doctors and reconnect the system with family physicians and their patients at the core of the system to make it more accessible and user-friendly. During an emergency situation, communications with community-based family physicians are crucial.
3. To provide an early warning system, family doctors need to be better supported to function in the key role of sentinels in the system by recognizing trends as they occur. When they see 2 or 3 patients with the same symptoms or one patient with an unusual presentation, they need at their fingertips a system to contact the local Public Health Department and the Central Co-ordinating Agency. It was demonstrated during SARS I and II that patients prefer to be seen by their own doctor when facing a frightening disorder. Family doctors can adequately look after most of the complaints that drive people to Emergency Departments, but we must supply them with resources and support to do so. Better co-ordinating must be in place between Emergency Departments, SARS Assessment Clinics and Family Doctors' offices.
4. Public Health nurses should be assigned to family doctors' offices to ensure **better integration of primary care and public health**, not only for surveillance purposes but also to address the health promotion and prevention needs of the patient population.
5. Human resource shortage in both sectors must be addressed as key to the effective management of SARS III and other crises.

2.3 **Information Technology/ Communication System:**

In addition to strengthening our people-to-people connections (such as we saw between the Department of Family Medicine at The Scarborough Hospital and its

members), we need to invest in information technology. We need well-designed family-medicine-friendly software to assist with tracking and communications. Pigeon-holes in the doctors' lounge at the local hospital is not good enough, and all physicians need to be connected, not just those with privileges at their local hospital. We need a reliable communication system to direct information both ways (from the front lines to the agency and from the agency to the front lines).

2.4 **Hospital Restructuring:**

Restructuring has meant that patients are sent all over the City of Toronto for care depending upon their diagnosis and where the program addressing their needs is located, their level of recovery can be addressed, or where a bed may be available. SARS spread from hospital to hospital and from acute care to rehab to long-term care. We need to think long and hard about the clustering of service models versus full-service hospitals. In addition, outpatient services, including many physician services, were brought to their knees because of their locations within acute care hospitals. Resources should be shifted to strengthen family practices so that much of the work of these clinics takes place in the community rather than in a hospital setting. Plans need to be put in place to relocate our outpatient/physician offices to the community where they are not vulnerable to closures/restructure.

2.5 **Community Services:**

CCACs were asked to ramp-up services to prevent patients in their homes and in long-term care facilities from being shipped to emergency departments for assessment, diagnosis and treatment of disorders that SARS demonstrated could easily be addressed by "sure capacity" in the community. Resources need to be shifted to allow CCACs to deliver care in this manner. It is important to remember that the home and community sector is highly reliant on unpaid volunteers and family caregivers and their needs must be taken into account.

3.0 Supplies and Equipment

3.1 **A Reliable Source of Supplies and Equipment:**

We need a reliable materials management system with immediate surge capacity. The "just in time" delivery system did us in. It may have looked good to the financial gurus and our hospital bean counters, but it simply took too long to get supplies and equipment to front-line care providers.

3.2 **Distribution System:**

Supplies and equipment are useless without an effective distribution system. Family doctors are the ones who identified the system that will work for us, but it stopped at the borders of the Toronto Public Health Department. Each community needs to identify in advance how they will acquire and distribute needed supplies and equipment.

4.0 Education:

Family physicians and their staff need opportunities to enhance their knowledge and skills to deal with the care of patients with infectious disease and to improve infection

control practices. This is a key educational role that the OCFP is ideally suited to undertake.

5.0 Preparation for Future Disruption to the System:

Flu season will be upon us very shortly. If every person with a cold or the flu rushes to their family doctor or an Emergency Department, we will be quickly overwhelmed, especially if we isolate until we are able to prove that the patient does not have SARS. What is our plan for the flu season? What will the messages to the public say? How will we prevent a total shutdown of the system? How will we deal with the need to balance the fear factor with the apathy that may occur as healthcare professionals return to the pre-SARS modus operations? We need answers to those questions and we need them now. We need a grand plan so that we are not left with our "pants down" in the event of another infectious disease or a terrorist attack, or any other major disruption to the system, and we need it today not tomorrow, not next year, not five years from now. Today. We know what needs to be done. The time for study should be completed as fast as possible. We need to plan based on what we know today and then adjust our plan as we get more information. If we wait, like we did at the beginning of SARS I, until we have all the information, until all the i's and t's are dotted and crossed, we will be in the same mess that we were in then and that's just not good enough.

I'll turn it back to Jan

Jan:

Family physician offices were stretched to the limit struggling to cope with patient calls, concerns and visits. Trying to access equipment, dealing with increased cost and decreased incomes made the provision of care difficult. The atmosphere of enormous uncertainty and increased sense of alienation and abandonment made it next to impossible. It must not happen again. Do we have all the answers? No. Are we willing to work with the government and with our peer organizations to find those answers? Yes. At the end of the day, we want every healthcare worker to regain the trust that was lost during SARS I and II. When they make an ethical decision regarding their ability to accept the care of a patient with an infectious disease or a possible contact, we want them to be confident that they have the knowledge, skills and judgement to perform the assessment competently. We want them to have the appropriate supports (guidelines, policies and procedures and protective gear) to know that they can do so safely, and we want to reassure them that they are not placing their loved ones, their staff and other patients in jeopardy. We want the Toronto/GTA area to be a magnet region in the province and the country. We sincerely hope that actions that are taken in response to this Commission will ensure that family doctors recover from both "mask fatigue" and especially, mushroom syndrome.

We are so very proud of all our family doctors and would like to thank all of them for a job well-done.

In recognition for all the wonderful work they did during the SARS crisis, the OCFP is presenting Certificates of Achievement to the following members of Family Physician Toronto:

Dr. Val Rachlis	:	Founder of FPT and Ontario's Family Physician of the Year
Dr. Yoel Abells	:	Chair of Family Physicians Toronto
Dr. Paul Caulford	:	Chief of Family Medicine at The Scarborough Hospital
Dr. David White	:	Chief of Family Medicine at North York General Hospital (NYGH)
Dr. Stan Lofsky	:	OMA liaison to Family Physicians Toronto (NYGH)
Dr. Phil Berger	:	Public Health liaison, (St. Michael's Hospital)
Dr. Phil Ellison	:	Member of the SARS Scientific Advisory Committee representing family doctors (University Health Network)

and to Dr. Rex Verschuren from the Lapsley Clinic

with special recognition to Lynn Lawrie, Toronto District Health Council and Dr. Brian Schwartz, Vice Chair Ontario SARS Scientific Advisory Committee (Sunnybrook & Women's Health Sciences Centre).

Justice Campbell:
Each story you hear will be from the perspective of the speaker and we may be looking at the world through a narrow lens and see the ground. We need to open the shutter wide and see the stars.

We are grateful to each one of them for all that they did on behalf of family doctors and the patients they serve.

Thank you for your kind attention.