CHAPTER SEVEN: Aftermath

Airport Screening

Airport screening was a controversial matter that, in the end, turned out to contribute little or nothing to the fight against SARS. When SARS was over, it was clear that airport screening was ineffective and that the most effective screening point was the first portal to the health system, whether it be advice from a family doctor or a trip to a hospital emergency room.

The screening measures were the subject of great bickering between the Ontario and federal governments, which regrettably showed the tendency of governments sometimes to fight rather than fix. The lesson learned is that in crisis governments must forgo political sniping and join together in the job of protecting the public.

Health Minister Tony Clement at one point wrote federal Health Minister Anne McLellan to complain that screening measures at Pearson International Airport in Toronto were not vigorous enough to prevent SARS from entering Ontario.[846] Two and a half weeks later, the WHO issued a travel advisory against Toronto, and McLellan was accused in the House of Commons and elsewhere of bringing on the advisory by ignoring requests for better screening of people entering the country.

Medical professionals questioned the effectiveness of the airport screening. For example, Ontario's then Commisioner of Public Safety and Security, Dr. James (Jim) Young, told the CBC that the chances of the screening process catching someone with the disease were slim:

> The airport isn't picking the cases up. People come in, and then they get sick and they go to hospital. We ask them questions if they're sick and we pick them up there.[847]

846. Letter from the Honourable T. Clement, Minister of Health Ontario, to the Honourable A. Anne McLellan, Minister of Health Canada, April 4, 2003.

847. "Airport screening ineffective against SARS," CBC news online, www.cbc.ca, June 11, 2003.

Dr. Andrew Simor, a microbiologist at Sunnybrook, said the airport screening measures were put in place largely to try to satisfy the World Health Organization (WHO):

> The reality is I don't think it was really warranted and I think the costs used for airport screening could well have been spent on other sorts of control measures.[848]

On April 3, 2003, a WHO official described the Pearson Airport screening as an example of best practices.

SARS was not detected by any measure utilized by Health Canada at Canadian airports, as described in the Naylor Report:

> As of August 27, 2003, an estimated 6.5 million screening transactions occurred at Canadian airports … None had SARS … The pilot thermal scanner project included most inbound and outbound international passengers at Toronto's airport … and again none were found to have SARS.[849]

The federal government instituted airport screening on March 18 in hopes of decreasing the risks of travellers importing SARS from Southeast Asia. The initiative began with Health Alert Notices (HANs): posters directing arriving passengers to pick up information on signs and symptoms of SARS and to see a physician if the symptoms developed. This information was printed on 8" by 11" yellow cards and included key telephone numbers.

Vancouver and Toronto international airports received the yellow HANs first, then the initiative was expanded to 12 other airports that received international travellers who might have been in the Far East. Also included were 18 land border crossings to the United States.

On April 3, the federal government distributed "cherry cards" to passengers departing Toronto's Pearson Airport on international flights. This was expanded on April 7 to include Toronto Island Airport and the train stations:

848. "SARS threat persists, screening wanes," *Toronto Star*, November 20, 2003.
849. Naylor Report, p. 205.

> With the advent of SARS transmission in Toronto, Health Canada implemented similar HANs in a different color (cherry) to mitigate the risk of exporting SARS cases. The cherry-colored HANs were distributed to persons departing for international destinations from Toronto's Pearson International Airport. Passengers with symptoms or signs of SARS were asked to self-defer their travel. In these instances, Health Canada requested airlines to waive their policies on non-refundable tickets, and while many did so, the refund and rescheduling policies and conditions were not uniform.[850]

Six days later, in-flight distribution of yellow cards and contact forms began on nine airlines with flights from Asia. The program underwent a series of expansions and revisions, the most significant being the implementation of thermal screening at airports. On May 23, six thermal scanners were set up in Toronto's Pearson Airport for all incoming and outgoing international travellers. This followed a pilot study started May 8:

> In parallel to these measures, Health Canada initiated a pilot study on May 8, 2003, on the use of infrared thermal scanning machines to detect temperatures >38˚C in selected international arriving and departing passengers at Vancouver's International and Toronto's Pearson International airports. Thermal scanning complemented other measures in the overall screening process by helping to triage the large volume of passengers who transit airports. Any passenger with an elevated temperature reading was referred to the screening nurse for confirmation, completion of the screening protocol, and referral to hospital, if necessary.[851]

A study by the Public Health Agency of Canada (PHAC) provided statistical data regarding the number of travellers screened during SARS:

> As of July 5, 2003, a total of 1,172,986 persons received either yellow or cherry HANs. A total of 2,889 persons answered yes to at least 1 screening question on the HAN and were referred to secondary screening according to protocol. None of the 411 outbound passengers who were

850. R.K. St. John, A. King, D. de Jong, M. Bodie-Collins, S.G. Squires, T.W.S. Tam, "Border screening for SARS, *Emerging Infectious Diseases* 11, no. 1 (2005), http://www.cdc.gov/ncidod/EID/vol11no01/04-0835.htm (St. John et al, "Border Screening for SARS").

