



**Diocese of Toronto**  
Anglican Church of Canada

**A REPORT CONCERNING THE  
RISK OF TRANSMISSION OF  
CONTAGION VIA THE COMMUNION CUP  
AND OTHER LITURGICAL ACTS**

November 2003

Prepared by the SARS Working Group of the Diocese of Toronto  
Chairperson, Rev. Douglas Graydon, Co-ordinator of Chaplaincy Services  
Edited by Stephen Sword

# 1

## PREAMBLE

Toronto, as a large urban centre and transportation hub of Canada, is familiar with the health care challenges presented by the spread of viral infections. On an annual basis, public health care officials deal with everything from the common cold to the yearly arrival of each new strain of flu. In March of 2003, the city of Toronto faced a health care crisis. A new and, at that time, unknown virus was spreading throughout the community and the health care system. What made this viral infection different was the speed with which the infection spread and the high rate of mortality associated with it.

Severe Acute Respiratory Syndrome, SARS, as the mysterious illness came to be known, created fear among the citizens of Toronto as thousands of people were quarantined, hundreds were hospitalized and dozens eventually died. International travellers were alerted to the risk of visiting Toronto. Health care professionals put themselves at risk of infection as they cared for the ill and searched for treatments. By the time the crisis was declared over, 43<sup>1</sup> people had died from SARS. The experience exhausted the resources of Toronto's health care system and shook the economy of the city.

In April of 2003, the Archbishop of Toronto directed parishioners to refrain from two traditional liturgical practices: sharing the communion cup and shaking hands as part of exchanging the peace of Christ. This direction was in response to the extreme caution being encouraged by public health officials at that time regarding any and all public interaction by citizens of Toronto.

In addition, Archbishop Finlay established a working group of infectious disease professionals, other health care professionals, laity and clergy to review current practices of worship in terms of risk of transmission of disease.

That working group has produced this report. It reviews current applicable literature, identifies the place of liturgy in a world of risk, suggests changes in current liturgical practice and includes educational material for parishes. Membership included:

Committee Chair: Rev. Douglas Graydon, Co-ordinator of Chaplaincy Services

Committee Members: Canon Eric Beresford, National Church Office

Rev. Kenneth Davis, All Saints, Whitby

Rev. John Hill, Doctrine and Worship Committee

Alison Knight, CAO, Diocesan Centre

Stuart Mann, Editor, [The Anglican](#)

Gloria Wiebe, Parish Nurse, St. James' Cathedral

Rev. John Wilton, Liturgy Canada

Consultants: Susan Edwards, Assistant Professor of Nursing, Ryerson University

Dr. Michael Gardam, Infectious Diseases, University Health Network

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<sup>1</sup> As of August 18, 2003, 43 people in the Greater Toronto Area had died of SARS. This included two nurses and one physician.

## 2

## WHAT SCIENCE TELLS US ABOUT THE RISK OF TRANSMISSION

The investigation of the possibility of transmission of disease centres on two features of public worship within a parish: the communion (or common) cup and the exchange of peace with a handshake. In this post-SARS era, it is instructive to review what science tells us about the risk of transmission as we have learned more precise details about transmission.

It is important to remind ourselves that the absence of evidence is not a rationale for the drawing of conclusions. It is commonly thought that because there is no evidence or history of higher than normal rates of illness among clergy, therefore, the common cup is not a source of transmission or infection. Only by tracking longitudinally rates and occurrences of disease, **as linked to the specific behaviour of sharing the common cup**, can a conclusion be drawn as to the degree of risk of contagion.

### THE COMMON CUP:

Questions were raised as far back as the late 1800's as to whether the common cup was a significant source of contagion. In 1894, the Philadelphia County Medical Society, U.S.A., suggested the use of individual communion cups in all Christian Churches.<sup>2</sup> More than 70 years later, a Canadian study in 1967<sup>3</sup> concluded that bacteria can survive on the surface of the chalice and that the sharing of a common communion cup should be understood to be an effective vehicle for the transmission of infectious agents. In 1987, two British articles addressed concerns of transmission in general<sup>4</sup> and, in particular, concern regarding the transmission of HIV/AIDS.<sup>5</sup> Both concluded that while sharing the common cup may transfer bacteria, transmission **does not** imply infection.

