



***International Association of Fire Fighters
AFL-CIO, CLC***

Testimony before the Standing Committee
on Justice and Human Rights:
Bill C-217, the *Blood Samples Act*

February 26, 2002

Good morning,

My name is Sean McManus and I am Assistant to the General President for Canadian Operations with the International Association of Fire Fighters (IAFF).

On behalf of General President Harold Schaitberger and the more than 17,000 professional fire fighters and emergency medical services personnel we represent in Canada, the IAFF appreciates this opportunity to provide the committee with our position on Bill C-217, the *Blood Samples Act*, as this proposed legislation speaks to important health and safety issues that affect our members, who are front-line workers in the field of emergency response.

I would like to begin by thanking each of you personally, on behalf of our 245,000 members across North America, for the many kind words of condolence and support that have come from Parliament Hill in response to the loss of more than 340 members of our association in the World Trade Center attacks on September 11.

These brave professionals showed us the finest examples of selflessness and public service when they gave their lives on that day so that others might live, and we, too, continue to mourn their loss.

At the outset, we want to make it perfectly clear that the IAFF supports and advocates for fire fighters' right to know whenever there is a potential or actual exposure to any type of infectious disease. Fire fighting is dangerous enough without the added stress and threat to a fire fighter's safety by not knowing or not being able to access that vital information. As will be seen from our submission, we have some reservations as to whether the bill, as currently worded, would afford fire fighters the information in a timely manner so that an informed decision on medical treatment could be made. In that regard, we have proposed some changes to address our concerns.

Fire fighting is inherently a dangerous occupation. While most people understand that fire fighters are routinely exposed to toxic smoke and dangerous structural conditions in the course of their duties, it is also a fact that fire fighters, at fire scenes, at medical calls and while responding to vehicular accidents and other emergencies, commonly face exposure to pathogenic hazards, as they deal directly with injured victims, who may be suffering heavy blood loss due to traumatic injury or who may be carrying an infectious disease that can be transmitted through the air.

To illustrate this point, a 1998 survey of professional fire fighters showed that one in every 32 fire fighters was exposed to a communicable disease in the line of duty during that year. The most common exposures were tuberculosis, HIV/AIDS, meningitis, Hepatitis C and Hepatitis B. Ninety-nine per cent of these exposures occurred at the scene of an emergency incident, with 87.4 per cent occurring while the fire fighter responded to a medical emergency, 8.7 per cent during fire suppression activities and 2.9 per cent during victim rescue.

A victim at a fire or accident scene must be removed from danger as quickly as possible to ensure the best chance of saving his or her life. This means an emergency responder must act quickly, often without regard for their own safety. Such extrications commonly occur in difficult-to-access conditions, such as a building that has endured structural damage, or a mangled vehicle. Once extrication of the victim is complete, fire fighters may be involved in on-scene medical treatment, ranging from basic first aid intervention to the most advanced and invasive lifesaving procedures. It is during these time-critical operations that a fire fighter can be exposed to pathogenic agents and communicable diseases.

At the time of extrication and medical treatment of victims, the emergency responder almost never knows the infectious disease status of the victim. For two critically-important reasons, a fire fighter must have the right to know, as soon as possible, whether there has been exposure to an infectious disease in the course of his or her duties. The first reason is that if there has been exposure, it is extremely important that prophylactic treatment or some other appropriate medical care is initiated as soon as possible. The second reason is that the emotional stress of not knowing whether infection has occurred can become overwhelming for the fire fighter and his or her family.

In Canada, the issue of infectious disease notification is currently addressed by a federal protocol that was passed in 1995 which has been adopted at a provincial level in British Columbia, Alberta, Saskatchewan and Ontario. This protocol details the manner in which emergency responders are able to obtain information about the infectious status of an individual with whom they have come in contact during the course of their duties. These protocols apply when an emergency response worker is exposed to an individual's blood or other body fluid, through the skin or through a mucous membrane, or suffers airborne exposure in the case of tuberculosis, in the course of attending, treating, assisting, transporting or otherwise encountering an individual during the line of duty.

