



May 3, 2024

TO: CPSO Consultations

**RE: Feedback on “Infection Prevention and Control for Clinical Office Practice” policy and draft “Advice document”.**

Dear CPSO Policy Committee and Board of Directors,

I made some brief comments on this policy via the online survey. However, I felt it important to provide a more cohesive, narrative reply.

My concerns are about the issues not addressed in the draft policy.

**There is a lack of acknowledgement of the importance of maintaining good air quality (both adequate ventilation and HEPA/UV filtration) within the clinical office.** This should be a principle of regular IPAC procedures going forward.

I am concerned that the significance of airborne transmission of disease was not mentioned even once following the worst pandemic of a century, one that claimed over 60,000 Canadian lives (likely much higher). One must ask why?

The Ontario death rate from COVID19 fell by 72% in 2023 compared to 2022 when it was the third leading cause of death. However, 1707 Ontarians died from COVID19 in 2023, over four times the number of motor vehicle related fatalities (1). COVID19 remains a serious health risk in 2024 especially among the elderly and those with predisposing conditions including pregnancy, immunosuppression or primary immunodeficiency, and organ transplantation. Frequent mutations and emergence of new waves of infection about twice annually necessitate at least annual vaccinations to remain well. Superimposed is the re-emergence of highly infectious diseases such as measles and therefore, we must consider the clinical office in light of the evolving risks posed by airborne pathogens.

The focus of this draft IPAC policy is primarily on mitigating the transmission of pathogens via hands or fomites. The COVID19 pandemic taught us this highly infectious disease (SARS-CoV-2) was largely transmitted by airborne aerosols, which linger for many minutes following occupation by an infected person. It also taught us about the significance of pre-

symptomatic transmission of disease, one for which a screening survey is unlikely to be helpful.

In 2024, highly pathogenic avian influenza virus H5N1 is spreading amongst fowl, bird populations, and cattle in North America. Viral particles are present in milk. The CDC is increasingly raising alarms about the risk of transmission to humans. All cattle and poultry workers are urged to wear respirators, goggles, and protective gear in their routine duties (2). Other mammalian species have been infected and extensive deaths have been observed amongst colonies of seals. In keeping with the precautionary principle, it would seem now is the most opportune time to add guidelines and/or requirements for ventilation and HEPA+/-UV air filtration to improve the health and safety of physicians, office staff, and patients alike.

I am a retired Oncologist with a primary immunodeficiency and autoimmune neurological disorder. I am considered high risk for COVID19. My “pandemic” experiences as a patient and physician may be surprising. I am unusual I suppose, in that I have had *several* specialist physician appointments through the pandemic (2020-2023) including my family physician, clinical immunologist, rehabilitation medicine specialist/physiatrist, endocrinologist, neurologist etc. I observed that there wasn’t a uniform approach to COVID19 related IPAC procedures during an airborne pandemic. In one office, no staff or physicians were masked. In several offices the physicians were masked but not the staff. Perhaps several physicians wore the mask below their nose. The physicians who were not masked always offered to put on a mask, but I am sure there is a bias that works against the patient (who doesn’t want to inconvenience one’s doctor). I believe in all those interactions I saw at most, one portable HEPA filter. Contrast these interactions with my dentist visits. Every room was sealed with a vapour barrier or door. Each room had a large, portable HEPA filter while staff wore respirators. Even today, the staff remain masked, and the HEPA filters remain. Dentistry is no doubt higher risk by its nature. Nevertheless, their profession recognizes the airborne spread of respiratory pathogens and actively mitigates transmission in the office. **We should do the same in our offices.**