A controlled study in 1995 found that the practice of intinction<sup>6</sup> did **not** increase the risk of transmission when the individual communicant intincted. However, the risk **did** increase if the communion minister intincted for communicants.<sup>7</sup> This 1995 report focused concern (substantiated by evidence) that the inadvertent contact of the intinctor's finger tips with the shared wine heightened the risk of disease transmission because of the possible presence of microscopic fecal matter and other pathogens. This heightened risk to all communicants could be offset if the intinctor's hands were thoroughly cleaned immediately before administration.

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<sup>2</sup> Loving, Anne LeGrange: A controlled study on intinction: A safer method for receiving Holy Communion, *Journal of Environmental Health*; Denver, Jul 1995.

<sup>3</sup> Gregory KF, Carpenter JA, Bending GC: Infection Hazards of the common communion cup. *Can. J. Public Health* 1967: 58:305-310.

<sup>4</sup> Gill, Noel, O.: The hazard of infection from the shared communion cup. *The British Society for the Study of Infection*; 0163-4453/88.

<sup>5</sup> Gould, David: Eucharistic Practice and the Risk of Infection; submitted to the Doctrine and Worship Committee, National Anglican Church of Canada, April 1987, revised 1999.

<sup>6</sup> Loving, Anne LeGrange: A controlled study on intinction: A safer method for receiving Holy Communion, *Journal of Environmental Health*; Denver, Jul 1995.

<sup>7</sup> Loving, Ann LeGrange: *Ibid*.

Research also indicates that the wiping of the chalice with a purificator can reduce residual bacterial contaminants. Some studies suggest the elimination of up to 90% of contaminants.<sup>8</sup> An even higher percentage is attainable with the use of sterilized purificators, if replaced frequently during communion.

Therefore, from a scientific point of view (as reflected in this brief survey of applicable literature) the common cup is or can be a route of transmission for disease. This includes both the sharing of the cup and the practice of intinction.

Anecdotal evidence, as we are often reminded, is not scientific evidence, but the experience of Diocesan clergy is included here as a worthwhile final observation. Clergy report that some communicants do (either inadvertently or deliberately) dip their fingertips into the wine during intinction. One cleric indicated that one communicant dipped the wafer so that it would touch the bottom of the chalice. Intinction involves a significant risk of contagion for two reasons: first the communicant's exact actions are almost impossible to predict or prevent, and secondly, no cleansing option is available before the next communicant participates.

### **THE EXCHANGING OF THE PEACE:**

Actual scientific studies regarding hand to hand transmission of contagion do not form a part of this particular section of the investigation into what science can tell us about risks in liturgical practices. However, as Dr. Michael Gardam (consultant to this report) reminds us: "Viruses and germs live on our hands and can be easily passed from surface to surface. They can't hurt you while they remain on your hands, but how many times do you touch your mouth, nose or rub your eye during the day? That's when you introduce the virus or bacteria into your system."<sup>9</sup> Some viruses, of course, are spread through the air, the result of coughing and sneezing.

Within the framework of public worship, there are clearly many opportunities for transmission, whether through touch or air-borne. Current scientific knowledge allows us to understand that some viruses (influenza, Norwalk, SARS) can live for days if not weeks. Within liturgical spaces, then, pews, service books, communion rails all become possible sites for transmission of contagion.

As Associate Professor Susan Edwards (consultant to this report) advises: "The human immune system can normally defend itself from infections spread this way. However, when the immune system is compromised due to prolonged illness, age or exhaustion, then the handshake, used commonly within the liturgical exchanging of the peace, can become a route of contagion."<sup>10</sup>

From a scientific point of view, then, it is clear that handshaking, embracing or exchanging a kiss of peace are all possible routes of contagion. Realistically, gestures of caring (as well as uncontrolled sneezing or coughing, as unintentional as they may be) require scrutiny in this post- SARS world.

