CUPE Local 79

Presentation to Justice Archie Campbell

Commission into the SARS Outbreak

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CUPE Local 79 represents about 16,000 workers at the City of Toronto and Bridgepoint Hospital. We are the largest municipal local in Canada, representing a diverse group of public sector employees including hospital workers, public health personnel, homes for the aged staff, Emergency Medical Services dispatchers, shelter workers, social services workers, building inspectors, housing staff, parks and recreation staff, cleaners and many other personnel normally associated with the delivery of municipal government services.

During the SARS outbreak our members wrestled with issues of vulnerability that one would normally expect from individuals dealing daily with a considerable number of public interactions. On any normal day, one would encounter individuals exhibiting symptoms of ill health, such as a cough. During the SARS outbreak, front-line staff worked with the additional stress of not knowing if such individuals were carrying a frightening new and potentially fatal disease.

In one such front-line situation, staff at Toronto Community Housing Corporation arrived to work in the midst of the SARS outbreak to find that their countertop glass security panels had been removed to make the office more "client friendly." Given the spate of stories about how the disease can be transmitted by respiratory secretions -- spittle from coughing -- we found this to be a poor time to implement such changes and demonstrated the often thoughtless attitude of some managers to staff anxiety over SARS. While the Toronto Community Housing Corporation denied there was any legitimate threat with the removal of the screens, Emergency Medical Services was sending out memos like the one from Peter Macintyre, Manager, Community Safeguard Services, on April 4, 2003: “One of our medics had a scare on Thursday night, when they (sic) received a face full of cough debris from a pneumonia patient when they (sic) were not wearing eye protection. Please remember to wear eye protection when there is any possibility of facial contamination with secretions.” A similar scare took place in Social Services, where no protective equipment was authorized.

In other areas, such as the City's Homes for the Aged, the union was engaged in a much more productive way. The Homes for the Aged Division kept the union updated daily.

When the Ministry of Health and Long Term Care restricted staff mobility to prevent transmission between health care facilities, it adversely affected staffing levels at the Homes owing to a large complement of mostly part-time registered staff who were also employed at hospitals and other long term care facilities. Effectively, it meant that staff had to choose which of their employers they would work for during this period. The union negotiated with the Homes for the Aged Division to essentially allow it to "compete" with these other facilities who were offering incentives, such as additional hours, to entice staff to work exclusively for them. Although Ministry of Health and Long Term Care restrictions were lifted before any such plan could be put in place, the consultative response demonstrated a more proactive approach that would have benefited employer, employee and health care client. This incident did demonstrate the growing realization on the part of the Ministry of Health and Long Term Care that a part-time labour force in health care poses increasing challenges with the spread of infectious diseases between facilities.

Similarly, Emergency Medical Services sent out updates, sometimes several times a day by e-mail, and involved our members in the decision-making process. Emergency Medical Services was the first department to provide an information phone hotline operated by and created for staff.

Both Barry Gutteridge, Commissioner of Works and Emergency Services, and Sandra Pitters, General Manager of the Homes for the Aged Division, recognized the importance of involving both front line staff and the union in their response to SARS.

While some parts of the City of Toronto rose to the occasion, the corporate-wide response was, by contrast, confused, poorly communicated, inconsistent in its protocols and dismissive of the input of front-line staff and their representatives. While we recognize the need to manage the public's anxiety in the face of a fatal virus, we felt normal precautions associated with occupational health and safety principles were sacrificed to minimize the economic impact on the city’s already tarnished image. Instead of taking common sense precautions, often the City appeared to be waiting for direction from the Province before taking action. Instead of initially providing as much

protection possible, then removing any unnecessary protocols as the evidence eliminates risk, the opposite was true in this case.

On April 11, 2003 Toronto Public Health became aware of a City of Toronto employee who may have been symptomatic with SARS while at work in Metro Hall between March 31 and April 4, 2003.

More disturbing, when public health investigated, there was a link between the worker and the original Scarborough Grace SARS outbreak. While organizations such as Atlanta's Center for Disease Control were still considering the possibility that the virus could be airborne, the City of Toronto had ruled out such method of transmission and was taking decisions accordingly. At the initial meeting with the union to discuss the response to the incident at Metro Hall, they insisted that SARS could only be passed on through prolonged close personal contact. As a result, they were only prepared to quarantine a small number of employees who worked closely with the individual in question.

