

**The College of Physicians and Surgeons of Ontario provided some important advice to the independent SARS Commission on October 1, 2003. Registrar Dr. Rocco Gerace provided an overview of the role played by the College during the SARS emergency, and some recommendations based on the lessons learned from that experience. The following is a transcript of Dr. Gerace's presentation:**

Good afternoon, my name is Rocco Gerace. I am the Registrar of the College of Physicians and Surgeons of Ontario. In addition, I am a physician. Most of my career has been spent in the practice of emergency medicine. I welcome this opportunity to present to the Commission on behalf of the Council of the College.

The College of Physicians and Surgeons of Ontario is the body that regulates professional activities for all physicians in this province. We are given this statutory responsibility under the Regulated Health Professions Act (RHPA) – the Act that sets out the regulatory framework for all health care professions in Ontario.

- We issue certificates of registration to allow physicians to practise medicine in Ontario;
- We monitor and maintain standards of practice through peer assessment and pro-active education;
- We investigate complaints against doctors on behalf of the public; and
- We discipline doctors who are found guilty of professional misconduct or incompetence.

The CPSO regulates approximately 26,000 physicians in Ontario and while we are a physician organization, our focus, in keeping with the RHPA, is (and I quote from the act) “to serve and protect the public’s interest.”

In opening, I would first like to recognize the outstanding contribution made by all health care workers during the SARS outbreak. This was a difficult and intensely disruptive time. Hospital services were curtailed, elective surgeries were cancelled, and many health care workers were quarantined. Those still allowed to work had to speak to patients through a mask. The health care profession puts us on the front lines of difficult battles, and SARS proved to be a formidable foe. On behalf of the College specifically, and the medical profession generally, I'd like to thank the thousands of health care workers who rose to the challenge and worked tirelessly to treat and contain the spread of SARS. I would also like to offer my condolences to the families of the patients and the health care workers who lost their lives to this disease.

This crisis was a test of the capability of the Ontario health care system to respond to a mysterious new disease. While the response was energetic, we have heard that mistakes were made.

It is well known that mistakes specifically or error generally is not unusual in the delivery of health care. It has been reported that up to 100,000 people per year die in the US as a result of error in the delivery of health care. If an analogy were drawn to the airline industry, it would be the equivalent of three jumbo jets crashing every two days. Like

health care, the airline industry is complex. If we draw on the experience of the airline industry, we will learn that the response to mistakes is not in naming and blaming but addressing the complexity of the system in which the error occurred.

Shifting to the context of SARS, there are clearly lessons to be learned. This College is committed to the idea that the investigation of clinical care issues must include an examination of systems, procedures and interactions within the health care system. It cannot be an exercise in naming, blaming, and shaming. Assigning blame and engaging in finger-pointing will not generate the kind of system improvement that we need to better prepare ourselves for the future. When mistakes happen, we have learned to ask, “what happened and how can we ensure it will not happen again” and not “who made the mistake.” I congratulate this forum for taking that approach.

The task you have been charged with is extremely important and on behalf of the Council of the College, we appreciate the opportunity to provide an overview of the role we played during the SARS crisis and make some recommendations based on the lessons learned from that experience.

In this presentation, I would like to address several matters that deal directly with the College’s perspective from the SARS outbreak. They include:

- Ensuring there are enough doctors to take care of patients;
- Ensuring that physicians are working with the latest infection control guidelines;
- Communicating quickly and effectively with the profession;
- Developing new approaches to investigate system errors.

### **Physician Resources**

During the SARS emergency, extraordinary measures were needed to deal with a health care system that was already straining at the seams. As you will remember, many physicians, including many of the province’s top infectious disease specialists, were put into quarantine. This measure left those physicians still working overwhelmed and exhausted. In communications with the Commissioner of Public Safety and Security and the Commissioner of Public Health, it was decided that we desperately needed to shore up the medical services in the hospitals most affected by the SARS outbreak. As a result, the College facilitated the granting of a short-term certificate of registration to physicians outside the province that allowed them to provide much needed medical care at the bedside. During the emergency, the College registered 20 infectious disease specialists from outside the province to provide SARS-related medical services in Ontario.