### **CONCLUSIONS ABOUT DEGREE OF RISK:**

A combination of current literature and expert medical advice leads us to these conclusions:

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<sup>8</sup> Loving, Anne LeGrange: Ibid.

<sup>9</sup> Interview with Dr. Michael Gardam, Infectious Disease specialist, University Health Network, May 2003.

<sup>10</sup> Interviews with Susan Edwards, Professor of Nursing, Ryerson University and Dr. Michael Gardam, Infectious Diseases, University Health Network, May/June 2003.

- 1) **sipping** from the common cup represents a **minimal risk** of transmission of contagion;
- 2) sharing a **handshake** in the exchange of the peace presents a **minimal risk** of transmission of contagion.

**Both of these activities fall within the parameters of the normal risks of daily living.** The level of risk compares to any of the following daily behaviours: shaking hands with a neighbour, attending a buffet dinner, sharing a cup or utensils, attending the theatre or welcoming a friend with a hug or kiss.

Obviously, none of these activities is totally risk free. Neither is sharing the common cup or exchanging the peace.

- 3) **The practice of intinction can be perceived as a higher risk activity.** Fingertips of intinctors may contaminate the shared wine with pathogens other than those found in saliva.

**POSSIBLE INTERVENTIONS:**

With the heightened awareness since the SARS crisis concerning transmission of disease, it may seem that these two liturgical practices (the sharing of the common cup and the exchange of peace) are “under fire.” “Under scrutiny” is probably more accurate. **We submit that there are interventions, which can be adopted in Anglican liturgies, which can reduce the risk of transmission of disease.** These interventions appear in section Six of this report.

It is important first to explore, within the context of SARS and the transmission of contagion, how risk (or the perception thereof) influences our activities; secondly, to remind ourselves of what we understand our liturgies to mean; and thirdly, to explore our understanding of the history and place of intinction within the church.

<b>3</b>	<b>CONFRONTING RISK</b>
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SARS 2003, reminded us of the power of infectious disease. It brought sickness and death which disrupted the lives of our families and catalyzed fear which fractured our communities.

For many years now, infectious diseases have appeared to be under control. In some ways this control has been deceptive. Infectious disease specialists have repeatedly warned us that the appearance of new and serious infectious illnesses is inevitable. Such warnings remind us that we live in a world of uncertainty and risk-taking.

Fear is a natural and human response to what we do not know or understand. Avoiding risk is the precautionary behaviour fuelled by fear. Fear can all too easily break communities and isolate particular groups or individuals. In times of fear, it is important that the church remembers its

vocation to be witness to the possibility of a new and inclusive community where all people may hear and respond to the grace of God, a place where people may gather in order to overcome the fear of taking a risk.

A healthy response to the emergence of new fear or risk requires several factors. First, we need to be informed, in a reliable and timely manner, about the true nature and extent of the risk we face. This would be helped by more effective communication and co-operation between health authorities and the church. Secondly, we need to be informed about what activities and behaviours are genuinely risky. Although early information about any new illness is always incomplete, we do have a great deal of information from our earlier experiences with infectious diseases. For example, we know that medical studies indicate that there is always the risk of infection from the use of the common cup but that this risk is minimal and normative in our world. We also know that the handshake is a route for contagion. Yet we accept such a risky behaviour because the benefits of such an act far outweigh the risks. In fact, it appears that the most dangerous things we do together, as a faith community, are the things that all groups of people do. We gather, we touch each other, and we touch surfaces used by everyone, such as door handles or handrails.

Thirdly we need to be able to recognize those risks that must be accepted and those which can be avoided. (When the fear of risk grows out of bounds, it becomes a prison that constrains our lives and a barrier to relationships with others and with God.)

Eliminating all risk is impossible; human life is full of risks. Our witness of faith is one which embraces risk. Jesus risked his life in loving God, teaching us that when we live as a community of faith, we can embrace fully the risk of living within our world. Our faith in God allows us to move forward with the understanding that while we as a community cannot escape risk, we possess those virtues required to face risk: wisdom, compassion, generosity, courage, love and faith.