It was only after a lengthy meeting with the union that the City was persuaded to quarantine the entire floor in which the employee had worked. After meeting the union, public health officials actually invited us to come up to the floor in question to meet with the staff to be quarantined. Astonishingly, when we asked if they would provide protective equipment for such purposes, we were told "no."

While the hospitals and other health care facilities were dressing front door screeners in full protective equipment -- mask, goggles, and gown -- City public health officials were denying protective equipment to those who were coming into contact with people known to be in quarantine. This ban extended beyond union officials invited to meet with the Metro Hall group.

April 9, 2003, Stephen Leacock Collegiate Institute was ordered shut and staff and students put into quarantine after a student suspected of having SARS showed up to class.

Public Health officials later went to the school to set up a depot to distribute protective equipment and provide instructions to family and friends of the quarantined individuals. It became quickly apparent that many of those showing up at the school were individuals that were supposed to be in quarantine. Four public health inspectors and eight public health nurses were there to distribute the materials. One inspector thought it prudent to put on the N95 masks as a result of this unexpected contact. When told by management to remove the mask, the inspectors pointed out the unsafe conditions they were being asked to work under. When management refused to change their position, the inspectors chose to leave rather than continue working in an unsafe environment.

Similarly, public health nurses were denied full protective equipment when making home visits to quarantined mothers who had given birth at a SARS-affected hospital.

The union repeatedly asked for full protective equipment in these cases, and was denied until it took the issue before Shirley Hoy, the City of Toronto CAO, and the Executive Management team. In Hoy's letter of April 17, 2003, she reversed the policy, allowing full protective equipment to those coming in contact with quarantined individuals.

Throughout the SARS outbreak, the media became aware of many individuals who were not taking the quarantine seriously. Instead of demonstrating the seriousness of the virus by wearing personal protective equipment while engaging with quarantined individuals, the City instead sent the opposite message. If we come to your home while you are under quarantine and not worry about wearing protective equipment ourselves, why should you worry about similarly interacting with others? It is no wonder reports surfaced of quarantined individuals shopping at the mall or attending church.

The Stephen Leacock incident also demonstrated a further need: While four health inspectors felt the need to leave under unsafe working conditions, the eight public health nurses felt intimidated into remaining, according to the inspectors. The inspectors allege the nurses, while also concerned about unprotected contact with quarantined individuals, were more concerned about the visit later that afternoon by a TPH Director. The nurses

were more concerned about the potential of disciplinary action than exposure to a deadly disease. It is inevitable that during such an outbreak, workers will come into conflict with the employer over risk assessment. In this particular case, should workers wait for the Ministry of Labour to arrive and assess a work refusal when to do so could potentially put their lives at risk? CUPE Local 79 believes that legislation around work refusals needs to be re-examined under such circumstances. If it wasn't for the intervention of the City's labour relations department, we have no doubt these employees would have faced discipline for taking the decision to protect themselves.

As such, the issue of what right employees have to protect themselves is an important one in the face of such threats. That would also extend to whistleblowers, who put their careers at risk to maintain the safety of themselves, their colleagues, and the public.

While employers needed a clear message that employees faced with quarantine should not be penalized, the City's own response depended on how the employee came to be quarantined.

In an April 7, 2003 bulletin, the City states that those showing symptoms from a work-related exposure to SARS were to be covered by WSIB. However, they were premature in stating that those with work-related exposure but without symptoms should also apply for WSIB. WSIB rejected quarantine claims from individuals without symptoms. Further, if you are quarantined as a result of non-work related exposure, the City states that you can access your sick bank or short term disability plan. If neither of these is available, the employee can access vacation, lieu time, or float holidays. If no earned benefit was available - such as in the case of a recent probationary employee - the city would consider requests on a case-by-case basis. While there is clearly an attempt to find accommodation, surely this is a tepid response where a clear one is required. At the very least, the City should have clarified the situation with WSIB before putting out a bulletin about who should apply. But it goes further than that. One could say the public sector should have shown leadership by unequivocally meeting any financial obligations to any employee facing quarantine, whether they are symptomatic or asymptomatic.

