13. One Local Story: Parry Sound

SARS was not restricted to Toronto. The northern community of Parry Sound had two probable cases and quarantined 697 people. To quarantine 697 people in a town of 6,500, more than 10 per cent, is the equivalent of quarantining hundreds of thousands of people in the Toronto area[156].

The Parry Sound experience demonstrates that an infectious disease like SARS can emerge anywhere in Ontario and that each local hospital and each local health unit is a vital link in the chain that protects the entire province. The Parry Sound experience also demonstrates the structural weaknesses inherent in the local Medical Officer of Health system. Parry Sound's local Medical Officer of Health had resigned just before SARS II, a later phase of the outbreak that occurred after May 22, 2003, hit. The interim Medical Officer of Health had been on the job for under a week. There was no apparent mentoring or backup system to assist him. This created a dangerous gap in the province-wide system of surveillance directed by experienced local Medical Officers of Health.

The SARS cases in Parry Sound presented at the local hospital, the West Parry Sound Health Centre, between May 23 and June 1. One patient had been an inpatient in the Orthopaedic Ward at North York General Hospital in Toronto and the other patient had visited their spouse at the same ward. They were diagnosed, treated, and transferred to the Toronto area for further treatment. Another suspect case had been at North York General for a diagnostic MRI test. Because her children were also suspect cases, and had attended day care and school, it was necessary to impose the quarantine mentioned above.

More will be said in the final report about the impact of SARS and quarantine on Parry Sound. More will be said about the extra precautions taken by the hospital after SARS appeared to be over, precautions which ensured that the unexpected SARS cases were screened immediately and put under precautions before they entered the emergency department, thus avoiding spread within the hospital. This interim report

156. West Parry Sound Health Centre and the Muskoka-Parry Sound Health Unit, *SARS – Impact in a Rural Community: Parry Sound's Experience*, November 2003.

will deal with the systemic problems in the public health system demonstrated by the Parry Sound experience.

The hospital and the local public health unit faced major difficulties in their attempts to secure information on the actual SARS status of the patients who had been diagnosed with probable SARS or suspected SARS and transferred to Toronto for treatment. A hospital official noted:

> We had extreme difficulty in tracking patients and their status after they left. We still don't know officially whether they had probable SARS.

The hospital and the public health unit faced major difficulties in their attempts to get direction about the quarantine that appeared to be necessary because of the above-noted attendance at day care and school of the children of a suspect SARS case. On Saturday May 31, the senior hospital physicians and officials met all day. They had trouble getting in touch with the very newly designated interim Medical Office of Health who was busy with emergency patients in a hospital in another community about 80 kilometres away. They were unable to reach anyone in Toronto who could speak on behalf of the Chief Medical Officer of Health. The just-appointed interim Medical Officer of Health, when reached, was naturally reluctant to make any decision. It was initially suggested that officials in the local Parry Sound public health unit could make the decision, although in fact the decision to quarantine can only be made under the *Health Protection and Promotion Act* by the local Medical Officer of Health or the Chief Medical Officer of Health in Toronto. No one seemed to be in charge. The interim local Medical Officer of Health referred the local doctors to provincial officials in Toronto, and provincial officials in Toronto referred them back to the interim local Medical Officer of Health. The buck kept passing. The interim Medical Officer of Health tried to get in touch with the appropriate officials in Toronto. This indecision and confusion went on for a good part of the day. Eventually, the decision was made to quarantine but only after a decisive local physician made it clear that if no decision was forthcoming he felt himself bound to alert the media to the danger.[157] To this day the local people do not know how the decision came to be made.

157. This quarantine decision has not been free from controversy. The Ontario Medical Association at the SARS Commission's Public Hearings suggested that ". . . the quarantine recommendation was made without adequate understanding of quarantine protocols. This led to the unnecessary quarantine of nearly 10 per cent of the town's population" (See *SARS Commission Public Hearings,* September 29, 2003, p. 51.) To the people at the ground on the time, struggling to contain what looked like a possible community outbreak, things looked much different than they do now to those who look at the decision with the benefit of hindsight. But everyone agrees that the Parry Sound situation was seriously hampered by the lack of a permanent local Medical Officer of Health.

It ascribes no criticism to anyone to say that the Parry Sound experience demonstrated serious systemic problems in Ontario's public health system. The first problem, the inability to get information about the status of the patients diagnosed with probable SARS is part of the general lack of adequate information and communication systems, noted above.

The second problem, the confusion, indecision, and lack of transparency around the quarantine decision, demonstrates the weakness of a system of local public health control in a province where there are still, notwithstanding the Walkerton recommendations, eight Medical Officer of Health positions that have not been filled on a permanent basis. The Commission has also heard that there is a shortage of potential candidates with sufficient experience in infectious disease control and other public health disciplines.

There was, in the Parry Sound situation, no apparent machinery to support the newly appointed interim Medical Officer of Health; no sign of any mentoring system, no sign that there was anyone to turn to in a crisis for authoritative and experienced advice and assistance. This is no system for an emergency when decisions must be made quickly. It is fortunate, thanks to the judgment of a decisive local physician, that this dangerous gap in the system of public health protection did not lead to serious consequences.

The third problem is that the Muskoka-Parry Sound Public Health Unit, like many others in Ontario, did not have an adequate infectious disease team. Starting at the top, there was an interim temporary Medical Officer of Health who had been on the job less than a week. The position of epidemiologist, a vital function in outbreak management and infectious disease control, had been vacant since 1997. In 2000 the Board of Health agreed to fill the position but the Medical Officer of Health of the day did not think it was a priority. Attempts are now being made to secure approval to recruit an epidemiologist. A full communicable disease team would comprise, optimally, a Medical Officer of Health fully qualified in communicable disease, an epidemiologist, two or three communicable disease nurses, and two or three public health inspectors with communicable disease expertise. Far from a full team, the Muskoka-Parry Sound unit at the time of SARS had only 0.8 of the time of one communicable disease nurse.[158]

158. Some progress is being made. The 0.8 nurse will go to full time on communicable disease. There are now two part time communicable disease nurses in Parry Sound, the equivalent of one full time person. There is now an acting communicable disease manager, which the Board will be asked to turn into a full time position, and there are three public health inspectors trained in communicable disease.

Part of the general problem in recruiting and retaining the necessary professionals is that salaries set by local boards are not always competitive. A public health inspector making $47,000 in a small Ontario unit can move to Alberta tomorrow and do the same work for $60,000. While it is commendable that Ontario hospitals are increasing their infection control capacity by hiring infection control nurses, it is regrettable that they are hiring some of them away from local public health units who cannot compete with the salaries set by hospitals. Balanced against the strengths of local control over public health administration, is this inherent weakness, that local salary differentials can make it very difficult to attract and retain the level of professional expertise required.

If the present system of local control over public health and infectious disease is to be maintained, it is essential that machinery be put in place to ensure continuous unbroken oversight and authority in every public health unit in Ontario supported by the necessary cadre of public health professionals.