<b>4</b>	<b>LITURGY</b> What are we doing that is risky and why does it matter?
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Gathering at the Lord's table, Sunday by Sunday, is a central act of Christians which summons us to remember what happened in the life of Jesus and to remember it in the particular way he invited us to.

This offer of a new way of being human together, participating in God's kingdom, met misunderstanding, resistance and violent rejection. He chose to accept, trusting that God would use his suffering and death to unlock the cycle of violent resistance to God's will. Our participation in the Eucharist identifies our solidarity with Jesus who gave his life for the life of the world.

Solidarity takes two forms. If we choose to "circle the wagons," we consciously, deliberately exclude risk and danger. But if we choose to "circle the altar," we welcome into our community the very one we had excluded because we considered him dangerous. We now understand Jesus has returned to

offer us forgiveness and reconciliation. We remember, recognize and resolve, risking – for the sake of love – rather than safely excluding those who frighten us.

Honouring our commitment does not, of course, require meaningless risks. The risk of love and faith – the spiritual, meaningful reminders of Christ’s invitation to remember him symbolically – is of higher priority than the fear of violence, danger and loss (the pragmatic). Sharing bread and wine with him becomes a strong collective “no” to the voices of pragmatism, fear and avoidance, (the voices that encourage us to collective amnesia rather than collective remembrance).

Any attempt to reshape the liturgy must be judged by this alone: Do the changes maintain and enhance our collective remembrance and help us to live with a truer awareness of Jesus and his venture of love? The example of the health care workers during the 2003 SARS crisis is instructive. They did not choose to avoid all risk. They took unavoidable risks (in some cases paying with their lives) in order to care for those suffering from or suspected of having SARS.

**Our** calling as Christians entails risks too; and our liturgy of faithful remembering must not make the avoidance of all risk the primary criterion – that would mean avoiding any authentic celebration of the Eucharist. After all, this gathering at table is of no practical use whatever (a morsel of bread, a sip of wine do nothing to fill the belly). But at the symbolic level, the bread and wine are food for life, a meal of hope, a banquet “rich in delights and suited to every taste” (*Wisdom 16:20*). Whenever we forget the symbolic nature of the Eucharist and are tempted to be merely practical (even for the sake of avoiding risk), we run the greater risk of losing the symbol altogether and slipping again into a ritual of collective amnesia.

<b>5</b>	<b>RECEIVING THE HOLY SACRAMENT BY INTINCTION AND OUR PRACTICE OF FAITH IN THE FUTURE</b>
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**ORIGIN:**

“Intinction” originally referred to the practice of dipping consecrated bread into consecrated or unconsecrated wine for one reason only: a communicant who was ill could consume it more easily. Intinction, therefore, formed no part of public worship attended by healthy parishioners.

**HISTORY:**

In the early church, we know there were others who were not physically ill who wished to receive the sacrament in this way. They may have been following a localized practice in the ancient church. They may have adhered to an early Roman Catholic belief that dipping consecrated bread into unconsecrated wine exercised a “consecratory effect on the unconsecrated wine.” **More than once**, the Church Catholic has banned this practice by those who were not ill. By 1200 C.E., intinction of **every kind** had virtually disappeared.<sup>11</sup>

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<sup>11</sup> W.H. Freeseone, *the Sacrament reserved*(1917; Alcuin Club Collections, XXI), ch. x. M. Andrieu, *Immixtio et Consecratio*, La consecration part contact dans les documents liturgiques du moyen age (1924).

## **PRESENT:**

Intinction within our Anglican tradition is a recent revival, not a longstanding practice. Many parishes reserve consecrated elements for eucharistic use in institutions or private homes where parishioners who cannot attend public worship reside. The communion minister, in these cases, has possibly thought that intinction offered a more hygienically sound method of offering the sacrament.