851. St. John et al, "Border Screening for SARS".

> referred for secondary screening in Toronto were asked to defer their travel. All persons were cleared, and none were referred for additional medical examination.
>
> In addition, 763,082 persons (467,870 inbound and 295,212 outbound) were screened by the thermal scanners. Only 191 persons had an initial temperature reading of 38°C and were referred for secondary evaluation. No data were collected systematically to correlate thermal scanner results with results of temperature taking by secondary screening nurses. Some of the persons arriving or departing Toronto and Vancouver airports were screened by both HAN and thermal scanning measures.[852]

It became apparent that airport screening did not work and that the best way to identify SARS cases was at the first point of entry to the health system, Dr. Young said on the CBC. Later studies supported what Dr. Young claimed at the time. The PHAC study concludes:

> We suggest that in-country, acute-care facilities (hospitals, clinics, and physicians' offices) are the de facto point of entry into the health care system for travelers with serious infectious diseases.

One of this study's authors, Dr. Ron St. John, was quoted in another article as saying:

> They didn't detect any SARS … Sometimes what seems like a reasonable thing to do doesn't turn out that way.[853]

Another study, from the U.K., reported in the *British Medical Journal*, has similar findings:

> Entry screening is unlikely to be effective in preventing the importation of either SARS or influenza. The incubation period for SARS is too long to allow more than a small proportion of infected individuals to progress to symptomatic disease during flight to the UK from any destination.[854]

852. St. John et al, "Border Screening for SARS".
853. "Screening methods used during SARS outbreak had limited success: study" The Canadian Press, December 28, 2004.
854. *British Medical Journal*, September 23, 2005.

Dr. Naylor gave a presentation to the Standing Senate Committee on screening systems that were used during SARS. He stated that there is a need for information in people's hands and for a good public health infrastructure to support the information being handed out:

> Absent that, you have to focus on two things. One is information. You have to put masses of information in the hands of people. Assuming that most people are good, well intentioned and want to do the right thing, they will bring themselves to public notice quickly if they have suspicious symptoms and have been travelling. Second, you need a strong, local public health infrastructure so that when someone phones and says, "I have this information packet, I was just in wherever and I have the symptoms that match, I am worried that I may have X or Y," there is an instant response. Someone is at the house in 30 minutes. They get the information about what to do on the phone. They are transported, with appropriate precautions, to an emergency room that has an isolation area. They go into hospital, if need be, and into a negative pressure room, if that is required.
>
> There must be a local system that knows how to respond to the traveller who has concerns or suspicious symptoms. We believe, and we have recommended, as I think honourable senators will have read, that there is a need for a multilateral, international process to reconsider travel screening; but also that we need in Canada to take a sober and critical look at the results of our screening activities. Millions of people went through thermal scanners and card systems with no cases detected. Let us have a critical look at it and decide what we need to do as a country in terms of information for travellers and screening.
>
> Quarantine officers are another issue that has been covered in the report in some detail. We need a proper set of quarantine officers at all ports. This is all there. The United States government has become increasingly concerned about global travel as a means for the spread of new or re-emerging communicable diseases … A National Response Guidelines Manual has been developed by the U.S. Department of Transportation which provides a "big picture" for those involved in both planning for and responding to a quarantinable, communicable disease incident at an airport.[855]

855. The Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby, October 9, 2003.

The Commission agrees with Dr. Naylor's observations, as set out in the Naylor Report:

> Screening for a rare disease like SARS in a large population (i.e., millions of travelers) is both difficult and ineffective with an extremely low likelihood of actually detecting cases.
>
> Also, travel screening fails to detect those who may be incubating the disease – these individuals would still be symptom-free. Screening healthy people for infectious diseases should be based on certain premises: that a disease is present in the general population, that it can be detected by screening measures, and that there is a high risk of transmission by asymptomatic individuals. None of these conditions were met by SARS. In the absence of such features, screening healthy people is expensive, possibly highly intrusive, and can create a false sense of security or needless anxieties.[856]

The screening program was well intentioned and was somewhat helpful in that it provided some information to the public. However, it turned out in SARS to be an ineffective measure with the potential to divert resources from more effective work and can create needless anxiety in individuals and a false sense of public reassurance.

856. Naylor Report, p. 206. The Naylor Report made a series of recommendations to ensure that travel screening is imposed only when evidence suggests it will be effective, to improve quarantine officer resources, to improve communication of health risk to travellers and the travel industry and to develop cooperative intergovernmental protocols to these ends. The Commission endorses the thoughtful recommendations of Dr. Naylor, listed at p. 207 of his report.

The SARS Alliance

During the second SARS outbreak, the Ontario government decided to concentrate the treatment of SARS in four key hospitals that became known as the SARS Alliance. It was a decision made in an emergency, but one that was not widely acclaimed.

