

interprovincial travel limitations in the event of a flu pandemic or a disease outbreak, as recommended in the final report of the National Advisory Committee on SARS and Public Health (CMAJ 2003;169:824).

"We are very cognizant of that recommendation but we sort of have to do it in a step-wise fashion," Njoo said, adding that such jurisdictional issues remain the subject of intergovernmental negotiations towards a Memorandum of Understanding (MOU) about public health emergency protocols and surveillance requirements.

In the absence of an MOU, the Act falls short of meeting Canadian obligations under the WHO's International Health Regulations, argues Dr. Kumanan Wilson, University of Toronto professor of medicine and health policy, management and evaluation.

Reviews of the SARS outbreak indicate information exchange from local to national levels is critical in the management of outbreaks, Wilson says.

The second issue centred on defining the federal government's legislative authority when a public health emergency is confined to a single province. Wilson says provincial officials may be reluctant to declare a public health emergency, or share information for fear of the economic consequences. "We sort of experienced that to a certain extent with SARS, when it was clear the federal government didn't get all the information that it was hoping to get. It's disconcerting."

Wilson argues the revamped Act should be embedded within a broader legislative framework that clearly states federal authority and protocols for managing outbreaks.

Wilson is also skeptical about the likelihood of an imminent intergovernmental MOU. Such an agreement has been under negotiation since 1995 and the Auditor-General has twice expressed concern. Wilson says conditional funding is needed because of the expense of surveillance and public health infrastructure. "The provinces say, 'We will perhaps agree to do all of this in exchange for you helping us develop the capacity to do all of this.' And then there's an argument over how much and what responsibilities the provinces have and that inevitably is where it runs into problems."

However, Njoo argues that an MOU is within reach. "In principle, the provinces are certainly on board. In terms of the final product, obviously, there's a little bit of a ways to go."

Moreover, a broader legislative framework articulating federal authority to oversee disease outbreaks is unnecessary, he says. In the event of an emergency, existing national security laws or "other acts of last resort" would provide Ottawa with the requisite authority, Njoo says. "I don't think we need to ever get to that type of situation" as there's a "good history of collaboration" between levels of government. — Wayne Kondro, CMAJ

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## Connection and communication vital to handling a pandemic in Ontario

If Ontario had regionalized its health care delivery system like many other provinces, would Toronto's 2003 severe acute respiratory syndrome (SARS) outbreak have been handled better? Would a decentralized and regionalized system mean better

integration and communication among the players? It's a question that has been raised by many both within and outside the Ontario system.

Ontario Health Minister George Smitherman concedes that the question "might be a fair comment," but others are more equivocal. "Maybe," says Professor Colleen Flood, scientific director of the Institute for Health Services and Policy Research of the Canadian Institutes of Health. "But the fact of regionalization itself would not have ensured a better response," she adds.

BC, which has a regionalized health system, handled the SARS outbreak more effectively than Toronto, but Dr. David Patrick, director of communicable diseases and epidemiological services for the BC Centre for Disease Control is loath to link Ontario's lack of regionalization with SARS as "causation." While there are advantages to regionalization, there are a lot of different models, he adds. "The important thing is preparedness and communication, whatever the underlying structure."

Two major reports have now indicated that communication and connection among hospitals and other health care institutions was clearly a problem in Toronto during the SARS outbreaks.

The recently released final report (CMAJ 2007;176:434-5) of the Commission to Investigate the Introduction



Every hospital had its own rules and procedures during the 2003 SARS outbreak.

and Spread of SARS in Toronto (the Campbell report), states that “A combination of robust worker safety and infection control culture at the Vancouver General, with a better systemic preparedness ensured that BC was spared the devastation that befell Ontario.”

The 2003 report of the National Advisory Committee on SARS and Public Health also noted that respondents “highlighted weaknesses in systems for communicating infectious disease alerts from public health agencies to the operational levels of the health care system. The process for issuing alerts was apparently more successful in BC.” It recommended that provinces and territories improve “linkages between public health and segments of the personal services system (hospitals, home care agencies, primary care).”

In Saskatchewan’s regionalized system, for example, the chief medical officer of health for Saskatoon’s region “sits at the table” with the chief executive officers and vice presidents of hospitals and long-term care facilities in his region. Dr. Cory Neudorf says that when SARS hit Canada, “we had a plan in place quickly. We didn’t have to build links because they were already there.”