Within public worship, some communicants have been choosing to hold onto the bread/wafer until the common cup is offered. By dipping, the intinctors may, if displaying clear symptoms of an illness, feel that fellow communicants will feel less exposed to the illness. Equally, intinctors may, if clearly healthy, assume that they are better protecting themselves from the illness of others. Both of these behaviours are now known to be based on incorrect assumptions.

Within our tradition then, we currently see intinction practised in two ways: 1) for the sick, infirm or immobile (aligning with the original justification for intinction); 2) for communicants in public worship (whose choice of communicating this way has neither traditional nor hygienic justification).

## **ANGLICAN TRADITION:**

The original preface to our Book of Common Prayer, 1549, reminds us that our ancestors in faith turned attention to the question “*Of Ceremonies why some should be abolished and some retained. ... We think it convenient that every Country should use such Ceremonies as they shall think best to the setting forth of God’s honour and glory, and to the reducing of the people to a most perfect and godly living, without error or superstition.*” Obviously, the message is from an ancient time but the import is clear. The Church is obliged to take stock of where it is at any given time as regards liturgical practice. In this post-SARS world, we suggest that there is a clear need to choose worship practice that reduces *error*, (based on increasingly precise medical knowledge), encourages communal well-being (as opposed to personal liturgical preference) and increases our life of faith in ways most in keeping with Christ’s commands.

## **THE IMPORTANCE OF THE COMMON CUP:**

In our public worship, Anglicans seek to praise, meet and follow God in Jesus Christ. Specifically, in Anglican liturgies, we offer “ourselves, our souls and bodies” to God. Our holistic, obedient approach to God involves a great act of faith and trust, with God and with each other. We participate, faithfully re-enacting the sharing of the original cup, trustfully engaging with other worshippers who serve one another. The sharing in the broken bread and common cup symbolizes our trustful union with Christ and his Church. Not to be able to share in this way would remove a crucial feature of Anglican liturgical practice.

## **FUTURE:**

Our devotion to the sharing of the common cup is central to our liturgy. Nevertheless, we are obligated not to be careless in our worship practice. Having sought expert advice, we are prepared to propose the following:

- 1) We must thoughtfully incorporate medical advice into our liturgical practice.
- 2) We must respect our faith tradition and current liturgical practices, unless the proposal mentioned above reveals them to be unsafe.

- 3) Public and even ritualized sanitizing of the hands of all leaders and worshippers is a reasonable expectation as we continue to obey Christ’s command to “do this in memory of me.”
- 4) We must pay close attention to the information based upon current infectious disease principles and public health practice that suggests that disease transmission risks would decrease if we discontinued the practice of intinction altogether.
- 5) We must continue to follow Christ’s command to partake of the Cup of Blessing as an act and statement of unifying faith.

**RECOMMENDATION:**

- 1) **That the Diocese of Toronto develop and institute clear policies discontinuing the act of intinction as relates to public worship.**

<b>6</b>	<p><b>RESPONSE OF THE CHURCH</b></p> <p>Principles of infection, the chain of infection, and suggested interventions</p>
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SARS is the most recent and serious manifestation of contagious disease. Although we have known for centuries that communicable diseases exist, until recently we have not sufficiently understood the degree to which contagious transmission is possible in all sorts of activities of daily living. When liturgical practices involve known health risks, the challenge for the Church is to strike a balance between liturgical acts and good health.

What does the Church know? Current literature teaches us that the risk of transmission of contagion via the common cup and the exchange of peace is minimal. No research is available to identify what is meant by “minimal risk.” If the Church were to invest time and resources in research to determine what constitutes “minimal risk,” the task would necessarily be time-consuming and costly. It would require tracking hundreds, if not thousands of Anglicans, documenting when, where and how they contracted communicable diseases. Such a study might then determine whether the sharing of the common cup involved a more significant risk for disease transmission than, for example, sitting in a doctor’s waiting room with other ill persons. Such research, arguably quite worthwhile, does not provide us with helpful evidence in our current need for a timely response in these brief months after the SARS crisis of 2003.

What the Church does know is precise information based on basic infectious disease principles and community health practices. To reduce or eliminate the transmission of contagion, we need to understand the science of transmission, the behaviours involved which either promote or hinder transmission and the interventions which are most effective at reducing risk.