The SARS Alliance was a stopgap measure for a provincial or regional emergency plan that, as noted elsewhere in this report, Ontario did not have in place.

The hospitals designated were North York General Hospital, St. Michael's Hospital, Scarborough General Hospital and the William Osler Health Centre. The idea behind the move was to concentrate the treatment of SARS to these four hospitals. This would pool the expertise that had developed and, it was hoped, would free up other health care facilities to carry out their normal functions without the heavy burden of dealing with SARS patients.

Tony Clement, Ontario's Minister of Health at the time, said in a media release:

> We are concentrating the treatment and expertise of SARS at four key sites around the Greater Toronto Area to ensure we quickly identify and contain the disease during this current wave of cases … This will help us protect the capacity of the health care system as well as ensure that the health care system in the GTA keeps running safely and efficiently.[857]

Mr. Clement said the four hospitals would work together:

> … to develop a plan for moving patients in alternative levels of care, establish specialized units with dedicated staff, formalize agreement on staffing, resources and supplies, and ensure transfer protocols are in place.[858]

857. Ontario Ministry of Health and Long-Term Care, media release, Canada News Wire, May 27, 2003.
858. Ontario Ministry of Health and Long-Term Care, media release, Canada News Wire, May 27, 2003.

People interviewed by the Commission and those who spoke at the public hearings praised those who volunteered to work at the Alliance hospitals, but generally the move received a lukewarm reception.

The most critical comment came from an emergency medicine physician who worked in various capacities during the outbreak. In a submission to the Commission, he said that the SARS Alliance provided minimal, if any, benefit:

> NYGH, Scarborough General frequently did not have beds. Etobicoke General was not prepared until late to accept patients, and St. Michael's Hospital appeared to limit its transfers to intubated patients. The cost was prohibitive as nurses and other were given 2x contract pay. The non-SARS hospitals still had to care for SARS patients while waiting for beds and were not being paid the same rates. This pay inequity led to tremendous anger with some staff taking leave of absence or resigning.[859]

In hindsight, the physician said, it would have been better to protect some hospitals that provide specialized care such as trauma, burns, surgery and oncology from accepting SARS patients.[860]

The additional pay at the SARS Alliance hospitals was clearly a contentious issue. The Naylor Report noted that it created inequities, as health workers at other hospitals who had treated SARS patients did not get the benefit of double-time pay. Dr. Naylor also noted that the Ministry of Health and Long-Term Care did not sanction the move:

> The SARS Alliance hospitals chose to provide double-time pay to those individuals working in SARS affected areas/SARS units. The OMHLTC did not sanction this action. It was heavily criticized from an equity perspective since other hospitals that treated SARS patients did not provide the same benefit to their staff. Further, staff were provided the additional salary whether or not the SARS unit they worked on actually treated SARS patients. As a result, in some cases staff treating SARS patients received no added compensation benefit, while others who did not treat SARS patients did receive additional compensation.[861]

859. Dr. Laurie Mazurik, submission to the SARS Commission, September 7, 2003, p. 2.
860. Dr. Laurie Mazurik, submission to the SARS Commission, September 7, 2003, p. 2.
861. Naylor Report, p. 154.

The Ontario College of Family Physicians paid tribute to those who volunteered when North York General Hospital was asked to become a SARS Alliance hospital. The College's Executive Director and CEO, Jan Kasperski, told the Commission at its public hearings:

> … they quickly stepped up to the plate. I can tell you that no one was thrilled with the idea, but it was their own colleagues, their co-workers, who had fallen ill, and they wanted to bring as many of them as possible back into their own institution so they could care for them … Several family physicians and our residents volunteered to act as the attending physicians on the SARS ward.[862]

The president and CEO of a Toronto-area hospital was not impressed with the SARS Alliance as a response to the crisis:

> I think there needs to be much more focus on infection control so that you can handle these things … Designating a SARS hospital [is not enough]. Next week it's some other disease.

She said she favoured a more general approach:

> This was an outbreak. We didn't know what it was. So you're designating something [SARS Alliance] way after the fact. Its [success depends] on how you deal up front with something that you don't know about. My own view is that you have to, as much as possible, put in place mechanisms which control the possibility of those outbreaks occurring.

She told the Commission that such precautions should include universal precautions and building hospitals that can handle the virulent diseases that may be on the horizon:

> I think what you need [is] to have hospitals that can deal with outbreaks of infectious diseases. You need hospitals where, when people come into an emergency department, it's not like a cattle car and they're all put together … I think somebody talked about the reality of coming into an emergency department with somebody sitting, or in the next cubicle, two

862. SARS Commission Public Hearings, October 29, 2003.

> feet away. Hospitals aren't designed to deal with these diseases, whether it's emergency departments, intensive care units, etc.