What I learned from my own advocacy during the COVID19 pandemic is the health profession cannot rely on our provincial government to ensure we have the safest environments in public buildings. My own Freedom of Information (FOIPPA) request to the Chief Medical Officer of Health (CMOH) in October 2022 revealed that the Ontario government chose not to follow advice from a Senior Ministry of Health official, COVID19 Advisory Science Table Members, and Public Health Ontario scientists who all strongly recommended the use of N95 masks by the public to mitigate the spread of COVID19. The CMOH Schools Working Group recommended N95 masks be provided to students who wished to wear them in the fall of 2022 when public health measures were removed from schools. The government also failed to heed that advice. Students, some vulnerable, were not supplied with N95 masks. Student absenteeism in the fall of 2022 was at an all time high. My critical appraisal of the documents provided in response to my FOIPPA request is summarized in my **July 19<sup>th</sup>, 2023, Healthy Debate article: “If public health is not there**

**to protect the vulnerable, then why bother?”**

(<https://healthydebate.ca/2023/07/topic/public-health-not-protect-vulnerable/>).

A more comprehensive document was prepared for opposition MPPs, the Ontario Ombudsman and the Ontario Auditor General: **Stepping Away from an Evidence-Based Public Health Policy and the Precautionary Principle during the Time of Omicron: Did the Ontario Government Fail to Consider the Potential Harms to Highly COVID-19-Vulnerable Ontarians?** (<https://bit.ly/4b2AEdk>)

The spread of previously common pathogens was greatly reduced in the community by mask wearing in public spaces. Mask mandates were associated with about a 50% reduction in COVID19 cases as supported by a modelling study completed by University of Toronto scientists at the Dalla Lana School of Public Health (3,4). There’s no doubt we can reduce the spread of infectious disease in clinical practice by wearing masks. However, if we mitigate aerosols through improved ventilation and HEPA/UV filtration then compliance with masking becomes less of a concern outside of active infectious disease outbreaks. Health Canada is currently developing a policy on improving indoor air quality in office buildings (5). Here the focus is on air exchange and HVAC. Air quality is essential for health.

**The COVID19 pandemic taught us that cleaning the air should be as routine as washing our hands.**

I have encouraged civil engineers to respond to your request for feedback. Even if the guidelines for air quality improvement are voluntary, consider obtaining expert guidance and include those best practice guidelines for the optimal exchange of air volume per hour, use of HVAC or fresh air exchangers, and the use of HEPA + / – UV filtration (central or with portable HEPA filters).

#### **References:**

(1) M. Ogilvie and K. Wallace, “How deadly has COVID been in 2023? Here’s what the Ontario numbers are telling us”, The Toronto Star, Dec. 16, 2023.

([https://www.thestar.com/news/canada/how-deadly-has-covid-been-in-2023-here-s-what-the-ontario-numbers-are-telling/article\\_32b52a12-9b8c-11ee-a23d-a30f2261773d.html](https://www.thestar.com/news/canada/how-deadly-has-covid-been-in-2023-here-s-what-the-ontario-numbers-are-telling/article_32b52a12-9b8c-11ee-a23d-a30f2261773d.html))

(2) Highly Pathogenic Avian Influenza A (H5N1) Virus in Animals: Interim Recommendation for Prevention, Monitoring, and Public Health Investigations. Centres for Disease Control and Prevention, April 15, 2024. (<https://www.cdc.gov/flu/avianflu/hpai/hpai-interim-recommendations.html#:~:text=Farmers%2C%20workers%2C%20and%20emergency%20responders,potentially%20or%20confirmed%20infected%20birds%2C>).

(3) Leech G et al. Mask wearing in community setting reduces SARS-COV-2 transmission.

119(23)e2119266119. <https://doi.org/10.1073/pnas.2119266119>

(4) Peng A, Bosco S, Simmons A, Tuite A, and Fisman D. Impact of community mask mandates on SARS-CoV-2 transmission in Ontario after adjustment for differential testing by age and sex. PNAS February 2024, 3;2:1-8.

(5) Health Canada: “Draft guidance on improving indoor air quality in office buildings: Overview”, <https://www.canada.ca/en/health-canada/programs/consultation-draft-guidance-improving-indoor-air-quality-office-buildings/overview.html>

These are my own comments. I hope they are constructive.

Respectfully,