Neudorf says when public health operated at a municipal level, as it does in Ontario, “we had our hands full dealing with local issues, bylaws.” Regionalization allows public health to become part of the continuum of care and take a population health approach to prioritizing services. New links to acute care allow public health to use its surveillance to improve the whole system’s responsiveness to, for example, influenza outbreaks.

While other provinces began regionalizing 10 or 15 years ago, Ontario is “working from the back of the pack,” says Smitherman. However, Ontario is now taking “big strides forward,” he asserts, by establishing Local Health Integration Networks (LHINS), which are “responsible for” public and private hospitals, long-term care and some other services. The province retains responsibility for public health, physicians and drug plans. The result is “much better communication than we had before,” Smitherman says, noting in particular the province’s new integrated public health information system.

But Brenda Zimmerman, a professor with the Health Industry Management Program at York University’s Schulich Business School, argues that it is “very challenging” to get improved communication and knowledge transfer within the current governance structure in Ontario. That’s because within LHINS hospital governance structures have remained intact — “essentially an extra level of bureaucracy” each with its own protocols — whereas in regionalized systems individual hospital boards are disbanded.

Zimmerman says “there is a disconnect between the front line, government and the hospitals,” yet it is at the hospital level that policies are enacted. More attention needs to be paid to sharing learning and pooling resources among hospitals, she argues.

Dr. David Walker, dean of the Faculty of Health Sciences at Queen’s University, notes that the 16 to 18 hospitals in his region each have different information systems and protocols. “We don’t have a system. It is not integrated or coordinated, not enough,” says Walker, who chaired an Ontario expert panel on SARS that reported in April 2004. “It is set up to be discordant,” like having a basketball team playing against a hockey team, he says. — Ann Silversides, Toronto

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## Cisapride class-action suit approved

**A**n Ontario Superior Court Justice has certified a class-action lawsuit against Johnson & Johnson, its Canadian subsidiary, Janssen-Ortho Inc. and the Attorney General of Canada, on behalf of Canadians who took the antireflux drug cisapride (Prepulsid).

Cisapride made headlines in March 2000 when Vanessa Young, 15, of Oakville, Ont. died of a heart arrhythmia after taking the drug to ease bloating related to bulimia. Cisapride was contraindicated for patients with bulimia.

Cisapride was pulled from the North American market a few months later. A

coroner’s jury ruled in 2001 that Young died of heart arrhythmia caused, at least in part, by cisapride toxicity. The jury made 50-plus recommendations, including mandatory reporting of adverse drug reactions by health care professionals and clear label warnings of contraindications. None of the major recommendations have been implemented.

An estimated 350 000 Canadians took cisapride. Lawyers involved in the case say thousands may have experienced adverse effects. In 2004, Johnson & Johnson agreed to pay up to \$90 million to settle US lawsuits involving more than 300 deaths and 16 000 injuries related to cisapride. The company has argued that physicians failed to properly prescribe the drug, especially to children.

The Canadian class action claims the company failed “to adequately warn Canadian physicians and their patients of the risks associated with ingesting [cisapride]” despite knowledge of serious problems, and that there was little scientific evidence the drug even worked.

The lead plaintiff, 69-year-old Aline Boulanger of Timmins, Ont. was prescribed prepulsid in 1995 and suffered chest pains and shortness of breath. She was diagnosed with ventricular tachycardia with prolonged QT interval that was linked to the use of cisapride. She continues to require heart medication.

Since Vanessa Young’s death, her father, Terrence Young, has been an outspoken advocate for drug safety reform. He says he hopes the class-action case, which is not expected to begin for a year or more (and only if litigants don’t settle out of court), will force changes in how doctors report adverse drug effects and how Health Canada manages drug safety issues.

“The delay in this case should show the federal government that the courts are a totally inadequate way to deal with prescription drug safety,” says Young.

When asked to comment, a spokesperson for Janssen-Ortho Inc. faxed a brief statement to the *CMAJ* indicating it had served notice of intent to appeal the decision and that the company believes the drug “is a safe and effective medicine when prescribed appropriately.” — Pauline Comeau, Ottawa

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