But she said that newly constructed hospitals are taking these problems into account:

> Hospitals are built now to handle the really virulent diseases that you get. If you look at the evolution, for instance, of intensive care units in the country, it used to be that an intensive care unit [ICU] was one big room and there'd be a nursing station at the front and you'd sit and watch all the patients … Over the years, new ICUs are built now where they're all individual rooms. One of the reasons is that if you get [an outbreak], you have to shut down the whole ICU … If any hospital would have to shut down an intensive care unit, it would be a mess. So there is now a move towards having ICUs that are individual rooms with individual air pressure systems so if you have a patient in a room with a infectious disease, you could handle that through negative air pressure.

The SARS Alliance was a decision made in the middle of a crisis, and it is hard to fault the government for trying to get control over the situation. But it would have been much better to have an emergency plan in place that had already considered and resolved the issues that arose when the SARS Alliance hospitals were designated during SARS.

Ministry of Labour Investigations

The Ministry of Labour, pursuant to the *Occupational Health and Safety Act*, investigated the SARS deaths of nurses Tecla Lin and Nelia Laroza and of physician Nestor Yanga[863] and conducted occupational illness and critical injury investigations into the illness from SARS of 146 health workers. Although these investigations and the legal decisions arising from them are not at the core of the Commission's mandate, they do come within its outer margins and warrant brief comment here.

Investigations into the deaths of Ms. Laroza and Ms. Lin recommended the laying of charges under the *Occupational Health and Safety Act*. In the case of Dr. Yanga no such recommendation was made.

To guard against potential conflict of interest, the charge screening process was conducted outside the Ministry of Labour, by Crown counsel at the Ministry of the Environment. Following these reviews, decisions were made not to lay charges in connection with either the death of Ms. Laroza or the death of Ms. Lin.

The decision whether to lay charges as a result of any Labour investigation, including these investigations, is made in the end by Ministry legal advisors on the basis of investigation reports and of legal and quasi-judicial considerations, for example: Are there in law reasonable and probable grounds to believe that there has been a violation of the *Occupational Health and Safety Act*? Is there a reasonable prospect of conviction if charges are laid? Are defences open to the potential accused, such as due diligence or necessity? Is it in the public interest to proceed with charges in particular case? The basis of the legal decision not to lay charges in these cases is beyond the reach of the Commission because the legal opinions that underpin those decisions are the subject of a claim of solicitor-client privilege asserted by the Ministry of the Attorney General.

863. The names of Ms. Lin, Ms. Laroza and Dr. Yanga are used here because the circumstances of their illnesses and deaths are in the public domain.

None of the critical injury[864] and occupational illness[865] investigations into how 146 health workers contracted SARS recommended the laying of charges.

These investigations were seriously hampered by the fact that they did not begin until February 2004, leaving insufficient time for a full and thorough investigation before the expiry in March 2004 of the time for laying charges imposed by the one-year limitation period under the *Occupational Health and Safety Act*.

In all, the Ministry received 146 occupational illness and critical injury notifications and three fatality notifications.[866] Under the *Occupational Health and Safety Act*, employers must notify the Ministry in writing of a critical injury within 48 hours of the occurrence[867] and of an occupational illness within four days.[868] This timely notification allows the Ministry the opportunity to quickly investigate the events that led to the critical injury or occupational illness and to prevent its recurrence.

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864. A probable case of SARS was considered a critical injury.

865. A suspect case of SARS was considered an occupational illness.

866. There were major problems with the notification process. The Ministry told the Commission:

> The majority of these notifications were received after employers were ordered to do so by MOL inspectors. (Ministry of Labour, submission to SARS Commission, March 15, 2006, p. 19)

867. Section 51. (1) of the Act states:

> Where a person is killed or critically injured from any cause at a workplace, the constructor, if any, and the employer shall notify an inspector, and the committee, health and safety representative and trade union, if any, immediately of the occurrence by telephone, telegram or other direct means and the employer shall, within forty-eight hours after the occurrence, send to a Director a written report of the circumstances of the occurrence containing such information and particulars as the regulations prescribe.

868. Section 52. (2) of the Act states:

> If an employer is advised by or on behalf of a worker that the worker has an occupational illness or that a claim in respect of an occupational illness has been filed with the Workplace Safety and Insurance Board by or on behalf of the worker, the employer shall give notice in writing, within four days of being so advised, to a Director, to the committee or a health and safety representative and to the trade union, if any, containing such information and particulars as are prescribed. R.S.O. 1990, c. O.1, s. 52 (2); 1997, c. 16, s. 2 (12).

Note that the Act defines "Director" as follows: "Director means an inspector under this Act who is appointed as a Director for the purposes of this Act; ('directeur')."

On February 24, 2004, teams of inspectors were assigned to begin investigations at Toronto Emergency Services, St. John's Rehabilitation Centre, North York General Hospital, the Scarborough Grace and Scarborough General Division hospitals, and Mount Sinai Hospital. On March 3, 2004, another team was assigned to begin an investigation at Sunnybrook.