Having established this precedent, the College should continue to collaborate with the Ministry of Health to be certain that if acute personnel needs occur in a similar circumstance, effective links are in place to mobilize personnel without hesitation.

In the larger picture, over the last year the College has been working closely with the key stakeholders in the health community to develop a practical plan for long term, permanent solutions that address the province’s urgent need for physicians.

The Physician Resources Task Force was established to find timely and effective ways to increase Ontario's physician supply without compromising the quality of care standards and patient safety.

It has been estimated that the new plan will add more than 650 new physicians to the health care system over the next five years. Having enough doctors is necessary at the best of times and essential during a crisis. Acknowledging the significant contribution of the Government of Ontario, we look forward to continuing this work with stakeholders to further enhance this effort.

### **Infection Control**

Health care providers were directed to comply with the College's guidelines on *Infection Control in the Physician's Office* and other existing and updated recommendations for infection control from Health Canada.

The College's infection control guidelines were developed and revised by a team of specialists lead by Dr. Anne Matlow, Director of Infection Control at the Hospital for Sick Children and Ms. Carol Goldman, Infection Control Practitioner. The current guidelines include information on routine infection prevention practices; special office considerations for airborne infections and for antibiotic-resistant organisms; and the importance of immunizing medical office staff and health care workers.

We have sent this essential information about infection control to every physician in Ontario twice, and during the SARS crisis, we ensured that there was ready access to the complete guidelines on our website.

However, the next infectious disease outbreak could easily be more contagious and more virulent. For that reason, Ontario must strengthen its ability to control the spread of infections in all health care settings and communities. Institutions responded by implementing strict measures of health care protection, patient isolation and visitor screening. But, the ability of family doctors to adequately respond to the next 'SARS equivalent' will continue to be concerning within a health care system that does not easily allow for the coordination and mobilization of primary care practitioners across the province. This is key. It is family doctors who will see these types of cases first, while they still appear to be upper respiratory infections. Ontario's family doctors faced personal risk on the front lines, and were expected to serve as experts in situations where they had limited clinical experience or science to guide their judgements. Individual physicians in primary care practices need guidance from provincial medical leaders, encompassing infection control practices, up-to-the-minute information, and effective education. We need to put knowledge into the hands of doctors to make immediate and informed decisions about patients who present with a wide range of symptoms.

The College has embarked upon a process to review and amend our existing infection control guidelines. In addition to providing solid guidance for routine infection control practices, the new guidelines will be characterized by a heightened awareness of emerging infectious diseases, including SARS. We will be working with top infection control experts and Dr. Jim Young has expressed a desire to work with us on the revision

to ensure the completeness of the new guidelines. We are committed to completing a draft version of the guidelines in the coming months.

Guidelines are of no value in the absence of the ability to quickly and accurately communicate with the profession.

### **Communicating with the profession**

During the SARS outbreak, as the regulator of the medical profession, we communicated with the profession to reinforce the importance of complying with the directives of the Provincial Operations Centre. We wrote to every physician in Ontario, clarifying their responsibilities, outlining relevant procedures as well as providing other necessary information.

In respect to communication, we bring two unique strengths to the table. The first is that, as the regulator, the messages that we send to the profession are recognized to be important. Doctors pay attention to what we say. The other strength is that we maintain the most current and complete physician database in the province. Doctors have a statutory obligation to give us their most up-to-date contact information. As you might imagine, such a repository of accurate information is critical during an emergency. When called upon, we were able to reach the majority of the profession electronically and the rest we reached quickly by letter. We ensured that our expectations of the profession were clear - extreme measures must be taken to effectively control the spread of SARS.

We are currently dialoguing with the Ministry of Health to coordinate the ability to communicate even more rapidly and completely with the profession using our current database. The completion of this project is critical.