In the private sector, an employee at Hewlett Packard did go to work while symptomatic. It resulted in the quarantine of 197 HP employees in Markham on April 9, 2003, and eventually, the fatality of the individual involved. Having only read about this incident in the media, we can only speculate as to why someone would show up to work sick when specifically told to stay home.

No doubt income security would be a major factor in anybody's decision. In our society, financial health is strongly linked to physical well-being. When it was learned that WSIB would not cover non-symptomatic quarantines, it was pointed out that employees with no other means could access Employment Insurance. While this may offer some support, the shortcomings of EI become more than evident under such circumstances. Maximum EI benefits were rolled back in 1996 and frozen since 1997. Maximum insurable earnings are set at $39,000/annum, well below average rates of income in Toronto. At benefit rates set at 55% of your insured income, this means anybody taking time off for quarantine could earn a maximum of $413 per week. When we consider what mortgage payments would be on an average home price of $275,371 in Toronto, the inadequacy of this benefit and the necessity to keep at work for many individuals is apparent.

An employees' desire to go to work sick may also have roots in the present downsizing trend. With fewer employees, the threat of further downsizing and the burden of overwork, there is every incentive for the individual to do everything possible to remain at work. The cult of economic efficiency has replaced our sense of obligation to each other as a member of society. There is more perceived value in showing up sick and being a "trooper" than of staying at home and preventing the spread of disease to your co-workers. Clearly, in a new era of deadly viruses, we need to reverse that culture.

At the City of Toronto that extends to an Attendance Management Program that penalizes those who use their sick time. The legitimate use of earned sick days can be used as a factor in deciding promotion as well as warrant discipline or even termination. The use of a certain amount of days can also trigger a degree of harassment, such as the demand for

doctor's notes on a single day's absence. It is not acceptable that employees who are legitimately ill be penalized for their absences. In the age of SARS, the Province should ban the use of such programs to intimidate legitimately ill employees into showing up for work. The Union has repeatedly asked the City to scrap this program.

What was truly surprising during the SARS outbreak was the total absence of a role for Occupational Health and Safety Committees. March 31, 2003 -- three weeks after the first SARS-related death in Toronto -- we wrote to Chief Administrative Officer Shirley Hoy advocating that the central Occupational Health and Safety Coordinating Committee meet immediately to set in motion plans and protocols to deal with the outbreak.

At that point, we had not been consulted at all in defining the City's response to this emergency, despite the fact that many of our members were directly impacted. Local 79 has a responsibility to represent members on health and safety matters, including providing advice to them on the Occupational Health and Safety Act.

It was our opinion that the Occupational Health and Safety Coordinating Committee should have been given the task of defining the at-risk workers within the City of Toronto, develop strategies for their protection, draft protocols on who has the authority to quarantine individuals, and put in place a plan for effective communications during this period.

While the Occupational Health and Safety Coordinating Committee eventually did meet upon our insistence, its work and input had been usurped by a team of senior management who had completely taken over without any front-line or union representation. Instead, the Committee met only once for a so-called "information session" and to listen to our concerns. No follow up meeting was proposed on this subject.

This top-down approach to managing the emergency only fueled anxiety, miscommunication and inconsistency of approach.

That inconsistency of approach could be seen in the City's dental services, for example. While the dentists, hygienists and their assistants upgraded to N95 masks during this period, those left to screen patients at the door were given no protection whatsoever. If it was felt that there might be a threat to the dental staff to warrant upgrading their protection, how is it that front line staff in the same office would have been completely denied any protection?

The union had specifically asked that any City staff member who felt vulnerable be allowed to choose for themselves whether or not to wear personal protective equipment. We had argued that it was unlikely staff would show up at every service counter wearing masks given the fact that the discomfort would be a major factor in assessing one's personal risk. We were particularly concerned about those who may have compromised immune systems.