The investigations faced a time constraint because section 69 of the *Occupational Health and Safety Act* states that charges must be laid within a year of the event under investigation:

> Limitation on prosecutions
>
> 69. No prosecution under this Act shall be instituted more than one year after the last act or default upon which the prosecution is based occurred. R.S.O. 1990, c. O.1, s. 69.

The delay in starting the investigations meant that Ministry inspectors were pressed for time. Observers familiar with the investigation said the late start date did not leave the investigators enough time to do a proper investigation, that they basically ran out of time.

The problem was not the competence of the investigators or the quality of their investigation, both of which appeared to the Commission to be high, but the delay in giving the investigators the go-ahead to proceed.

In explaining why these investigations were not begun earlier, the Ministry said:

> Investigations of the fatalities and preparation for the investigations into the occupational illnesses and critical injuries began prior to the receipt of the reports. The reports were received by MOL in early February 2004, and the MOL was then able to continue its investigations into all 146 occupational illness and critical injury notifications and the 3 fatality notifications.
>
> The MOL carries out a significant number of highly complex investigations such as structural collapses, geological stability, and asbestos removal each year involving input from various experts and information from a wide variety of sources. For the most part, these investigations involve long standing generally accepted scientific, engineering and/or medical standards.

> The SARS investigations, however, presented an even higher level of complexity. Information with respect to SARS continued to evolve from day one of the outbreak until well after the emergency was declared over. The criteria for a diagnosis of SARS changed during and after the outbreak as did the information with respect to its transmission. As a result, the MOL was required to analyse all of the POC [Provincial Operations Centre] directives issued during the outbreak as well as the evolving information from the WHO and other organizations involved in the ongoing monitoring of SARS.
>
> Unlike the overwhelming majority of workplace hazards, SARS was not a hazard localized to one particular workplace or even one area within a workplace. Contact tracing with respect to each worker, as reported by Toronto Public Health, had to be followed up by the MOL to attempt to determine where a worker had contracted SARS (i.e., a workplace, a public gathering or location other than a workplace). The movement of workers diagnosed with SARS was tracked within hospitals as well as from one facility to another to determine what precautions had been taken to ensure the disease was not spread within a facility, to the public at large and to the facility where a worker may ultimately have ended up. Details such as where and in which order personal protective equipment was put on and removed was analyzed.[869]

The investigations were begun very late into the one-year window for the laying of charges. No matter what difficulties faced the Ministry, and whatever the validity may be of its reasons for starting the investigations so late, it does not generally enhance the reputation of any regulatory and enforcement body if investigations are launched so late that investigators do not have sufficient time to do their work properly.

Public confidence is vital for any regulatory and enforcement ministry. In the case of the Ministry of Labour, this means that investigations into critical injuries and occupational illnesses arising from a disaster of the magnitude of SARS must be commenced expeditiously.

869. Ministry of Labour, submission to the SARS Commission, March 15, 2006, p. 20.

Public confidence in the process of investigation and in the decision to prosecute also requires an element of openness. The system under which the SARS labour investigations proceeded, and under which the decision was made not to prosecute, lacks the degree of openness necessary to secure public confidence.

Whenever a worker safety charge is laid and then proceeds to court, the principle of open justice requires that the proceedings and any decision to terminate proceedings short of a trial take place in public.

The difficulty occurs in cases like this, where the investigation recommended that charges be laid in certain cases and not others, where there have been no court proceedings, and where the public and the families of the deceased and the affected health workers are left completely in the dark.

Public accountability and openness require a better system to inform the public and those affected by these important decisions.

Because this issue is at the outer margin of the Commission's terms of reference, the Commission has no mandate to propose prescriptive solutions. Any prescriptive solution to this problem requires extensive consultation with health worker unions, the Ministry of Labour and the Crown law officers who bear the ultimate responsibility to decide whether charges of this nature will proceed. The solution is tangled up in a knot of laws that govern worker safety, privacy and freedom of information, and Crown privilege.[870] It is time to cut that knot.

The Commission therefore recommends legislative amendments and policies in relation to the waiver of potential Crown privilege claims, that in such cases where charges do not result from Ministry of Labour and other investigations of deaths and critical injuries in health workplaces, the results of the investigation and the reasons for the decision not to prosecute be made public.

Another problem arose during the course of the worker safety investigations, and also in the investigation by the North York General Joint Health and Safety Committee, that requires comment. That problem has to do with the amenability of

870. These problems are not insurmountable even within the current state of the law, as seen by the extensive reasons given publicly by Attorney General Roy McMurtry for a number of decisions not to prosecute high-profile cases, including those of Dr. Henry Morgentaler and the Honourable Francis Fox.

doctors to the system that protects worker safety and investigates workplace deaths and injuries.