Accurate information is paramount for physicians to adequately deal with uncertainty and risk. In this regard, dissemination strategies are crucial. We plan to work closely with the University of Toronto's Knowledge Translation Unit to optimize use of technology allowing quick and effective dissemination of our infection control guidelines. The success of guidelines for medical practice is dependent both on the rigours of development and the 30-second rule of implementation – in other words, is the information based on the best available evidence and can it be applied in competition with the plethora of unsolicited information in a physician's office.

Next spring, we will embark on a study that will focus on the medium of exchange and its capabilities in an emergency situation. Our infection control guidelines will be disseminated to all physicians through our College's publication and to a study group of at least 300 primary care physicians using technology such as e-mail, pager, cell phone announcements, webcasting, media watch services, and use of web-based repositories. The purpose of the study is not to evaluate the response of physicians, rather it is to evaluate the effectiveness of various technologic strategies in providing information to physicians in emergency situations. Our goal is to create, with other provincial agencies, the capability of immediately communicating with all physicians in this day of new disease and bioterrorism.

The College is also committed to a role that emphasizes professional development and continuous education for all physicians. The literature conclusively demonstrates the failure to change practice behaviours by the passive distribution of information. More appropriate strategies are necessary. The College has played a role, and will continue to do so, by helping to develop clinical practice guidelines that use the best available evidence and professional consensus, by distilling complex guidelines into educational materials for physicians and by highlighting ways in which doctors can directly apply new knowledge to their practice.

In addition, we are working on a system that will allow physician experts to be available by phone to their physician colleagues to answer more complex questions that might arise in their office and are not addressed by the guidelines.

### **System Error**

The SARS crisis was a loud wake up call for all of us. It became all too clear how an infectious disease outbreak can derail our health care system and threaten the health of our population very quickly. Granted, mistakes were made. However, assigning blame will not generate the kind of system improvement that Ontario needs to better prepare itself for the next infectious disease outbreak. We must codify a system's approach.

Contained in our submission in anticipation of regulatory change, we identified the need for a process similar to that of the Coroner's review in Ontario – a public process to assess system problems and develop recommendations to improve system design. Rather than an internal College activity, we envision a transparent process where other Colleges and relevant stakeholders could collaborate and sponsor a joint process, particularly when a number of health professionals may have been involved.

We believe that such a structure would be an important tool for improving the quality of care provided to the public. It's a belief backed up by a significant amount of literature, which indicates that addressing system issues rather than individual actions can more effectively decrease clinical error, thereby improve quality of care. Incident analyses that stop once "human error" is identified are simply an inadequate response to complex systemic problems.

### **Recommendations**

During the SARS crisis, we were able to "scramble" to come up with partial solutions to particular problems that are within our mandate to address. Had we certain elements of readiness in place, our response would have been faster, more complete, more effective, and cheaper. Therefore, I'd like to summarize our recommendations:

1. We will continue with strategies in conjunction with stakeholders to ensure that we have enough physicians in Ontario.
2. The need for rapid communication is critical. Efforts to ensure that information can be accessed rapidly so physicians have the most up-to-date information available at all times must continue.

3. Serious consideration needs now to be given to the “what” of communication in addition to the “how.” For example, during the course of the crisis, an unsuccessful attempt was made to patch together an educational package designed to help doctors at the front lines of medicine to exercise “best judgement” when faced with the difficult challenge of SARS diagnosis. Now, in the cold light of day, it seems clear that help was needed by front line doctors, but that without the presence of generic educational prototypes for rapid transfer of expertise, the kind of help needed could not be delivered.
4. We would like to echo the recommendation that we made during the legislative review three years ago; there needs to be a process that looks at how mistakes happen, not who makes them. This will allow us to learn from our mistakes and move forward to create a stronger health care system.

In closing, we congratulate the Commission for its enlightened approach, and offer our continued assistance in the areas of expeditious registration of doctors, guideline development, information dissemination in an emergency situation, and physician education in response to urgency and clinical uncertainty.

On behalf of the Council of the College, I want to thank you for this opportunity to address you today and I will be pleased to answer any questions.