Pursuant to the existing federal protocol, the employer designates an officer who is either a fire, police or emergency services employee with demonstrated experience in infection control, to be responsible for coordinating requests and responses. The designated officer is bound by strict rules of confidentiality regarding the infectious diseases status of both the emergency responder and the victim. The designated officer has the responsibility of maintaining communication with the department and all community health care professionals and the local public health officer. The designated officer also has the responsibility to investigate exposure incidents, notify members of exposure, document the exposure and ensure that appropriate medical follow-up is received.

If the designated officer determines through investigation that an exposure was sustained by an emergency response worker in the line of duty, a written request can be submitted to the receiving medical facility for notification of the victim's infectious diseases status. This must be performed within 48 hours of the exposure. The receiving medical facility must have in place a procedure for responding to these requests, as well as a procedure for automatically notifying the designated officer of any emergency responders who have transported a victim found to have infectious pulmonary tuberculosis.

In turn, the fire, police and emergency services departments must have in place procedures through which an emergency response employee can make requests to the designated officer regarding an actual exposure incident, as well as procedures through which the designated officer can properly carry out his or her duty to handle all such requests regarding exposure. The current protocol allows for the receiving medical facility, if it knows the infectious disease status of the victim, to report it to the designated officer.

As opposed to the infectious disease notification protocol, which relies on blood work already in existence, the *Blood Samples Act* proposes measures for obtaining a blood sample from an individual who has refused to provide it. Putting aside constitutional considerations for a moment, if the warrant process was initiated as an extension of existing infectious disease notification protocols, many of the confidentiality concerns would be addressed. In other words, the criminal process would only be required if the medical facility did not have the necessary information or if the victim was in fact not treated at a medical facility. For this reason, those provinces who have not yet introduced infectious disease notification protocols would have to do so to ensure uniform application and protection for fire fighters and emergency medical services personnel across Canada. As it currently stands, that uniformity does not exist.

The IAFF supports language specifying that the application for processing a warrant must be initiated by the employer, through the designated officer, and not the exposed individual. Accordingly, as this issue deals solely with on-the-job exposure to infectious diseases, all costs associated with processing the warrant and obtaining the sample must be borne by the employer.

With regard to the specific wording of Bill C-217, the IAFF proposes that the term “designated virus” should be changed to “designated infectious diseases,” to specifically include infectious pulmonary tuberculosis, Hepatitis B, Hepatitis C, HIV/AIDS, diphtheria, hemorrhagic fevers, meningococcal disease, plague and rabies.

Also, the term “contact” in the proposed legislation should be replaced with the terms inhalation and “percutaneous or mucocutaneous exposure,” meaning through the skin or through a mucous membrane respectively. This language would address situations where pathogens are introduced into the emergency responder’s body as in the case of being stuck with a bloody needle, sustaining a cut with a sharp contaminated object, and the entrance of blood or body fluids through an open wound, abrasion, broken cuticle or chapped skin, as well as situations when blood or body fluid is splashed into the eye, nose or mouth. An airborne exposure means contact with an individual with suspected or confirmed airborne disease or air that may contain aerosolized airborne disease. These changes would utilize the language found in the existing infectious disease notification protocols.

The IAFF also submits that the entire issue of infectious disease notification, as addressed in Bill C-217, demands the strictest confidentiality. The infectious disease status, as

obtained through the sampling process, must be given only to the designated officer, who in turn must provide it to the exposed emergency responder. The information should also be given to the person from whom the sample was obtained. The IAFF asserts there is no reason for this information to be given to anyone else, including the peace officer who executed the warrant. For the purpose of assuring compliance, the peace officer should be informed only that the infectious status sampling, as required by the warrant, was fulfilled.

In conclusion, the International Association of Fire Fighters wholeheartedly supports a fire fighter's right to know the infectious diseases status of an individual with whom they have come in contact during the course of their duties, so that appropriate prophylactic or other treatment can begin as soon as possible and to eliminate the stress that results from not knowing. For these reasons, it is critically important that there is a system in place through which an exposed fire fighter can quickly obtain information about the infectious disease status of an individual with whom they have come in contact during the course of their duties. However, it is also important that definitions contained in legislation that proposes to address these issues are examined closely, that costs associated with the process of infectious diseases notification are borne by the employer and that issues of confidentiality are given the utmost respect during this process.

Once again, thank you for the opportunity of appearing before you this morning on an issue of great importance to our members. I would be more than pleased to answer any questions you may have.