Difficulties arose during the Ministry of Labour death and critical injury investigations and the North York General Joint Health and Safety Committee investigation in respect of the status and obligations of hospital doctors under worker safety legislation. Doctors, by the nature of their work, are often obliged to give orders and directions to nurses and others that could affect their safety in the workplace. But every doctor is not an "employer" within the meaning of current safety legislation. Many doctors whose work has a profound effect on worker safety have arguably no obligations under safety legislation and arguably no obligation to cooperate with investigators who try to find out what happened in a worker's death or critical injury.

The problem is clear; the solution, less so. Independent doctors will be concerned about any legislation or regulation that makes them look like hospital employees or employers of hospital staff. Any solution must take account of these legitimate concerns about physician independence.

But those concerns should not frustrate the ability of our worker safety systems to get to the bottom of what has happened in the death or critical injury of a health worker. It makes no sense that two doctors work side by side, a hospital administrator and an independent physician in the hospital, each of them with a profound effect on the safety of hospital employees – one of them within the worker safety regime and the other completely exempt from that protective framework.

Worker safety in hospitals and in other health care institutions requires reasonable legislative measures to include all physicians within the worker safety regime without interfering with the essential independence of the physician and without making her a hospital employee.

Such legislative measures may need to include not only the *Occupational Health and Safety Act* but also those statutes which govern the administration of health care institutions and the medical profession.

It would be presumptuous for the Commission to recommend a prescriptive solution at this time. That task will require a good measure of consultation and a thorough analysis of the complex professional and statutory framework within which doctors work in health care institutions.

The Commission recommends the amendment of worker safety, health care and professional legislation to ensure that physicians who affect health worker safety are not excluded from the legislative regime that protects health workers. Because the prescriptive solution will require consultation and analysis and time and patience, it is essential to start now.

Seven Oaks: A SARS Footnote

Introduction

In the fall of 2005, an outbreak of legionnaires' disease[871] swept the Seven Oaks Home for the Aged in Toronto, infecting 70 residents, 39 staff, 21 visitors and five other people who lived or worked nearby. Twenty-three residents died.[872] The outbreak brought back memories of SARS and initially some talk about whether SARS was back.

Unlike SARS, legionnaires' disease is not spread by person-to-person contact. Instead, people are infected when they inhale mist from a water source with high concentrations of the *Legionella* bacteria. The source of the Seven Oaks outbreak was likely its cooling tower.[873]

Seven Oaks brought back memories of SARS[874] largely because of the mystery surrounding its causative agent, which was not identified until October 6, 2005, nearly two weeks after the first residents started getting sick.

The Ministry of Health commissioned an expert panel to investigate the response to the outbreak. The panel comprised two physicians who led the fight against SARS and another who had chaired an important SARS policy study.

871. A type of pneumonia caused by the *Legionella pneumophila* bacteria, it was first identified in 1977 after causing 34 deaths at a 1976 American Legion convention in Philadelphia.

872. Ministry of Health and Long-Term Care, *Report of the Expert Panel on the Legionnaires' Disease Outbreak in the City of Toronto September/October 2005*, December 2005, p. 4 (Seven Oaks Report)

873. "Given the high attack rate in the Seven Oaks facility, it seems very likely the long-term care home's cooling tower was the source, despite the fact that the home and its water and cooling systems were well maintained and that the maintenance program met current standards" (Seven Oaks Report., p. 28).

874. CNN sent a reporter to Toronto to cover the Seven Oaks outbreak. In a report broadcast on October 5, 2005, he said: "Keep in mind it was just two years ago there was a severe outbreak of Severe Acute Respiratory Syndrome, or SARS, right here in Toronto. Forty-four people died. There were certainly a lot of jitters in the community about that back then."

The Seven Oaks report provides the Commission with an opportunity to comment on developments in the health system since SARS.

The report said:

> The Legionnaires' outbreak was the first time since SARS in 2003 that Ontario faced the threat of an illness that could not be easily or quickly identified. It was also the first opportunity to test the lessons learned from SARS.[875]

Seven Oaks and Worker Safety

As noted throughout this report, the Ministry of Labour was largely sidelined during the SARS outbreak. When the Centers for Disease Control and Prevention (CDC) sent a team to Toronto to investigate the infection of nine health workers at Sunnybrook on April 13, 2003, for example, no one thought to notify the Ministry of Labour that a worker safety investigation was being conducted at Sunnybrook.

Two years after SARS, the Seven Oaks panel investigated an outbreak in a workplace where nearly 30 per cent of the victims were workers, but the Ministry of Labour was not an integral partner in the investigation[876] and the panel's membership did not include a worker safety expert.

This does not reflect on the qualifications and expertise of the three panel members, who are leaders in their fields and internationally recognized. It does show that worker safety is still not taken as seriously as it should be. It also meant that the panel, unfortunately, was not given the kind of worker safety expertise this type of investigation requires. That this would have been of value was demonstrated in a letter the Ministry of Labour sent to the Ministry of Health in February 2006. The letter identified issues that could have been better understood if the panel had had Ministry of Labour and worker safety representation.