Instead of a clear answer, Chief Administrative Officer Shirley Hoy wrote to us on April 17, 2003 that: "we will accommodate employees when they present confirmation of the need to be accommodated, as is our regular practice." Hoy went on to state that those who need PPE have already been provided with it. These employees include: paramedics, public health nurses who visit quarantined clients, and in certain cases, fire fighters and water/wastewater employees who may be required to enter quarantined homes to affect emergency repairs.

The City of Toronto failed to specifically provide any accommodation to those with compromised immune systems.

It is our understanding that the lack of resources to deal with a crisis like SARS has been in discussion both at this Commission and in the media. However, we would like to applaud the City of Toronto for establishing the much-needed Hospital Infectious Diseases Unit. The unit, a part of Toronto Public Health, is intended to enhance disease surveillance and the public health response to hospital-based infectious diseases. It is of concern to us, however, that it has been only given funding for two years. We are deeply

concerned that should no similar outbreak take place within that time, we will return to the vulnerable state we presently find ourselves in.

The Province should also make good on its offer to fund 100% of SARS-related expenses. During the outbreak, many staff members were pulled from other areas of prevention and put on the SARS file. Due to the fact that these employees were already on the payroll (funded 50/50 between the Province and the City), the Province did not set aside any funds for the backlog of work created by this reassignment. Effectively, it means we fought SARS by neglecting other transmittable diseases. This is incredibly short-sighted.

What can we conclude from our direct experiences?

1. There needs to be a strong link between occupational health and safety and infection control. The Occupational Health and Safety Committee should not be sidelined during such emergencies. If anything, they should have a clearly defined role to play and become an important conduit for policy and information traveling back and forth between front-line staff and senior managers. They should also meet on a regular basis during such crisis, possibly daily. Any issues raised by the Occupation Health and Safety Committee during such emergencies should be dealt with promptly, as opposed to the 21 days under the Occupational Health and Safety Act.

2. The reliance of part-time work means that transmittable diseases are more likely to move from one health care facility to another as part-time workers frequently maintain several jobs in order to support themselves. We need to fix the balance and move towards more full-time work. As a component of that, more stable long-term funding is required for all health care service providers to reduce cross over between institutions and to give employers the ability to provide full-time work.

3. Better coordination is required between the Province and Toronto Public Health.

4. Every encouragement should be given for staff to stay at home when ordered under quarantine, including removing any financial penalty. The public sector should show particular leadership on this issue.

5. If we are to rely on the Employment Insurance system during a major outbreak, especially in cases where no other compensation is possible, we should re-examine compensation levels and ease of access in such circumstances.

6. Sick leave should be a fundamental right written into legislation. To penalize an employee for legitimately taking earned sick leave should be a violation of the Occupational Health and Safety Act.

7. Failure of an employer to take reasonable precaution during a period of outbreak should be treated in much the same way as work-related injuries are treated. Any employer who knowingly fails to send home symptomatic or at-risk staff, or fails to provide reasonable personal protection equipment, should be subject to penalties in much the same way as they do when they fail to protect workers against injury.

8. During such declared emergencies, employees should have the right to a speedy appeal of any assessment that they feel compromises their right to protect themselves.

9. Whistleblower legislation is necessary for any employees who feel an employer is putting themselves or the public at risk.

10. No significant downsizing should occur in either the private or public sector without the requirement for a health and safety assessment, much in the same way an environmental assessment is required before any major new development takes place. We need to recognize overwork as a growing health and safety concern.

11. A new culture of health and safety is required that takes priority over economic concerns. We could argue that the SARS outbreak has proven that health and safety precautions and economic prosperity are, in fact, linked.

12. Municipalities should be required to develop clear protocols to put in place in the event of a similar outbreak. Those protocols should be clearly understood by all departments, staff, and their representatives.

13. The working environments of all public sector employees who interact with public should be examined to minimize risk of transmittable diseases. That includes restoring safety shields for all counter employees, not just those at Toronto Community Housing Corporation.

14. Long-term funding should be committed to improving the delivery of public health, including Bridgepoint Hospital, the Homes for the Aged, and the new Toronto Public Health Hospital Infectious Diseases Unit.

CUPE Local 79 is continuing to evaluate its SARS experience. We would be pleased to provide any additional information on any of the issues we have raised today. Thank your for your consideration.