## **TRANSMISSION: The Chain of Infection**

The image of a chain<sup>12</sup> is useful in discussing transmission of infection. The individual links are the contact points which allow for the spread of contagion from one site to another, from one person to another. Breaking just one of those links stops the spread of the disease.<sup>13</sup>

This chain of infection operates on two levels: macrobiological and microbiological. To infect a person, a virus must come into contact with the person on both levels.

For example, a virus from one parishioner's hand ends up on the handrail as she/he walks up the sanctuary steps. The virus lives on the handrail long enough to be transmitted to a second parishioner who touches the handrail seconds later. On the physical (macrobiological) level, the virus has now spread to another person. This constitutes one link. However, the chain of infection is not completed until the second link occurs. This second (microbiological) level of contact would, in fact, occur if the second parishioner had a small cut, open sore or other microscopic break in the skin, allowing the virus to enter her/his bloodstream.

## **BREAKING THE CHAIN:**

The first chance to break the chain appears when everyone is actively aware of the "risk of exposure." If a parishioner has recently been visiting a hospital, or works in a health care setting, or has been in close contact with ill people, he/she can break the chain by choosing behaviour **before** public worship that will drastically reduce the potential for infectious exposure. Handwashing after visiting the hospital, wearing latex gloves while working with ill people or using anti-microbial hand rinse immediately before Sunday worship are all behaviours this parishioner can adopt, behaviours that can become norms, based on awareness of the risk of exposure and on knowledge of the mechanics of transmission.

## **PATTERNS OF BEHAVIOUR:**

The specific behaviours alluded to in the last paragraph require deliberate consciousness. Other behaviours exist in a more generalized way, behaviours that illustrate clearly the degree to which we all truly are creatures of habit. We drift along until it becomes necessary to alter what we are doing. We sit in the same pew each Sunday, walk the same route for exercise, turn to our favourite section of the paper first – all of these behaviours produce comfort and pleasure and are benign. Other patterns of behaviour may not be. Drinking straight out of a shared milk or juice container in the refrigerator (instead of using a glass), enjoying a relaxing couple of glasses of wine (before driving to an evening meeting), removing cooked food from a microwave (without using oven mitts) – all of these behaviours **may** produce desired results but may also produce infection in the one case or injury in the others.

Within the liturgical context, we must carefully observe two behaviours. Sharing the common cup is a behaviour with a long and important tradition which produces comfort and unity within **the faith** community.<sup>14</sup> It is also a common route of transmission of contagion. Shaking another parishioner's

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<sup>12</sup>Susan P. Korn, Judith Lux: Infection Control for Nursing Students: Chain of Infection, an explanation., Truman College, copyright 2001.

<sup>13</sup>Pyrek, Kelly: Breaking the Chain of Infection, Infection Control Today, July 2002.

<sup>14</sup>It is an act of communal worship which is a fundamental witness to who we understand ourselves to be as Christians.

hand during the exchange of the peace is a wonderfully symbolic behaviour that we count on to give us a sense of community. It is also a common route of transmission of contagion.

In order to reduce the risk of transmission, we must examine these behaviours. We must determine how to **change** the behaviour itself (for example, we might eliminate the handshake during the exchange of the peace) or how to **modify** the behaviour in an effort to reduce the risk of transmission of contagion.

### **APPROPRIATE AND EFFECTIVE INTERVENTIONS:**

It is beyond the mandate of this working group to recommend changes within the Anglican liturgy as it currently exists. Therefore our focus becomes the introduction of precautions which can reduce the risk of transmission within those behaviours identified as significant routes of transmission. These behaviours are: the common cup and the exchange of peace.

#### **THE COMMON CUP:**

Effective interventions, concerning the sharing of the communion cup, are those which would reduce or eliminate residual pathogens on the rim or other surfaces of the chalice. The traditional wiping of the chalice with a purificator can remove significant amounts of these residual pathogens. However, changes can be made to current practice, which will increase the amount of pathogen eliminated, thereby reducing risk of transmission.