The Seven Oaks report said:

875. Seven Oaks Report, p. 4.

876. The expert panel did interview one or more officials at the Ministry of Labour. See page 41 of the Seven Oaks Report for a list of organizations that were interviewed.

> EMS workers were wearing a higher level protection, including N95 masks, as is the norm for their practice. EMS workers have a different standard for personal protective equipment because they regularly go into environments where the health risks are unknown. Their standard PPE is designed to protect them from toxins and chemical contaminants in the environment as well as infectious disease. Although the differences in PPE are based on science and practice, they are not well understood in the workplace.[877]

Labour responded:

> In MOL's view, based on "science and practice", EMS workers would require a supplied air respirator or a self-contained breathing apparatus for suitable protection against "unknown" chemical hazards. An N95 respirator would not be suitable, for example, where the unknown risk was from carbon monoxide. The use of an N95 in the presence of carbon monoxide may result in serious disability or death to the EMS worker. In fact, EMS workers use N95 respirators for protection against unknown infectious agents and for protection during high-risk aerosol generating procedures such as intubation and pulmonary suctioning. An N95 respirator is not suitable for protection against unknown "toxins of chemical contaminants". This report, in endorsing this incorrect use of N95 respirators, may lead to significant morbidity and mortality among EMS workers when exposed to unknown chemical health risks.[878]

The Seven Oaks report said:

> Ontario does not have specific standards for environmental maintenance.[879]

Labour responded:

877. Seven Oaks Report, p. 21.
878. Appendix to February 22, 2006, letter from Virginia West, Deputy Labour Minister, to Ron Sapsford, Deputy Health Minister.
879. Seven Oaks Report, p. 29.

> This statement is not correct. In fact, the *Occupational Health and Safety Act and Regulation* contains requirements to prevent Legionella growth in water and ventilation systems.[880]

Any deficiencies in the Seven Oaks report do not reflect on its distinguished authors, who, unfortunately, were not provided with sufficient worker safety expertise. These deficiencies are, however, sadly reminiscent of problems during the SARS outbreak when the response to the outbreak lacked sufficient involvement of the Ministry of Labour and of independent Ontario worker safety experts.

Also reminiscent of SARS and the sidelining of the Ministry of Labour was the recommendation of the Seven Oaks report that Labour's standard-setting powers regarding worker safety be given to the Ministry of Health.

The Seven Oaks report recommended:

> 3.2 Clarifying the responsibilities of different ministries and ensuring consistent messages (i.e., making the Ministry of Health and Long-Term Care responsible for establishing policy regarding the appropriate infection prevention and control measures in an outbreak and the Ministry of Labour responsible for enforcing and ensuring compliance with that science-based policy).[881]

SARS demonstrated that worker safety requires an independent regulator with two important roles. First, the regulator must be responsible for the development of worker safety standards that reflect the latest scientific research, occupational health and safety expertise and best practices, and the standards recommended by other agencies, such as the National Institute for Occupational Safety and Health (NIOSH). Second, once safety standards are set, the regulator must ensure that all workplaces are aware of and in compliance with those standards.

It would be improper for the Ministry of Health, as the Ministry that funds and oversees the health care delivery system, to regulate itself and the system for which it is responsible. This would place it in an untenable position.

880. Appendix to February 22, 2006, letter from Virginia West, Deputy Labour Minister, to Ron Sapsford, Deputy Health Minister.
881. Seven Oaks Report, p. 35.

The Seven Oaks report also argues against taking a precautionary approach to personal protective equipment:

> While many may think that, in terms of infection prevention and control, "more is better" – that is not the case. There are serious and inherent risks – to health care providers, to patients and to the system – in using higher-level precautions when they are not required.[882]

The report lists six risks related to what it called an inappropriate use of higher-level precautions:

- Personal protective equipment is uncomfortable and difficult to put on, so it is often misused or worn improperly
- Errors are more common
- Workers tend to become over confident in their equipment and neglect other key measures, such as hand hygiene
- Health care providers experience health problems (e.g., rashes, problems breathing)
- Patient care may suffer
- It is costly and uses supplies that may be required when the system is faced with diseases that require that level of protection[883]

Representatives of health workers took issue with the report's arguments against the precautionary principle:

> On page 22, the report lists the "Risks of Inappropriate Use of Higher Level of Precautions." We do not accept that any of the factors on this list offer a compelling argument against accepting the precautionary principle and providing better respiratory protection. The first risk cited is that "personal protective equipment is uncomfortable and difficult to put on, so it is often misused or worn improperly." The work environment of an HCW [health care worker] is not known for its ease or comfort. It is our

882. Seven Oaks Report, p. 22.
883. Seven Oaks Report, p. 22.

experience arising from SARS that most workers are prepared to accept a certain level of discomfort if they believe it may save their lives. We have seen no evidence to support the statement that because the equipment is uncomfortable or difficult to put on that it is *often* misused or worn improperly. Our experience during SARS was that workers had never been fit-tested, nor had they received prior training about putting on and wearing N95s and other new PPE – consequently, they made errors. However, the problem was lack of training and experience, problems which can be readily addressed.

The next risk cited is that "errors are more common." We have no idea of what kind of errors are being referred to, or what evidence there is of these "errors."

Next, the report states that "workers tend to become over-confident in their equipment and neglect other key measures such as hand hygiene." It is [a health workers' union's] experience that this is true in some instances, especially around the use of protective gloves and hand-washing. This has been documented in studies and anecdotally. However, no one has suggested that protective gloves should be abandoned because workers fail to wash their hands properly. The focus has been on developing guidelines on when gloves should be worn, what kind of gloves should be worn and ongoing training to ensure that workers wear gloves appropriately and practice good hand hygiene. Consequently, we do not find this a compelling argument to decide not to provide N95 respirators.

Another risk listed is that "health care providers experience health problems (e.g., rashes, problems breathing)." In the early 1990s when HCWs began to develop latex allergies that were in some cases life-threatening, no one suggested that HCWs should no longer be provided with gloves to protect them from infectious agents. Once the allergy was better understood, scientists and manufacturers worked to develop alternative gloves that would not make HCWs sick. Within less than 10 years, it was rare to find an HCW who could not be accommodated back into her workplace using a non-latex or low protein latex glove. It is simply unacceptable for the Panel to suggest that because some PPE may cause health problems that workers should not be offered proper respiratory protection. Most workers will be able to find an appropriate N95 respirator that will not cause a rash. Some workers may need other accommodations.

> The report states that "patient care may suffer." [A health worker union] does not know what evidence the Panel is using to support that statement. It is our position that in cases where workers are afraid of contracting an unknown illness and where they believe that their employer is not taking all reasonable precautions to protect them, it may have an effect on the quality of care they are able to deliver.
>
> The final risk is that higher level precautions are "costly and uses supplies that may be required when the system is faced with diseases that require that level of protection." If we believed that N95 respirators were unjustified, we would accept that statement. However, since it is our position that in cases where there is a risk of airborne infection, N95s should be used, we do not accept it.[884]

Other representatives of health workers also took issue with the Seven Oaks Report's arguments:

> A day in the life of a health care worker is replete with all varieties of discomfort. While health care workers (like all workers) would prefer not to wear respirators, they are prepared to adjust to discomfort when necessary to make the very air they breathe safe for themselves and safe to pass on to patients and family. Firefighters, steelworkers, chemical workers and others have for decades routinely crouched in cramped, confined spaces for hours at a time, dragged down by much heavier respiratory protection than the N95 respirators … Given information and training about hazards and the need for respiratory protection, all workers tolerate the discomfort.[885]

If the Commission has one single take-home message it is the precautionary principle that safety comes first: that reasonable efforts to reduce risk need not await scientific proof. The Ontario health system needs to enshrine this principle and to enforce it. It is the most important single lesson of SARS, and it is a lesson ignored only at our collective peril.

884. Letter from OPSEU to Premier Dalton McGuinty, January 24, 2006.
885. Letter from ONA to Premier Dalton McGuinty, December 15, 2005.

Conclusion

Seven Oaks showed the good side of Ontario's response to SARS: the excellent worker safety approach taken at North York General Hospital,[886] with the new infection control system under Dr. Kevin Katz in which health workers were enabled to choose the highest level of protection; the good communication between Toronto Public Health and the Ministry of Labour; and the fine leadership shown by Dr. David McKeown, the Medical Officer of Health for Toronto.

Seven Oaks also showed the bad side of Ontario's response to SARS systemic problems that remain unfixed; the problems at the provincial laboratory; the two solitudes between infection control experts and worker safety experts; the exclusion of the Ministry of Labour from the centre of the investigation and the subsequent report; the occupation by the Ministry of Health of worker safety territory, where one would expect greater presence and collegial involvement by the Ministry of Labour; the failure to ensure effective consultation with safety officials from health worker unions; and the strong echo of the turf wars between the health system and the worker safety system that so bedevilled SARS.

Seven Oaks demonstrated that many worker safety lessons of SARS have not been learned.

The Ministry of Labour must be independent in setting workplace standards and in enforcing them. It must be an integral member of the response to any infectious disease outbreak. It must be directly involved in any post-event review of any infectious disease outbreak in which workers have gotten sick. Any post-event review of an infectious disease outbreak in which workers have gotten sick must include worker safety experts.

The Seven Oaks outbreak also demonstrates the continuing reluctance of the health system to fully accept the importance of the precautionary principle in worker safety. Until this precautionary principle is fully recognized, mandated and enforced in our health care system, nurses and doctors and other health workers will continue to be at risk from new infections like SARS.

886. North York General Hospital was one of seven hospitals that treated cases.