The risk of transmission can be reduced by:

- 1) ensuring that chalices are cleaned properly, preferably sterilized or cleaned with an anti-microbial rinse, and stored within sealed containers between use;
- 2) sterilizing purificators and storing them in sealed containers between use;
- 3) replacing purificators frequently during communion (possibly every 4 to 5 communicants);
- 4) changing the chalice half way through communion (if a parish has more than one chalice) thereby reducing the number of communicants who share any one chalice;
- 5) having communion ministers exercise extreme care when wiping the chalice to ensure effective cleansing;
- 6) having all communion ministers wash their hands thoroughly with an anti-microbial rinse immediately before commencing administration. This can be accomplished discreetly at the side of the sanctuary.

#### **INTINCTION:**

**Intinction remains a viable practice as relates to the private administration of the sacraments to those who are ill or infirm. But within the context of public worship, it should be discontinued since it involves the unavoidable additional risk brought about by the contact of fingers with the shared wine.**

#### **THE EXCHANGING OF THE PEACE:**

The handshake is the most common form of recognition and greeting within our society today. It is unrealistic to discourage or discontinue the act of shaking hands both within the parish in general and within the practice of worship.

The risk of transmission can be reduced by:

- 1) encouraging ill or ailing parishioners to refrain from attending public worship;
- 2) encouraging parishioners who are sneezing or coughing to use a tissue;
- 3) encouraging parishioners to use an anti-microbial hand rinse before attending worship;
- 4) requiring all clergy, lay readers, greeters or any person who has a role within the worship service to use an anti-microbial hand rinse before worship services begin.

**Such interventions will not eliminate the transmission of pathogens; however, they can reduce significantly the risk of contagion.**

**RECOMMENDATIONS:**

- 1) **That the Diocese, in consultation with appropriate infectious disease specialists, develop a protocol for the handling, cleaning and storage of the chalice and purificators used for worship. This would include a protocol for the administration of the common cup, e.g. the rotation of more than one chalice, the use of purificators, etc.**
- 2) **That the Diocese, in consultation with appropriate infectious disease specialists, develop a protocol regarding the recommended use of anti-microbial rinses within the context of public worship.**

<b>7</b>	<b>EDUCATION</b>
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Education and the dissemination of information are vital tools in the fight against the spread of disease. Consistent and reliable information will be foundational in the establishment of a common threshold of practice, which can reduce the risk of transmission of disease and diminish anxiety or fear among Anglicans.

The working group suggests the following:

- 1) That this document form the basis of new clergy orientation as relates to this issue and that the Co-ordinator of Chaplaincy facilitate a session focusing on this issue;
- 2) That the text of this document be made available to all clergy and laity of the Diocese via such mechanisms as web-sites, pamphlets and summary sheets;
- 3) That the attached example of a pamphlet and the summary be approved by the College of Bishops for distribution within the Diocese;
- 4) That a communications plan be developed in consultation with the Director of Communications and implemented by the Co-ordinator of Chaplaincy.

# 8

## RECOMMENDATIONS TO THE DIOCESE OF TORONTO

The following are recommendations to the Diocese of Toronto based upon the findings of this document:

- 1) That a working group of Diocesan staff and health care professionals be established to design a protocol which would allow for a rapid response to questions and concerns of public health in urgent or critical public health situations;
- 2) That this protocol allow for and maintain an informal network of relationships with public health officials, infectious disease specialists and community health professionals so that regular and timely information is shared, as relates to this matter;
- 3) That all clergy receive information outlining the “science” of transmission so that there is a common level of knowledge and information throughout the Diocese;
- 4) That the orientation of all new clergy include education on this issue;
- 5) That a “liturgical protocol” be developed which establishes a threshold of common practice throughout the Diocese as relates to the use, cleansing and storage of chalices and purificators;
- 6) That a clear directive be given discontinuing the practice of intinction within public worship (for example, the Diocese of Niagara has instructed clergy to end the practice of intinction during parish worship).